



Office of the Family and Children's Ombuds

An Independent Voice for Families and Children

2018 Annual Report

Patrick Dowd, *Director*

ofco.wa.gov

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To the Residents of Washington State:

I am pleased to submit the 2018 Annual Report of the Office of the Family and Children's Ombuds. This report provides an account of OFCO's activities from September 1, 2017 to August 31, 2018. OFCO thanks the parents, youth, relatives, foster parents, professionals and others who brought their concerns to our attention. We take their trust in our office most seriously.

During this reporting period, OFCO received 901 complaints, and completed 923 complaint investigations regarding 870 families. As in 2017, the separation and reunification of families and agency conduct and services were by far the most frequently identified issues in complaints. In addition to complaint investigations, OFCO monitors practices and procedures within the child welfare system and makes recommendations to better serve children and families. Systemic issues discussed in this report include:

- The ongoing use of hotels as emergency placements for children in state care and the need for a continuum of placement resources;
- Foster care and involvement in the criminal justice system;
- Meeting the educational needs of youth in out of home care; and
- Enhancing parent-child and sibling visits.

In July 2018, the Department of Children Youth and Families (DCYF) assumed the duties and responsibilities of the Department of Early Learning and Children's Administration. In 2019 Juvenile Rehabilitation will also join DCYF. Integrating early learning, child welfare and juvenile justice in one agency will better align services and improve outcomes for children and families. The DCYF will be data driven with specific outcome measures related to child safety and well-being. Legislation establishing the DCYF also creates an independent Oversight Board to increase transparency and ensure that the DCYF achieves the stated outcomes and complies with laws, rules, policies and procedures pertaining to early learning, juvenile rehabilitation, juvenile justice, and children and family services. Restructuring our child welfare system presents a unique opportunity to improve service delivery and outcomes for children and families.

On behalf of all of us at the Office of the Family and Children's Ombuds, I want to thank you for your interest in our work. I am grateful for the leadership and dedication of those working to improve the welfare of children and families and for the opportunity to serve the residents of Washington State.

Sincerely,

Patrick Dowd, JD
Director Ombuds

EXECUTIVE SUMMARY

The OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS (OFCO) was established by the 1996 Legislature to ensure that government agencies respond appropriately to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. The office also promotes public awareness about the child protection and welfare system, and recommends and facilitates broad-based systemic improvements.

This report provides an account of OFCO's complaint investigation activities from September 1, 2017, through August 31, 2018, as well as recommendations to improve the quality of state services for children and families.

CORE DUTIES

The following duties and responsibilities of the Ombuds are set forth in state laws:¹

Respond to Inquiries:

Provide information on the rights and responsibilities of individuals receiving family and children's services, juvenile justice, juvenile rehabilitation, and child early learning, and on the procedures for accessing these services.

Complaint Investigation and Intervention:

Investigate, upon the Ombuds' own initiative or receipt of a complaint, an administrative act alleged to be contrary to law, rule, or policy, imposed without an adequate statement of reason, or based on irrelevant, immaterial, or erroneous grounds. The Ombuds also has the discretion to decline to investigate any complaint.

System Oversight and Improvement:

- Monitor the procedures as established, implemented, and practiced by the Department of Children, Youth, and Families (DCYF) to carry out its responsibilities in delivering family and children's services to preserve families when appropriate and ensure children's health and safety;
- Review periodically the facilities and procedures of state institutions serving children, and state-licensed facilities or residences;
- Review child fatalities and near fatalities when the injury or death is suspected to be caused by child abuse or neglect and the family was involved with the Department during the previous 12 months;
- Recommend changes in law, policy and practice to improve state services for families and children; and
- Review notifications from DCYF regarding a third founded report of child abuse or neglect, within a twelve-month period, involving the same child or family.

¹ RCW 43.06A and RCW 26.44.030.

Annual Reports:

- Submit an annual report to the DCYF Oversight Board and to the Governor analyzing the work of the office, including recommendations; and
- Issue an annual report to the Legislature on the implementation status of child fatality review recommendations.²

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2017 and August 31, 2018, OFCO completed 923 complaint investigations regarding 870 families. As in previous years, issues involving the separation and reunification of families were by far the most frequently identified complaint issues. The conduct of DCYF staff and other agency services comprised the next-highest categories of issues identified in complaints.

OMBUDS IN ACTION

OFCO takes action when necessary to avert or correct a harmful action or oversight, or an avoidable mistake by DCYF. Eighty-four complaints prompted intervention by OFCO in 2018. OFCO provided substantial assistance to resolve either the complaint issue or a concern identified by OFCO in the course of its investigation in an additional 39 complaints.

In 2018, OFCO made 40 formal adverse findings against DCYF. OFCO provides DCYF with written notice of adverse findings resulting from a complaint investigation. DCYF is invited to respond to the finding, and may present additional information and request a revision of the finding. This process provides transparency for OFCO's work as well as accountability for DCYF.³

WORKING TO MAKE A DIFFERENCE

Ongoing Placement Crisis Leaves Children Sleeping in Hotels

The number of children requiring out-of-home care has increased.⁴ As a result of limited placement resources, children in state care have been placed in hotels or Department offices, waiting for the Department to find an appropriate placement. This report describes 1,090 "placement exceptions" involving 195 children. OFCO found that this is primarily a regional concern, occurring most frequently in DCYF Regions 3 and 4. The ongoing practice of placing children in hotels indicates a shortage of foster homes and therapeutic placements. This report discusses recommendations for addressing this placement shortage, including:

- Provide an adequate supply and range of residential placement options to meet the needs of all children in state care; and
- Expand programs that support foster and kinship families and prevent placement disruptions.

² Child Fatalities and Near Fatalities in Washington State, August 2017. Available at: <http://ofco.wa.gov/wp-content/uploads/2017-OFCO-Critical-Incident-Report-.pdf>

³ An inter-agency agreement between OFCO and CA was established in November 2009.

⁴ Partners for Our Children Data Portal Team. (2017). [Graph representation of Washington state child welfare data 9/27/2017]. Children in Out-of-Home Care (Count). Retrieved from <http://www.vis.pocdata.org/graphs/ooh-counts>

Foster Care and the Criminal Justice System

Children with a history of involvement with the child welfare system have a high likelihood of coming into contact with the juvenile justice system. Frequent placement changes while in foster care are associated with an increased risk of juvenile delinquency. Additionally, youth exiting foster care are more likely to become involved in the criminal justice system. In reviewing information on hotel stays, OFCO observed occasions where law enforcement was called as a method for controlling a child's behaviors or attempting to coerce the child into doing something, such as leaving a hotel room or going to school.

Placement Instability and Education Challenges

Children in foster care typically make more unscheduled school changes than peers not in foster care. Recognizing the importance of supporting education and school success, state and federal law as well as DCYF policies, set forth requirements for meeting the educational needs of children in foster care. While keeping children in a placement where they can maintain their school enrollment is a high priority, a shortage of available placements means that youth often end up placed far away from their school. When a child's placement is disrupted and/or they are moving to new placements on a nightly basis, there are unique challenges to transporting and maintaining a child in school. This report summarizes observations from OFCO's review of placement exceptions that highlight the work of the Department and the challenges of enrolling and keeping these youth in school.

Parent-Child and Sibling Visitation

Visits between parents and children help maintain the parent-child bond and are necessary for parents to regain custody of their children after they are placed in out-of-home care. Concerns about visitation are one of most frequent complaints received by OFCO. OFCO received 116 complaints alleging the Department was not providing appropriate visitation for parents and/or other relatives of the child, as well as 13 complaints that the Department was not ensuring appropriate contact between siblings in out-of-home care. This report discusses recommendations that the Department continue stakeholder training efforts on child safety and parent-child visitation, and establish a framework to identify families that do not require supervised visits.

The Department of Children, Youth, and Families

On July 1, 2018, Children's Administration and the Department of Early Learning formed the Department of Children, Youth, and Families. This realignment of state agencies represents a fundamental change in the delivery of child welfare services with a focus on prevention, measurable outcomes, transparency and oversight. OFCO's duties expanded to provide information to individuals receiving juvenile justice, juvenile rehabilitation, and child early learning services. OFCO is also working to establish the Oversight Board for Children Youth and Families, which is comprised of legislators and representatives from external stakeholder groups, and provides unprecedented accountability and guidance for our child welfare system.

THE ROLE OF OFCO

The Washington State Legislature created the Office of the Family and Children’s Ombuds⁵ (OFCO) in 1996 in response to two high profile incidents that indicated a need for oversight of the child welfare system.⁶ OFCO provides citizens an avenue to obtain an independent and impartial review of Department of Children, Youth, and Families (DCYF) decisions regarding children and families involved with the child welfare system due to allegations of child abuse or neglect. OFCO is also empowered to intervene to induce the Department to change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and to recommend system-wide improvements to the Legislature and the Governor.

- **Independence.** One of OFCO’s most important features is independence. OFCO’s ability to review and analyze complaints in an independent manner allows the office to maintain its reputation for integrity and objectivity. Although OFCO is organizationally located within the Office of the Governor, it conducts its operations independently of the Governor’s Office in Olympia. OFCO is a separate agency from DCYF.
- **Impartiality.** The Ombuds acts as a *neutral investigator* and not as an advocate for individuals who file complaints, or for the government agencies investigated. This neutrality reinforces OFCO’s credibility.
- **Confidentiality.** OFCO must maintain the confidentiality of complainants and information obtained during investigations. This protection makes citizens, including DCYF professionals, more likely to contact OFCO and speak candidly about their concerns.
- **Credible review process.** OFCO has a credible review process that promotes respect and confidence in OFCO’s oversight of DCYF. Ombuds are qualified to analyze issues and conduct investigations into matters of child welfare law, administration, policy, and practice. OFCO’s staff has a wealth of collective experience and expertise in child welfare law, social work, mediation, and clinical practice and is trained in the United States Ombudsman Association Governmental Ombudsman Standards. OFCO and DCYF operate under an inter-agency agreement that guides communication between the two agencies and promotes accountability.⁷

AUTHORITY

Under chapter RCW 43.06A, the Legislature enhanced OFCO’s investigative powers by providing it with broad access to confidential DCYF records and the agency’s computerized case-management system. It also authorizes OFCO to receive confidential information from other agencies and service providers,

⁵ State law requires that all statutes must be written in gender-neutral terms unless a specification of gender is intended. Pursuant to Chapter 23 Laws of 2013, the term “ombudsman” was replaced by “ombuds”.

<http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Session%20Laws/Senate/5077-S.SL.pdf>

⁶ The death of three year old Lauria Grace, who was killed by her mother while under the supervision of the Department of Social and Health Services (DSHS), and the discovery of years of sexual abuse between youths at the DSHS-licensed OK Boys Ranch. The establishment of the office also coincided with growing concerns about DSHS’ role and practices in the Wenatchee child sexual abuse investigations.

⁷ The inter-agency agreement is available online at http://ofco.wa.gov/documents/interagency_ofco_dshs.pdf

including mental health professionals, guardians ad litem, and assistant attorneys general.⁸ OFCO operates under a shield law which protects the confidentiality of OFCO's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation. Additional duties have been assigned to OFCO by the Legislature over the years regarding the reporting and review of child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment.⁹

OFCO derives influence from its close proximity to the Governor and the Legislature. The Director is appointed by and reports directly to the Governor. The appointment is subject to confirmation by the Washington State Senate. The Director-Ombuds serves a three-year term and continues to serve in this role until a successor is appointed. OFCO's budget, general operations, and system improvement recommendations are reviewed by the DCYF Oversight Board.

WORK ACTIVITIES

OFCO performs its statutory duties through its work in four areas, currently conducted by *six employees* with an annual budget of \$670,000.

- **Listening to Families and Citizens.** Individuals who contact OFCO with an inquiry or complaint often feel that DCYF or another agency is not listening to their concerns. By listening carefully, the Ombuds can effectively assess and respond to individual concerns as well as identify recurring problems faced by families and children throughout the system.
- **Responding to Complaints.** The Ombuds impartially investigates and analyzes complaints against DCYF. OFCO spends more time on this activity than any other. This enables OFCO to intervene on citizens' behalf when necessary, and accurately identify problematic policy and practice issues that warrant further examination. Impartial investigations also enable OFCO to support actions of the agency when it is unfairly criticized for properly carrying out its duties.
- **Taking Action on Behalf of Children and Families.** The Ombuds intervenes when necessary to avert or correct a harmful oversight or mistake by DCYF. Typical interventions include: prompting the agency to take a closer look at a concern, facilitating information sharing, mediating professional disagreements, and sharing OFCO's investigative findings and analyses with the agency to correct a problematic decision. These interventions are often successful in resolving legitimate concerns.
- **Improving the System.** Through complaint investigations and reviews of critical incidents (including child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment), OFCO works to identify and investigate system-wide problems, and publishes its findings and recommendations in public reports to the Governor and the Legislature. This is an effective tool for educating state policymakers and agency officials about the need to create, change, or set aside laws, policies or agency practices, so that children are better protected and cared for and families are better served by the child welfare system.

⁸ See also RCW 13.50.100(6).

⁹ See RCW 74.13.640(1) (b); 74.13.640(2); and 26.44.030(15).

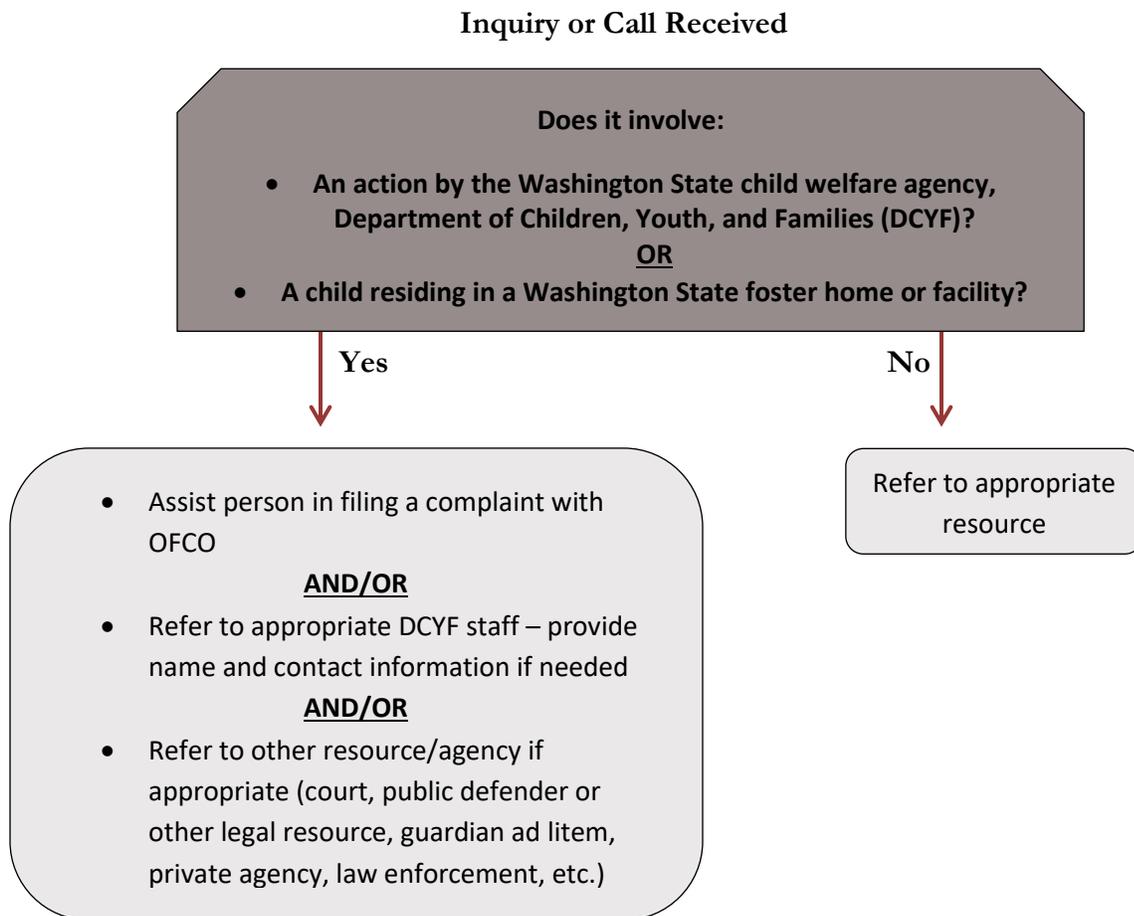
I. LISTENING TO FAMILIES AND CITIZENS

- Inquiries and Complaints
- Complaint Profiles
- Complaint Issues

INQUIRIES AND COMPLAINTS

The Ombuds listens to people who contact the office with questions or concerns about services provided through the child welfare system. Callers may include family members of children receiving such services, professionals working with families and children, or concerned citizens. By listening carefully, the Ombuds identifies what the caller needs and responds effectively. Callers may simply need information about the Department of Children, Youth, and Families' process and/or services, or they may want to know how to file a complaint. Callers may want verification about whether OFCO can investigate their concern, or guidance in framing or identifying their complaint issue. Those whom OFCO cannot help directly are referred to the right place for information or support.

Figure 1: **What Happens When a Person Contacts OFCO?**



COMPLAINT PROFILES

COMPLAINTS RECEIVED

This section describes complaints filed during OFCO’s 2018 reporting year — September 1, 2017 to August 31, 2018. **OFCO received 901 complaints in 2018.**¹⁰ While this is slightly fewer complaints than last year, the number received remains considerably higher than 2016 and earlier. Figure 3 shows that 88 percent of complaints are submitted electronically, with six percent taken over the phone and less than four percent submitted through the mail.

Figure 2: **Complaints Received by Year**

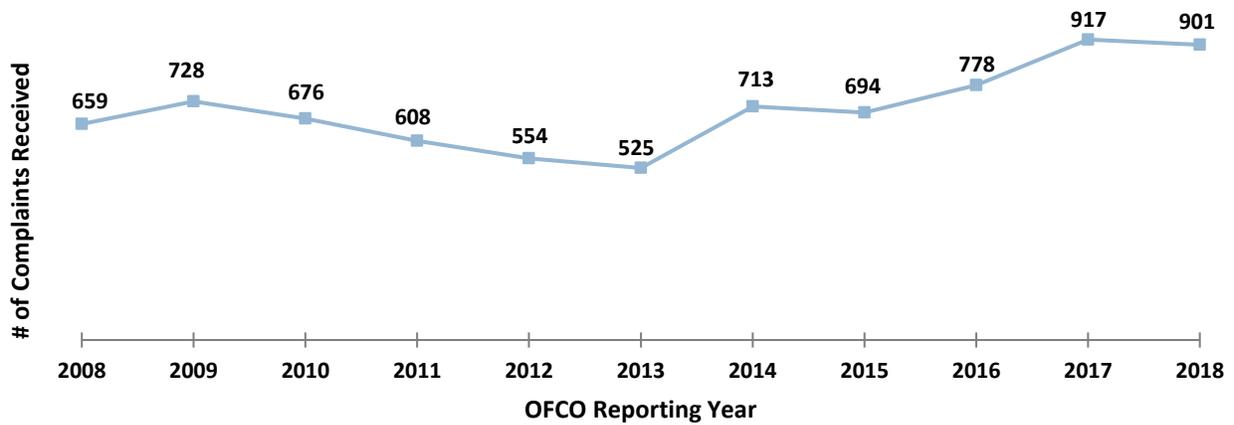
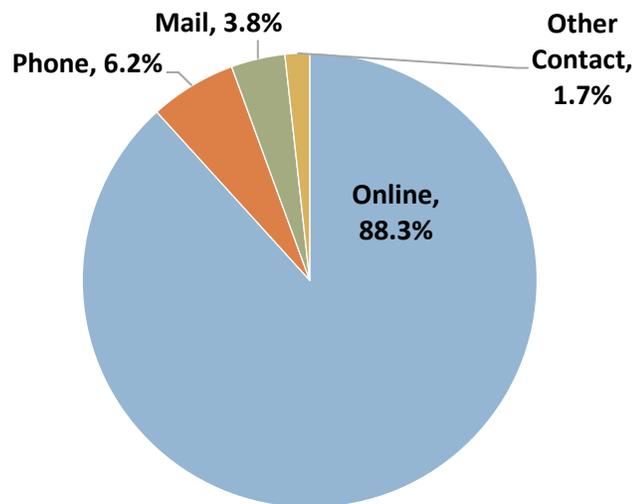


Figure 3: **How Complaints Were Received, 2018**

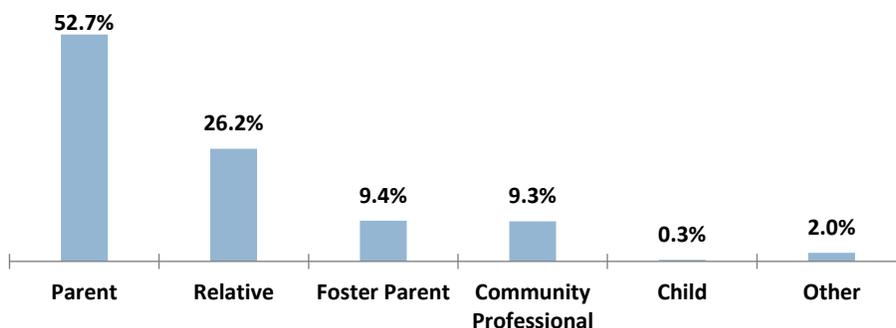


¹⁰ The number of complaints directed at each DCYF region and office is provided in Appendix A.

PERSONS WHO COMPLAINED

Parents, grandparents, and other relatives of the child whose family is involved with the Department of Children, Youth, and Families (DCYF) filed the majority of complaints investigated by OFCO (78.9 percent). Foster parents and community professionals each filed about nine percent of complaints respectively. As in previous years, few children contacted OFCO on their own behalf.

Figure 4: **Complainant Relationship to Children, 2018**



OFCO’s complaint form asks complainants to identify their race and ethnicity for the purposes of ensuring that the office is hearing from all Washingtonians.

Table 1: **Complainant Race and Ethnicity, 2018**

	OFCO Complainants	WA State Population ¹¹	Children in Out of Home Care ¹²
Caucasian	66.9%	79.4%	65.5%
African American or Black	8.5%	4.0%	8.9%
American Indian or Alaska Native	2.9%	1.9%	4.5%
Asian or Pacific Islander	1.8%	9.6%	2.4%
Other	1.0%	-	-
Multiracial	5.2%	5.1%	18.7%
Declined to Answer	13.7%	-	-
Latino / Hispanic	7.4%	13.1% ¹³	19.4%

¹¹ Office of Financial Management. Population by Race, 2018. <http://www.ofm.wa.gov/trends/population/fig306.asp>

¹² Partners for Our Children Data Portal Team. (2018). [Graph representation of Washington state child welfare data 9/13/2018]. Children in Out-of-Home Care (Count). Retrieved from <http://www.vis.pocdata.org/graphs/ooh-counts>

¹³ Office of Financial Management. Population of Hispanic/Latino origin, 2018. <https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-trends/population-changes/population-hispaniclatino-origin>

CHILDREN IDENTIFIED IN COMPLAINTS

Just over 40 percent of the 1,376 children identified in complaints were four years of age or younger. Another 31 percent were between ages five and nine. OFCO receives fewer complaints involving older children, with the number of complaints decreasing as the child’s age increases. This closely mirrors the ages of children in out of home care through DCYF.

Figure 5: Age of Children in Complaints, 2018

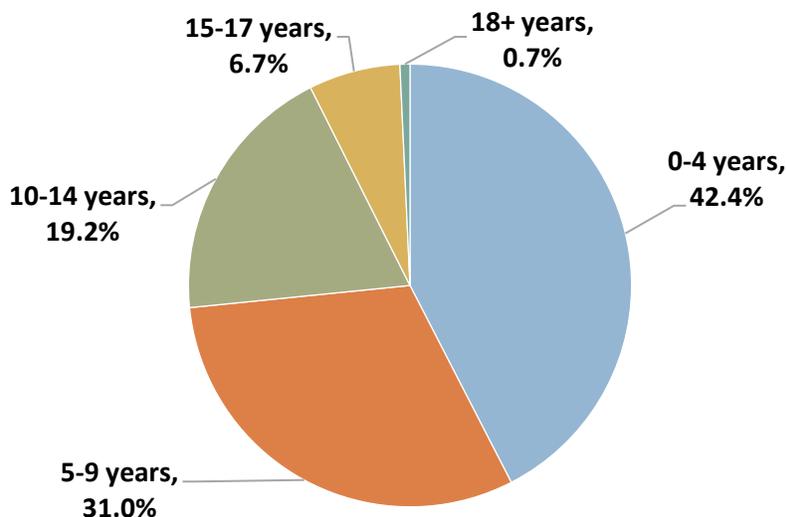


Table 2 shows the race and ethnicity (as reported by the complainant) of the children identified in complaints, compared with children in out of home placement through DCYF and the general state population.

Table 2: Race and Ethnicity of Children Identified in Complaints, 2018

	OFCO Children	Children in Out of Home Care ¹⁴	WA State Children (ages 0-19) ¹⁵
Caucasian	68.0%	65.5%	73.8%
African American or Black	10.3%	8.9%	4.8%
American Indian or Alaska Native	4.5%	4.5%	2.4%
Asian or Pacific Islander	1.5%	2.4%	8.8%
Multiracial	12.8%	18.7%	10.2%
Other or Unknown	2.8%	-	-
Latino / Hispanic	15.0%	19.4%	21.3%

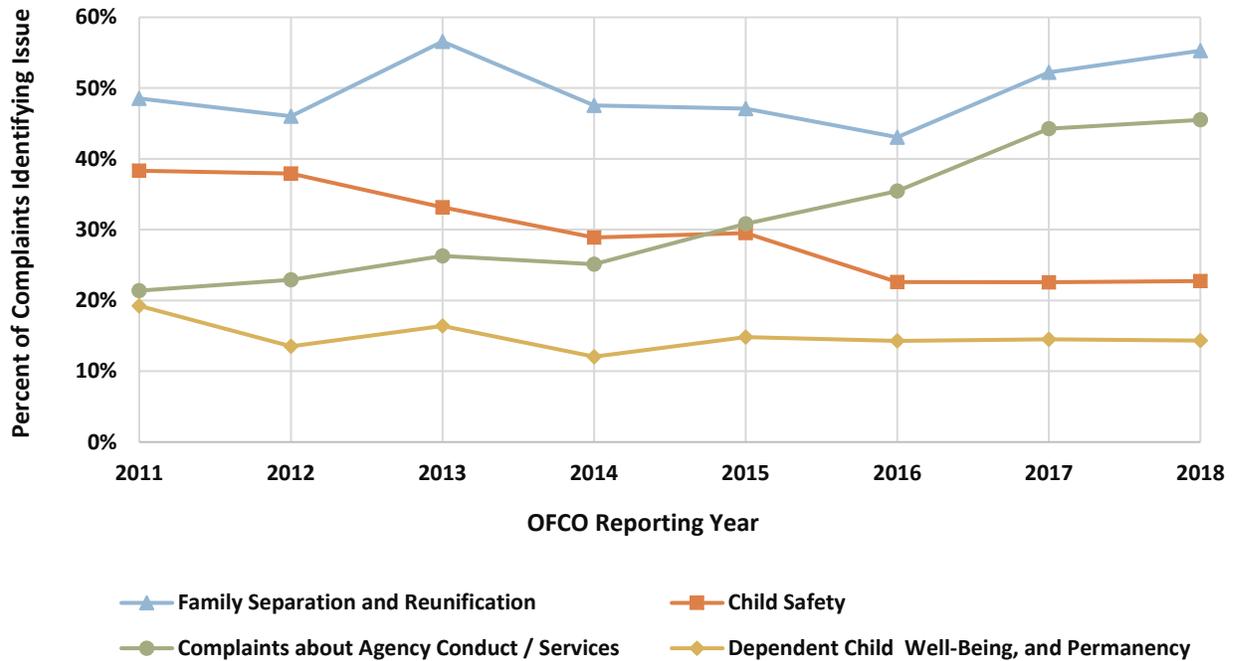
¹⁴ Partners for Our Children Data Portal Team. (2018). [Graph representation of Washington state child welfare data 9/13/2018]. Children in Out-of-Home Care (Count). Retrieved from <http://www.vis.pocdata.org/graphs/ooh-counts>

¹⁵ Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2017. <http://www.ofm.wa.gov/pop/asr/default.asp>

COMPLAINT ISSUES

Concerns identified in complaints to OFCO, while varying somewhat year-to-year, have remained largely consistent over time, as displayed below in Figure 6. Complaints can often be complex and complainants will identify multiple issues or concerns they would like investigated.

Figure 6: Categories of Issues Identified by Complainants



Family Separation and Reunification

As in previous years, issues involving the **separation and reunification of families** (raised 498 times in complaints) were the most frequently identified in complaints to OFCO. Over half (55 percent) of complaints expressed a concern about separating families and/or not reunifying with parents or other relatives. This category of complaints incorporates a broad spectrum of issues affecting family stability. The most frequently identified concerns include:

- **Children improperly removed from their parents** (131 complaints) or other relatives (24 complaints);
- **Failure to ensure appropriate visitation or contact** between children and their parents or relatives (116 complaints) or **siblings** (13 complaints);
- Delays in or **failures to reunite family** (98 complaints); and
- **Not placing children with relatives** (76 complaints) or with **siblings** (5 complaints).¹⁶

¹⁶ The remaining 35 of the 498 complaints in this category raised a variety of other family separation issues.

Conduct of DCYF Staff and Agency Services

Issues involving **the conduct of DCYF staff and other agency services** were the next-most identified concerns. The number of complainants expressing these kinds of concerns has steadily been increasing since 2010, with a particularly sharp increase since 2014. Complaints about agency conduct or services incorporate a broad range of concerns, including:

- **Unwarranted or unreasonable CPS interventions** (131 complaints);
- Concerns about unprofessional conduct by agency staff (100 complaints) such as **harassment, discrimination, bias, dishonesty or conflict of interest**;
- **Communication failures** (98 complaints), such as caseworkers not communicating with parents or relatives;
- **Breach of confidentiality** by the agency (34 complaints); and
- **Inaccurate agency records** (16 complaints).

Child Safety

Complaints involving child safety have held constant in the last three years, but have dropped steadily to the current level since 2011. Just over 40 percent of the **205 child safety** complaints concerned **safety risks to dependent children in foster or relative care** (84 complaints or 41 percent of all child safety complaints). Another 38 percent of child safety complaints alleged a **failure to protect children from abuse or neglect while in their parents' care** (78 complaints). Twenty-four complaints expressed concern about the safety of children being returned to their parents' care and twelve identified safety concerns during parent-child visitation.¹⁷

Child Well-Being and Permanency

Complaints involving the **well-being and permanency of children in foster or other out-of-home care** remained about the same this year (129 complaints). This category includes problems providing children in out-of-home care with **adequate medical, mental health, educational** or other services (identified in 52 complaints). It also includes complaints about **inappropriate placement changes**, as well as **placement instability**, such as multiple moves in foster care or abrupt placement changes (24 complaints). Twenty-five complaints raised concerns about an inappropriate permanency plan and seven concerned **delays in achieving permanency**.¹⁸

Table 3 on the following page shows the number of times specific issues within these categories were identified in complaints.

¹⁷ The remaining 7 of the 205 child safety complaints identified a variety of other child safety issues.

¹⁸ The remaining 28 of the 129 complaints in this category identified a variety of other child well-being and/or permanency issues.

Table 3: Issues Identified by Complainants¹⁹

	2018	2017	2016
Family Separation and Reunification	498	479	335
Unnecessary removal of child from parental care	131	106	100
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	116	120	78
Failure to reunite family	98	81	42
Failure to place child with relative	76	94	44
Unnecessary removal of child from relative placement	24	19	13
Other inappropriate placement of child	22	33	34
Failure to provide sibling visits and contact	5	6	3
Failure to place child with siblings	13	4	9
Inappropriate termination of parental rights	4	8	6
Concerns regarding voluntary placement and/or service agreements	4	3	3
Other family separation concerns	5	3	3

	2018	2017	2016
Complaints About Agency Conduct	411	400	275
Unwarranted / unreasonable CPS investigation	131	131	86
Unprofessional conduct, harassment, conflict of interest or bias / discrimination by agency staff	100	102	83
Communication failures	98	97	55
Breach of confidentiality by agency	34	17	16
Inaccurate agency records	16	13	8
Unreasonable CPS findings	14	26	21
Poor case management, high caseworker turnover, other poor service	12	11	4
Retaliation by agency staff (does not include complaints of retaliation made by licensed foster parents)	6	3	2

¹⁹ Many complaints to OFCO identify more than one issue. The total number of issues is therefore greater than the total number of complaints in any given year.

	2018	2017	2016
Child Safety	205	206	176
Failure to address safety concerns involving children in foster care or other non-institutional care	84	75	53
Failure to protect children from parental abuse or neglect	78	83	79
Abuse	34	40	41
Neglect	40	37	37
Failure to address safety concerns involving child being returned to parental care	24	18	21
Child safety during visits with parents	12	17	11
Child with no parent willing/capable of providing care	6	7	10
Failure by agency to conduct 30 day health and safety visits with child	2	5	3
Safety of children residing in institutions/facilities	1	6	0

	2018	2017	2016
Dependent Child Well-Being and Permanency	129	133	111
Failure to provide child with adequate medical, mental health, educational or other services	52	52	29
Inappropriate permanency plan/other permanency issues	25	16	13
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	23	41	33
ICPC issues (placement of children out-of-state)	11	1	8
Unreasonable delay in achieving permanency	7	9	12
Failure to provide appropriate adoption support services / other adoption issues	6	4	10
Placement instability/multiple moves in foster care	1	3	0

	2018	2017	2016
Other Complaint Issues	128	131	115
Failure to provide parent with services / other parent issues	39	32	38
Violation of parent's rights	30	24	34
Children's legal issues	5	4	3
Lack of support / services to foster parent / other foster parent issues	14	18	15
Foster parent retaliation	5	10	5
Foster care licensing	9	17	13
Lack of support / services and other issues related to relative / suitable other / fictive kin caregiver	23	26	7
Violations of the Indian Child Welfare Act (ICWA)	3	0	0

II. TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES

- Investigating Complaints
- OFCO's Adverse Findings

INVESTIGATING COMPLAINTS

OFCO's goal in a complaint investigation is to determine whether DCYF or another state agency violated law, policy, or procedure, or unreasonably exercised its authority. OFCO then assesses whether the agency should be induced to change its decision or course of action.

OFCO acts as an impartial fact finder and not as an advocate. Once OFCO establishes that an alleged agency action (or inaction) is within OFCO's jurisdiction, and that the allegations appear to be true, the Ombuds analyzes whether the issues raised in the complaint meet at least one of two objective criteria:

1. The action violates law, policy, or procedure, or is clearly unreasonable under the circumstances.
2. The action was harmful to a child's safety, well-being, or right to a permanent family; *or* was harmful to the preservation or well-being of a family.

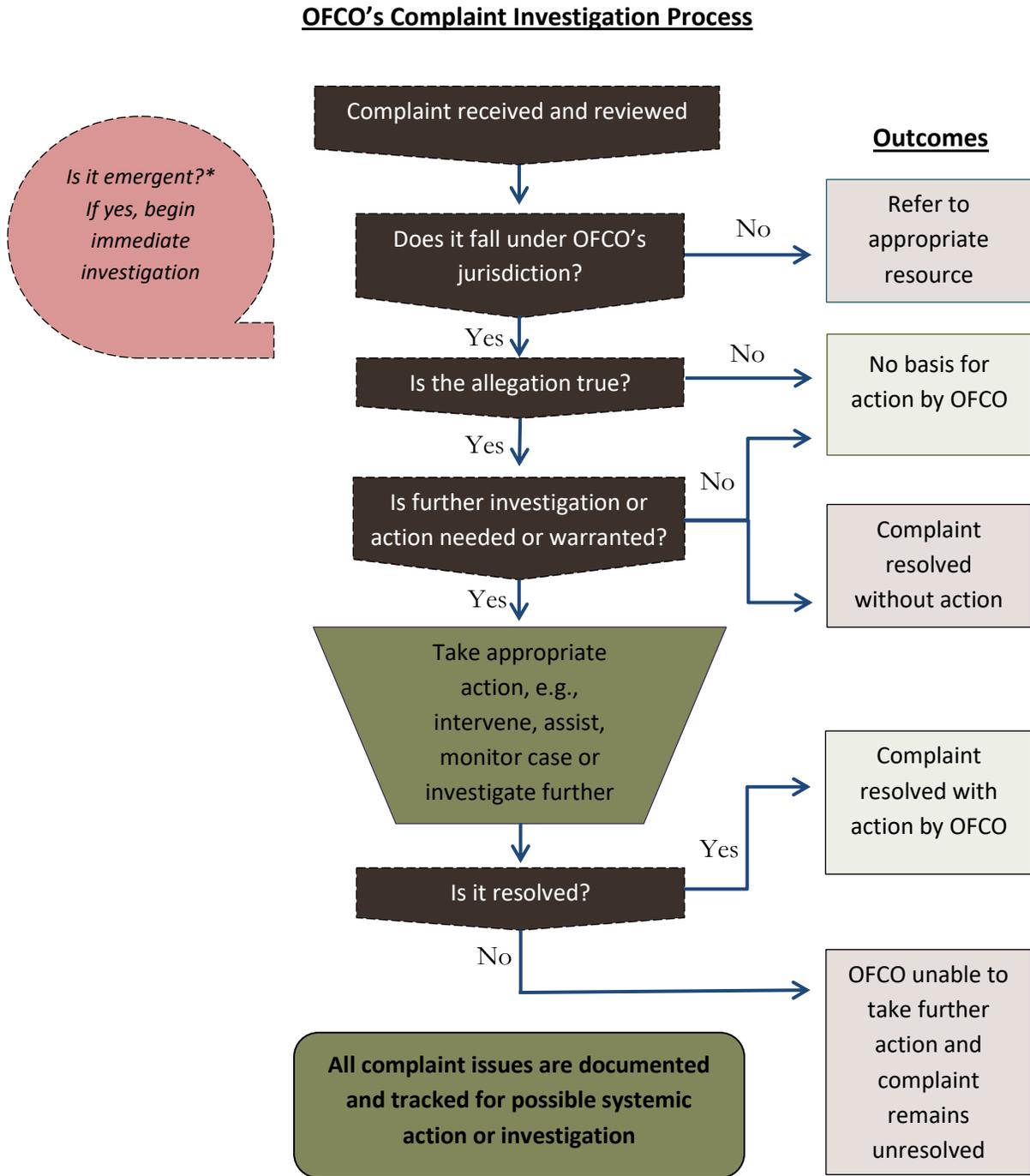
If so, OFCO may respond in various ways, such as:

- Where OFCO finds that the agency is properly carrying out its duties, the Ombuds explains to the complainant why the complaint allegation does not meet the above criteria, and helps complainants better understand the role and responsibilities of child welfare agencies.
- Where OFCO makes an adverse finding regarding either the complaint issue or another problematic issue identified during the course of the investigation, the Ombuds may work to change a decision or course of action by DCYF or another agency.
- In some instances, even though OFCO has concluded that the agency is acting within its discretion, the complaint still identifies legitimate concerns. In these cases, the Ombuds provides assistance to help resolve the concerns.

OFCO completed **923 complaint investigations** in 2018. These investigations involved **870 families**. As in previous years, the majority of investigations were **standard, non-emergent investigations** (87 percent). Only about one out of every eight investigations met OFCO's criteria for initiating an **emergent investigation**, i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by OFCO could significantly alleviate a child or family's distress. Once a complaint is determined to be emergent, OFCO begins the investigation immediately.

Over the years, OFCO consistently intervenes in emergent complaints at a higher rate than non-emergent complaints. In 2018, **OFCO intervened or provided timely assistance to resolve concerns in 17 percent of emergent complaints**, compared with **13 percent of non-emergent complaints**.

Figure 7: How Does OFCO Investigate Complaints?



*Emergent complaints are those in which the allegations involve either a child's immediate safety or an urgent situation where timely intervention by OFCO could significantly alleviate a child's or family's distress.

INVESTIGATION OUTCOMES

Complaint investigations result in one of the following actions:

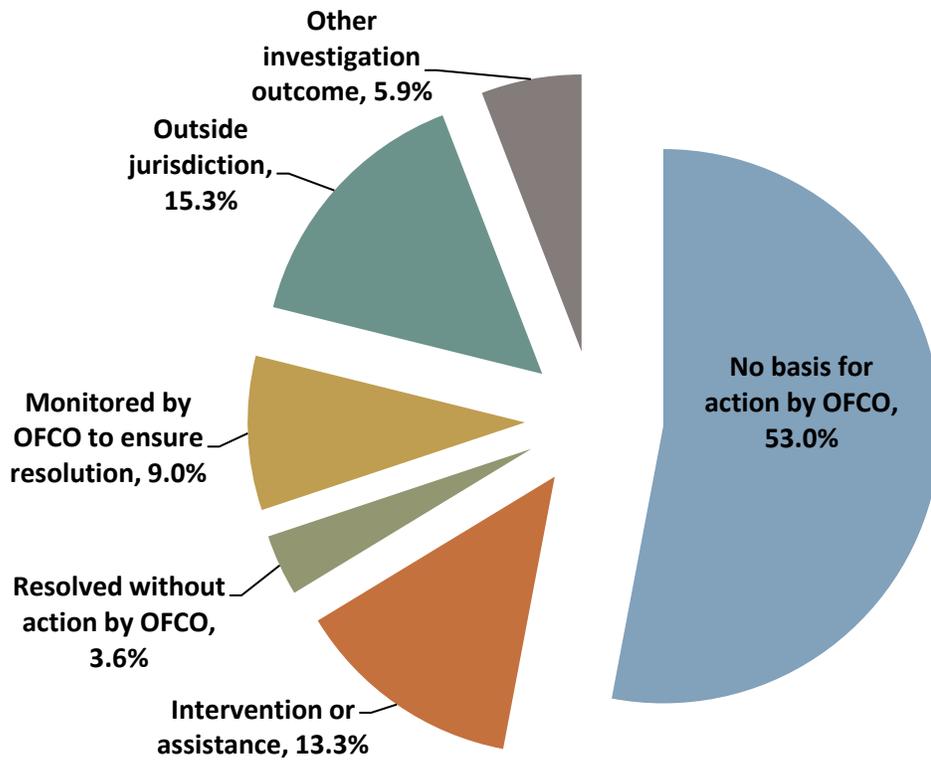
- **OFCO Intervention:**
 - OFCO substantiated the complaint issue and intervened to correct a violation of law or policy, or to prevent harm to a child/family; OR
 - OFCO identified an agency error or other problematic issue, sometimes unrelated to the issue identified by the complainant, during the course of its investigation, and intervened to address these concerns.
- **OFCO Assistance:** The complaint was substantiated, but OFCO did not find a clear violation or unreasonable action. OFCO provided substantial assistance to the complainant, the agency, or both, to resolve the complaint.
- **OFCO Monitor:** The complaint issue may or may not have been substantiated, and OFCO monitored the case closely for a period of time to ensure any issues were resolved. While monitoring, the Ombuds may have had repeated contact with the complainant, the agency, or both. The Ombuds also may have offered suggestions or informal recommendations to agency staff to facilitate a resolution. These complaints are closed when there is either no basis for further action by OFCO or the identified concerns have been resolved.

In most cases, the above actions result in the identified concern being resolved. A small number of complaints remain unresolved.

- **Resolved without action by OFCO:** The complaint issue may or may not have been substantiated, but was resolved by the complainant, the agency, or some other avenue. In the process, the Ombuds may have offered suggestions, referred complainants to community resources, made informal recommendations to agency staff, or provided other helpful information to the complainant.
- **No basis for action by OFCO:**
 - The complaint issue was unsubstantiated and OFCO found no agency errors when reviewing the case. OFCO explained why and helped the complainant better understand the role and responsibilities of the child welfare agency; OR
 - The complaint was substantiated and OFCO made a finding that the agency violated law or policy or acted unreasonably, but there was no opportunity for OFCO to intervene (e.g. complaint involved a past action, or the agency had already taken appropriate action to resolve the complaint).
- **Outside jurisdiction:** The complaint involved agencies or actions outside of OFCO's jurisdiction. Where possible, OFCO refers complainants to another resource that may be able to assist them.
- **Other investigation outcomes:** The complaint was withdrawn, became moot, or further investigation or action by OFCO was unfeasible for other reasons (e.g. nature of complaint requires an internal personnel investigation by the agency – which is beyond OFCO's authority).

Investigation results have remained fairly consistent in recent years. OFCO **assisted or intervened** to try to resolve the issue in **13.3 percent of complaints** in 2018 – this represents **123 complaints**. Interventions or assistance by OFCO almost always result in the substantiated issues in the complaint being resolved – in 2018, 90 percent of these complaints were resolved. **Eighty-three complaints (nine percent)** required careful **monitoring by OFCO** for a period of time until either the identified concerns were resolved, or OFCO determined that there was no basis for further action. OFCO found **no basis for any action after investigating in just over half** of complaints this year (53 percent).

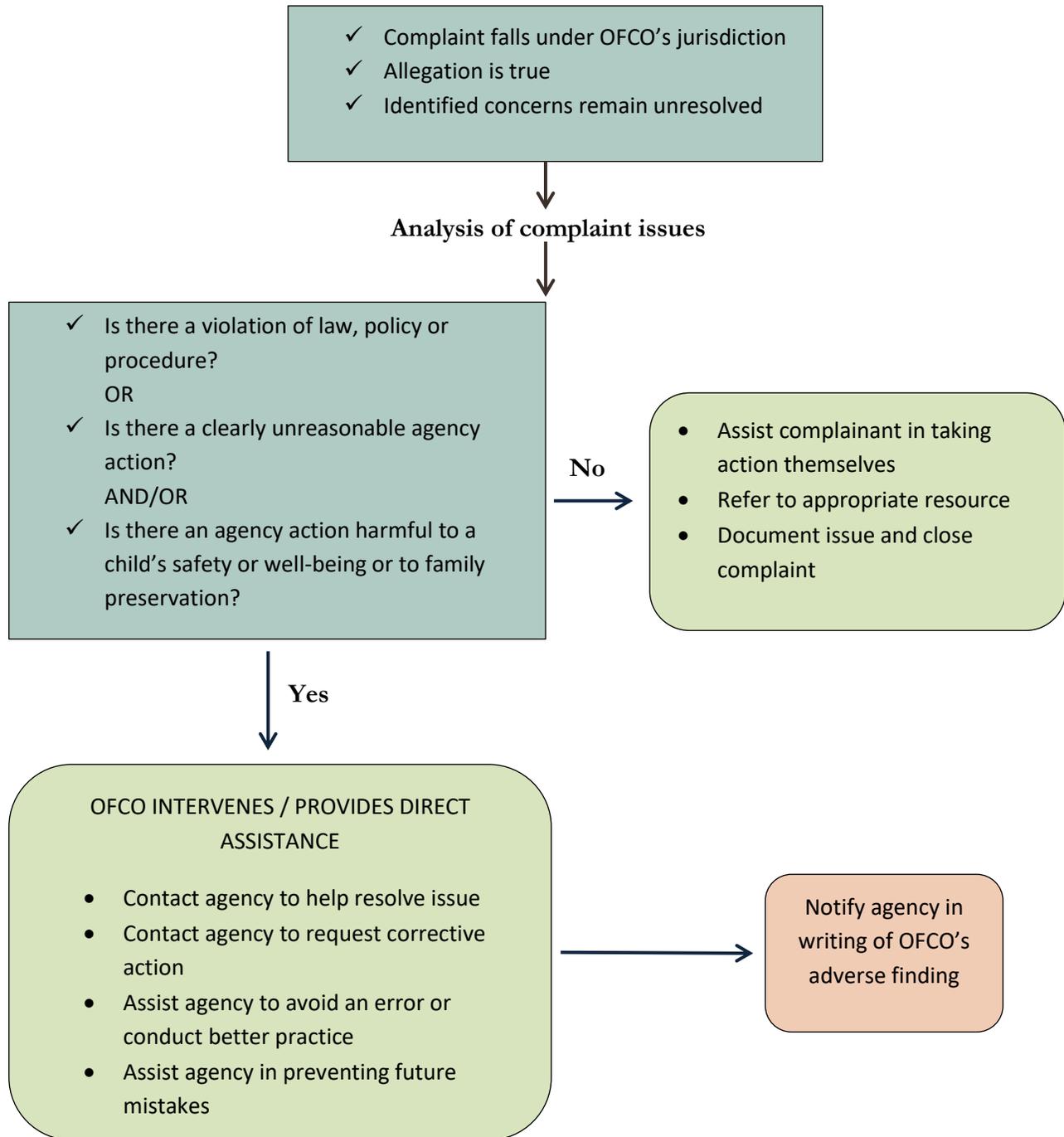
Figure 8: Investigation Outcomes, 2018



OFCO IN ACTION

OFCO takes action when necessary to avert or correct a harmful oversight or avoidable mistake by the DCYF or another agency. The chart below shows when OFCO takes action on a case and what form that may take.

Figure 9: **When Does OFCO Take Action?**



OFCO's ADVERSE FINDINGS

After investigating a complaint, if OFCO substantiates a significant complaint issue, OFCO may make a formal finding against the agency. In some cases, the adverse finding involves a past action or inaction, leaving OFCO with no opportunity to intervene. However, in situations in which the agency's action or inaction is ongoing and could cause foreseeable harm to a child or family, the Ombuds intervenes to persuade the agency to correct the problem. In such instances, the Ombuds quickly contacts a supervisor to share the finding, and may recommend a different course of action, or request a review of the case by higher level decision makers.

Adverse findings against the agency fall into two categories:

- The agency **violated a law, policy, or procedure**;
- The agency's action or inaction was **clearly unreasonable** under the circumstances, and the agency's conduct **resulted in actual or potential harm to a child or family**.

In 2018, OFCO made **40 adverse findings** in a total of 30 complaint investigations. Some complaint investigations resulted in more than one adverse finding, related to either separate complaint issues or other issues in the case that were identified by OFCO during the course of its investigation. Pursuant to an inter-agency agreement between OFCO and DCYF,²⁰ OFCO provides written notice to the DCYF of any adverse finding(s) made on a complaint investigation. The agency is invited to formally respond to the finding, and may present additional information and request a modification of the finding. DCYF provided a written response to all findings, and **requested a modification of the finding in three complaint investigations**. **OFCO modified the basis of the finding or edited the facts of the case to reflect additional information in one of these complaints**. In addition to the above 40 findings, OFCO also made two other findings that, after more information was provided by the Department, were withdrawn.

Table 4 shows the various categories of issues in which adverse findings were made. The number of adverse findings against the agency **decreased in 2018** (a total of 40 findings) from 2017 (52 findings). Findings most often related to the safety of children (18 findings), as well as findings involving violations of parents' rights or services to parents (9 findings). A full list of the adverse findings and the Department's response to them is shown in Appendix C.

²⁰ Available at www.ofco.wa.gov/documents/interagency_ofco_dshs.pdf

Table 4: Adverse Findings by Issue

	2018	2017	2016
Child Safety	18	19	17
Failure by DCFS to ensure/monitor child's safety:			
• Failure to conduct required monthly health and safety visits	4	6	4
• Unsafe placement of dependent child	4	5	5
Inadequate CPS investigation or case management	5	3	2
Failure to complete safety assessment	3	4	3
Other child safety findings	2	1	3
Parent's Rights	9	11	10
Failures of notification/consent, public disclosure, or breach of confidentiality	5	2	1
Delay in completing CPS investigation or internal review of findings	3	9	5
Failure to communicate with or provide services to parent	1	--	2
Other violations of parents' rights	--	--	2
Family Separation and Reunification	3	7	2
Failure to place child with relative	--	2	2
Failure to provide contact with siblings	1	3	--
Failure to provide appropriate contact / visitation between parent and child	2	2	--
Dependent Child Well-being and Permanency	4	4	0
Delay in achieving permanency	1	3	
Failure to provide medical, mental health, education or other services	2	1	--
Other dependent child well-being and permanency finding	1	--	--
Poor Casework Practice Resulting in Harm to Child or Family	0	3	10
Inadequate documentation of casework		2	
Poor communication among DCYF divisions (CPS, CFWS, DLR)		--	5
Other poor practice		1	5
Foster Parent/Relative Caregiver Issues	3	8	2
Issues relating to child's removal from foster placement	--	7	--
Other foster parent / caregiver issues	3	1	--
Other Findings	3	--	1
Number of findings	40	52	42
Number of closed complaints with one or more finding	30	36	31

Adverse findings involving child safety accounted for 45 percent of findings. This includes failures to conduct required monthly health and safety visits, inadequate CPS investigations or case management, and unsafe placement of a dependent child. Just over one-fifth (22.5 percent) of overall findings involved parent's rights, with failures to follow notification/consent policies, breach of confidentiality and delays in completing CPS investigations or internal review of findings being the most common.

Compared to the previous years, there were substantially fewer findings in 2018 relating to family separation and reunification and foster parent and relative caregiver issues.

FINDINGS OF UNREASONABLE ACTIONS OR INACTIONS

When OFCO makes an adverse finding against DCYF it can fall into one or more of four categories:

- that the agency action or inaction violated **law, policy, procedure**; and/or
- that the agency acted **clearly unreasonably** under the circumstances.

The vast majority of OFCO's adverse findings fall into one or more of the first three categories (78.4 percent of findings in reporting years 2016-2018 can be categorized as violations of law, policy, or procedure). However, every year OFCO makes a handful of adverse findings based on the clearly unreasonable standard (21.6 percent of adverse findings made during reporting years 2016-2018).

This standard exists to address the rare circumstances where DCYF has acted or declined to act in such a way that does not violate a written standard, but has a harmful result. If OFCO determines that this harm could and should have reasonably been avoided, it may make an adverse finding that the agency acted clearly unreasonably under the circumstances.

Mandated reporters experienced unreasonably long wait times when trying to report suspected child abuse or neglect to CPS intake

OFCO received three separate complaints from mandated reporters who were frustrated with what they felt were unreasonably long wait times when calling to make a report to Child Protective Services (CPS). One mandated reporter told OFCO that over the past two days, he had been on hold with CPS intake for two hours trying to report alleged physical abuse of a child with autism.

Two other complaints, both made by school counselors, reported similarly lengthy wait times when attempting to report suspected child maltreatment. The first counselor told OFCO she was on hold trying to make a report for 45 minutes before hanging up. When she called back, she waited 20 minutes before the call was finally answered. When the counselor told intake staff she needed to make reports regarding multiple families, intake staff said they could only take one report at a time and the caller must hang up and call back for each subsequent report. The second school counselor told OFCO she called CPS intake twice in one week attempting to make a report of suspected abuse and each time she had to wait 45 minutes for the call to be answered. OFCO made an adverse finding against the agency, finding that the delays experienced by these referrers was unreasonable. In its notification of adverse findings, OFCO also cited its own experience calling CPS intake to report suspected child maltreatment. An Ombuds waited 25 minutes for the call to be answered.

DCYF contests adverse findings based on the clearly unreasonable standard more frequently than findings based on violations of law, policy, or procedure. During the 2016-2018 reporting years, OFCO made 29 adverse findings based, at least in part, on the clearly unreasonable standard. DCFS requested modification or reversal of 48.3 percent of these findings, compared to only 24.6 percent of the findings based on violations of law, practice, or policy. This is likely due to the more subjective nature of these findings.

This subjectivity is precisely why the clearly unreasonable standard exists. Despite legislative and administrative efforts to standardize and regulate much of DCYF's action, there will always remain a measure of necessary latitude in the agency's work. Thus, a caseworker is required to exercise his or her judgment on a variety of matters throughout the life of a case. Because OFCO is an independent, uninvolved, and outside entity, it is able to assess these decisions free of investment or bias. OFCO considers the circumstances through an impartial lens, free from the influence of prior involvement or potential bias. It is a testament to the Department that OFCO makes so few clearly unreasonable findings, given the countless decisions caseworkers must make on a daily basis.

Unreasonable delay in the foster care licensing process resulted in prospective foster parents withdrawing their application.

OFCO received a complaint alleging an unreasonable delay by the Division of Licensed Resources (DLR) in completing a new foster home license. The prospective foster parents submitted a Family Home Study Application to DLR, in December 2017. The applicants were previously licensed through a private agency from November 2004 until August 2006, when they moved out of state. In January 2018, a DLR licensor contacted the applicants and let them know she would schedule a home visit once the required paperwork was submitted. The licensor also informed the prospective foster parents they were twelfth on her list of pending applications.

Later in January, the prospective foster mother followed up with the licensor to confirm that all the required paperwork except medical reports had been received. The licensor confirmed receipt of the paperwork. In February, the licensor completed a home inspection and indicated the home was "almost ready to license." In March, the licensor conducted a second home inspection and concluded the home met all licensing requirements. However, due to workload issues, the licensor was not able to complete the written home study in a timely manner. In June 2018, DLR notified the prospective foster parents that they needed to update their CPR and First Aid training as it had now expired. Also missing from their file were their medical reports, which the prospective foster parents reported had already been submitted and presumably either lost or misplaced by DLR.

OFCO found that the delay in the licensing process was clearly unreasonable. Due to workload, the licensor was unable to write up the licensing home study until five months after DLR received the family's application. It took five months for DLR to inform the prospective foster parents of missing paperwork, and subsequently expired training, after the prospective foster parents had asked several times whether there was anything else DLR needed.

Frustrated by this long delay and still not being licensed, the prospective foster parents withdrew their application in July 2018, resulting in the loss of a potential foster family.

The clearly unreasonable standard allows OFCO to identify decisions and practices that, while not in violation of explicit law or policy, had harmful impact which could potentially have been avoided. OFCO is uniquely positioned to access the information factored into decision making and, with a fresh perspective, determine if the decision was appropriate under the circumstances.

ADVERSE FINDINGS BY DCYF REGION

The adverse findings OFCO made against the Department were fairly evenly distributed across the six DCYF regions and the central office, as shown in Table 5. The number of adverse findings are further broken down by office in Table 11 in Appendix C.

Table 5: **Adverse Findings in Complaint Investigations by DCYF Region, 2018**

	Number of Findings	Percent of 2018 Findings
Region 1	7	17.5%
Region 2	3	7.5%
Region 3	6	15%
Region 4	9	22.5%
Region 5	3	7.5%
Region 6	8	20%
DCYF Headquarters	4	10%

III. IMPROVING THE SYSTEM

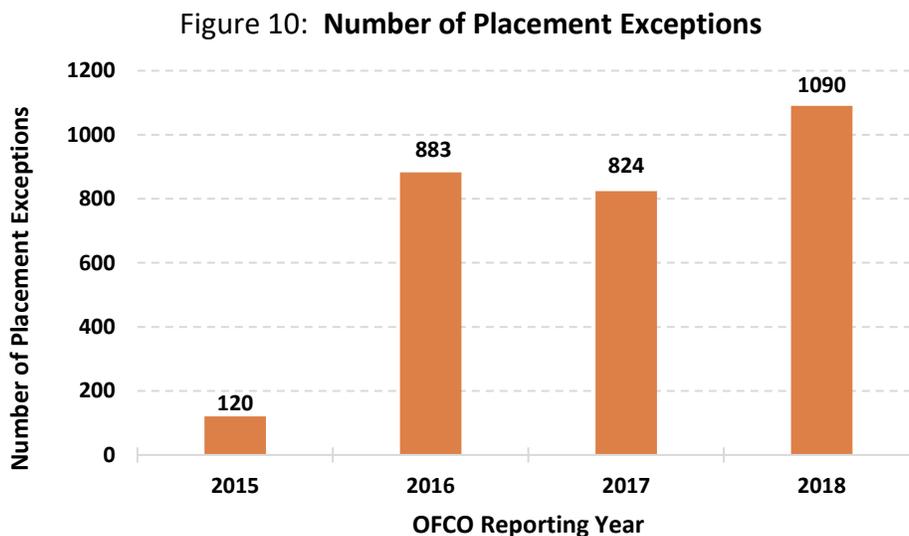
- Ongoing Placement Crisis Leaves Children Sleeping in Hotels
- Foster Care and the Criminal Justice System
- Placement Instability and Education Challenges
- Parent, Child, and Sibling Visitation
- Preparing for the New Department of Children, Youth, and Families

ONGOING PLACEMENT CRISIS LEAVES CHILDREN SLEEPING IN HOTELS

HOTELS USED AS EMERGENT PLACEMENTS FOR FOSTER CHILDREN

While Department policy specifically prohibits placement of a child in an “institution not set up to receive foster children”, a Regional Administrator may approve a “placement exception” at a DCYF office, apartment, or hotel if no appropriate licensed foster home or relative caregiver is available, and as long as the child is adequately supervised.

For the past four years, OFCO has tracked the use of “placement exceptions”, specifically the use of hotels and Department offices, as emergency placements for children.²¹ OFCO highlighted this issue in its past three annual reports, providing detailed data on these placements, as well as recommendations to alleviate the problem.²² Unfortunately, the placement of children in hotels continues at an alarming rate in Washington. From September 1, 2017 to August 31, 2018, OFCO received notice of **1,090 placement exceptions involving 195 different children**, the most since OFCO began keeping track in 2014.²³ The vast majority of these placement exceptions (1,075) involved children spending the night in hotels supervised by caseworkers. There were 15 instances of children spending the night in DCFS offices or another type of placement exception.



²¹ OFCO receives notification of placement exceptions and other critical incidents through CA’s Administrative Incident Reporting System (AIRS).

²² See 2015, 2016 and 2017 Annual Report, at <http://ofco.wa.gov/reports/>

²³ The number of placement exceptions recorded by OFCO and DCYF is slightly different. DCYF reported 1,197 placement exceptions for youth under age 18. This discrepancy does not significantly alter the trends discussed in this section.

Figure 11: Placement Exceptions by Month, 2018



For most hotel and office stays, at least two awake caseworkers supervised the children overnight, and in some cases a security guard was also present. These hotel stays followed unsuccessful attempts to locate an available relative caregiver or licensed foster home equipped to meet the child's needs. Some children had behavioral histories arising at foster homes or group care facilities where they had previously stayed, such as assaulting caregivers or peers, and therefore could not return. Many of these children were also served by other state systems such as juvenile rehabilitation, Developmental Disabilities Administration, or mental health treatment facilities. In several instances the children did not have extreme behaviors or therapeutic needs, but DCFS could not find any other placement options in time. In some cases, children were taken into custody or disrupted from placement late in the evening, making the placement search even more difficult.

Examples of hotels used for temporary placements include:

- ❖ A 10-year-old dependent child had been residing in the same foster home for several months. The youth is non-verbal and diagnosed with an intellectual disability, requiring very close supervision. This child had a stable placement but the caregiver needed respite. No respite providers could be found and the child ended up placed in a hotel for the respite stay. The child spent five nights in a hotel over a two-month period and each time returned to the foster home at the end of respite.
- ❖ A 16-year-old youth came into state care following allegations she had been physically and sexually abused. While in care the youth experienced numerous group home placements, including out-of-state facilities. The youth was approved for Behavior Rehabilitative Services (BRS) but it took a while to identify a provider. The youth had a history of drug abuse, running from care, assaulting staff and security guards and was a victim of commercial sexual exploitation. Eventually the Department found another out-of-state facility which agreed to accept the child, but the child refused to go. Over the past year this youth spent 67 non-consecutive nights in a hotel. The child is currently placed in an out-of-state group care facility.

- ❖ A 9-year-old dependent child had to leave a BRS licensed group care facility where he had been placed for about a year, due to the facility's closure. This child has significant mental health and supervision needs and placement options were limited. The child had a history of self-harming behaviors, physical aggression, mental health disorders and sexualized behaviors. The Department identified an in-patient child psychiatric facility that would accept the child, but a bed was not yet available. While waiting for this placement, the child spent a brief period of time in a group home and 15 nights in a hotel.
- ❖ A pair of siblings (an infant and a toddler) spent one night in a hotel after they were placed into protective custody by law enforcement late in the evening. Both parents were incarcerated and the children's caregiver contacted law enforcement requesting immediate placement of the children. The next day the siblings were moved to a short term licensed placement, until they were able to be returned to a parent.

Spending the night in a hotel or office, even just once, can be traumatizing for children who have experienced abuse and/or neglect, and creates unreasonable demands for Department staff. When a placement cannot be found, children are often handed from one caseworker to another as shifts change or caseworkers must tend to other responsibilities. Children often spend all day in a DCFS office before going to a hotel late in the evening, and are then taken back to the office or to school early the next morning. The inherent instability of placement exceptions puts already vulnerable children at additional risk of harm. In one example, youth were being transported to a hotel for the night when one child began unbuckling the seatbelt and assaulting another child in the car. In another instance, while awaiting placement a youth became aggressive towards another child in the office. When the caseworker and security guard stepped in to separate the two, the youth began hitting, kicking, and throwing office supplies.

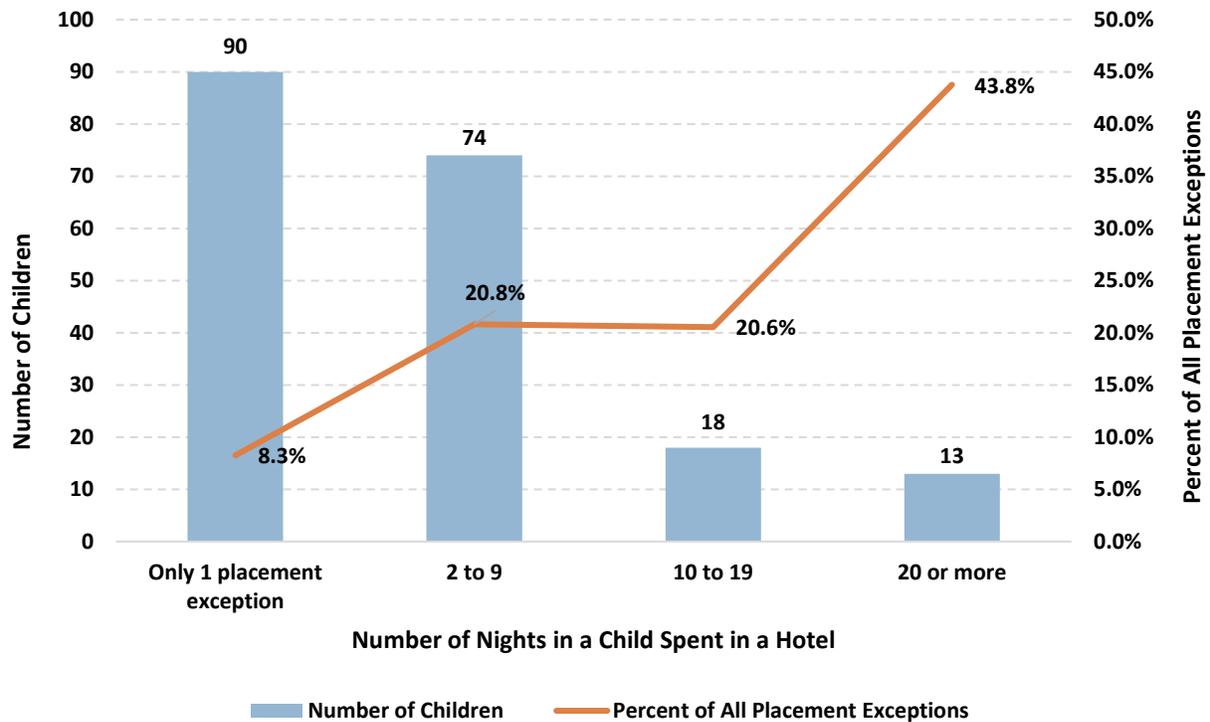
PLACEMENT EXCEPTIONS DATA

OFCO's review of the 1,090 placement exception reports received from September 1, 2017 to August 31, 2018 reveals a similar pattern to data from the three previous years – a **small group of children spent the majority of the nights** in hotels, **children are older** than the general out of home care population, the need and use for hotels is primarily a **regional issue**, **children of color** spend a **disproportionate** number of nights in hotels, and many of the children involved in placement exceptions have exceptional **behavioral challenges** and/or significant **mental health needs**.

A Small Group of Children Account for the Majority of Hotel Stays

Nearly half of the children who experienced a placement exception spent only one night in a hotel before a more suitable placement could be identified (90 children, or 46.2 percent of children involved in placement exceptions). These 90 children who spent a single night in a hotel represented only 8.3 percent of all hotel stays. Seventy-four children spent between two and nine nights in hotels. These 72 children comprised 20.8 percent of all placement exceptions.²⁴ Figure 12 shows that the vast majority of the 1,090 nights in hotels/offices were spent by just 31 children. Eighteen children spent between 10 and 19 nights in hotels and thirteen children spent 20 or more nights. These 31 children spent a combined 721 nights in hotels (64.4 percent of all placement exceptions). The highest number of nights any individual child spent in a hotel or office was 67. A closer look at the 13 children with the highest number of placement exceptions is provided below.

Figure 12: Number of Placement Exceptions per Child, 2018



²⁴ The number of nights a child spent in a hotel or DCFS office is the total number spent by that child over a one year period – not necessarily consecutive nights.

Youth Who Spent 20 or More Nights in Hotels: Who Are They?

Thirteen youth spent at least 20 nights in hotels. They ranged in ages from five to seventeen years. Five youth were identified as African American or Black (38.5 percent), two were identified as multiracial and six were Caucasian (46.2 percent). Nine of the 13 youth were male.

Behavior and Placement History

Twelve of the thirteen youth were noted to have a history of **physically aggressive behaviors**, some towards caregivers and others towards peers or younger children, which made finding a placement difficult. Half of the youth have **significant mental health needs**. This might include past inpatient psychiatric stays, a history of engaging in self-harming behaviors, and/or suicidal ideations/attempts. Seven youth were previously placed in **group homes**.

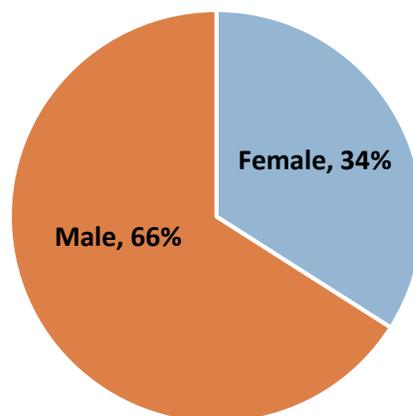
Where They Are Placed Now?

Over two-thirds of these youth were eventually placed in in group homes: six are now placed in **out of state group care facilities** and three reside at **in-state group homes**. Two youth are currently placed in foster homes, one is with a relative and another was returned home to parental care.

Demographics of Children Experiencing Placement Exceptions

Of the 195 children OFCO identified who spent at least one night in a hotel or DCFS office, **66 percent were male and 34 percent were female**. Figure 14 shows that the children who have been temporarily placed in hotels tend to be older than the total out of home care population.²⁵ **Most of the children were at least ten years of age** (69 percent).²⁶

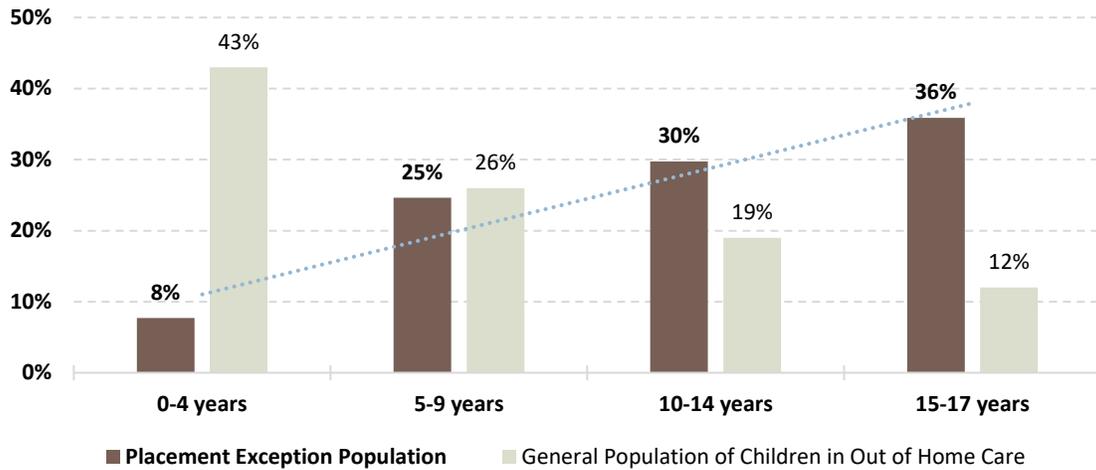
Figure 13: **Child Gender in Placement Exceptions, 2018**



²⁵ Partners for Our Children Data Portal Team. Ibid.

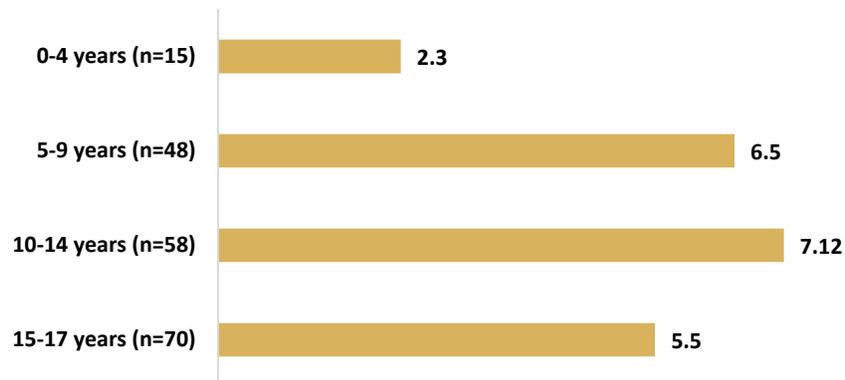
²⁶ The age of four children is unknown at the time of writing.

Figure 14: Child Age in Placement Exceptions, 2018



The average number of placement exceptions for these children was six, higher than in years past. The average number of placement exceptions by age of the child is shown in Figure 15. Children under the age of four spent the fewest nights on average in hotels, averaging 2.3 nights, whereas children ages ten to fourteen averaged just over seven nights in hotels.

Figure 15: Average Number of Placement Exceptions of Children by Age, 2018



A Regional Issue

This placement crisis continues to be most apparent in DCYF Regions 3 and 4: 96 percent of nights spent in a hotel during the 2018 OFCO reporting year involved children with cases assigned to a DCYF office in Region 3 or 4.²⁷ Just over 45 percent of Washington households with children are located in these two regions²⁸ and 31 percent of children in out of home care have cases out of Region 3 and 4.²⁹

²⁷ DCYF Region 3 encompasses Whatcom, Skagit, Snohomish, Island and San Juan counties. DCYF Region 4 encompasses King County.

²⁸ Partners for Our Children Data Portal Team. (2017). [Graph representation of Washington state child welfare data 9/26/2017]. Count of All Households with Children. Retrieved from <http://www.vis.pocdata.org/maps/hh-populationregions>

²⁹ Partners for Our Children Data Portal Team. (2018). [Graph representation of Washington state child welfare data 7/19/2018]. Children in Out-of-Home Care (Count). Retrieved from <http://www.vis.pocdata.org/graphs/ooh-counts>

Table 6: Placement Exceptions by Region, 2018

DCYF Region	Number of Placement Exceptions	Percent of All Placement Exceptions	Percent of Washington Households with Children
Region 1	11	1.0%	12.4%
Region 2	3	< 1.0%	9.7%
Region 3	242	22.2%	16.9%
Region 4	809	74.2%	28.6%
Region 5	10	< 1.0%	16.3%
Region 6	15	1.4%	16.1%

Racial Disproportionality

Children of color are over represented in placement exceptions compared to in the population of children in out-of-home care statewide, as well as to the Regions 3 and 4 populations where the majority of placement exceptions occur. Twenty percent of children spending a night in a hotel or office were African American or Black, while African American children comprise only 13 percent of the out of home care population in Regions 3 and 4, and 8.8 percent of the out-of-home care population statewide. Furthermore, this disproportionality becomes more pronounced for youth with a higher number of placement exceptions. African American or Black youth comprise 23 percent of youth who spent 2 or more nights in a hotel. Though the small population makes it difficult to draw significant conclusions, it is notable that of the 13 youth who spent at least 20 nights in hotels over the course of the year, seven (53.8 percent) were identified in the Department’s case management system as non-white.³⁰

Table 7: Child Race and Ethnicity, 2018

	Placement Exception Population	Region 3 & 4 Out of Home Care Population*	Entire Out of Home Care Population**
Caucasian	54.4%	49.6%	65.5%
African American or Black	20.0%	12.9%	8.9%
American Indian or Alaska Native	2.1%	5.5%	4.5%
Asian or Pacific Islander	2.1%	4.2%	2.4%
Multiracial	19.0%	14.7%	18.7%
Unknown	2.6%	--	--
Latino / Hispanic	11.3%	13.0%	19.4%

* Regions 3 and 4 encompasses Whatcom, Skagit, Snohomish, San Juan, Island and King Counties.

**Partners for Our Children Data Portal Team. (2018). [Graph representation of Washington state child welfare data 9/13/2018]. Children in Out-of-Home Care (Count). Retrieved from <http://www.vis.pocdata.org/graphs/ooh-counts>

³⁰ Five youth are African American and two are identified as multiracial.

Children with Significant Emotional and Behavioral Problems are at Higher Risk of Placement Exceptions

Research shows that behavior problems are commonly found among children who have experienced abuse and neglect, and that these behavior problems can have a significant negative impact on foster children's placement and permanency outcomes. Behavior problems contribute to risk for placement and adoption disruption, long-term foster care, and returning to care after reunification with parents.³¹ Many of the children who experienced placement exceptions have significant treatment, supervision, and other special needs which pose barriers to locating and maintaining an appropriate placement. Foster families, relatives, or group homes may not feel equipped to care for children with significant needs. Most of these youth were noted to have challenging behaviors that made identifying a placement more difficult. In response to OFCO's 2017 Annual Report, the Department noted 96.4 percent of youth who were placed in hotels had some kind of "known behavior issue" preventing placement within the agency's pool of available placement resources at the time.

To gather information on youth's history, behaviors, and supervision needs, OFCO reviewed the AIRS email notification of the placement exception (which frequently documents the barriers encountered by the Department in trying to find an appropriate placement for the child); the most recent Child Information and Placement Referral (CHIPR)³²; and if available, the most recent Comprehensive Family Evaluation.³³ OFCO observed several common characteristics among the youth, including:

- **Physically aggressive** or assaultive behaviors (37.4 percent of children involved in placement exceptions);
- Significant **mental health** needs (28.7 percent) and/or prior suicide attempts or ideations (13.9 percent);
- A history of **running** from placements (25.6 percent);
- **Sexually aggressive** behaviors that require high levels of supervision or placement without other children (16.4 percent); and
- **Developmental disabilities** (14.9 percent).

The descriptions of hotel stays and the circumstances that led up to them illustrate many youth are incredibly resilient when facing frequent disruptions and chaotic environments. For example, some of the youth demonstrated an ability to adapt and manipulate circumstances to gain some semblance of control in a situation where so much is out of their hands. In some cases, after a more suitable alternate placement was located the youth would refuse to go and insisted on staying in a hotel instead. In other instances, youth would insist on rooming with, or refuse to share a room with, another specific child or be supervised or driven by a particular Department employee.

³¹ "Behavior problems, foster home integration, and evidence-based behavioral interventions: What predicts adoption of foster children?" Leathers, Spielfogel, Gleason, and Rolock. *Children and Youth Services Review*, Volume 35, Issue 5. 2012, pgs. 891-899. Available at: <https://www.sciencedirect.com/science/article/pii/S0190740912000321>

³² The Child Information and Placement Referral (CHIPR) captures information about the needs, strengths and interests of a child placed in foster care. It enables the placement desk to match children with available placement resources and is provided to caregivers upon placement.

³³ The Comprehensive Family Evaluation is required to be completed within 60 days of a child's original out of home placement and at least every six months after. It captures key information on individuals and is intended to gain a greater understanding of how a family's strengths, needs and resources affect child safety, well-being and permanency.

There were plenty of examples of youth who were in Department offices during the day waiting for placement or until it was time to go back to the hotel who would leave the office for varying lengths of time resulting in run reports. In some instances, youth would return to the office while under the influence of alcohol or drugs. Some youth were able to gain access to knives or scissors, either in the community or in the DCYF offices. Oftentimes when youth were residing in a series of short term placements, including hotels, they were not attending school.

OFCO RECOMMENDATIONS

The ongoing practice of placing children in hotels and state offices highlights a shortage of foster homes and therapeutic placements, perhaps the single greatest challenge facing DCYF. The problem has only grown worse as providers have closed BRS beds in recent years because the program was not sustainable at contracted rates.³⁴ Recent changes to federal law³⁵ restricting placement of children in group care facilities will only make it more difficult to adequately meet the placement needs of children. It is therefore essential we build an array of placement resources, enhance mental health care for children, and increase support for foster parents, relative caregivers, and parents. OFCO renews previous recommendations to address the underlying issue of placement shortages including:

- **Provide an Adequate Supply and Range of Residential Placement Options to Meet the Needs of All Children in State Care.**
Increasing the number of licensed foster homes alone will not address this problem. Rather, our child welfare system must increase the capacity of placements able to meet the needs of all children in state care. Therefore, the Department must develop a continuum of placement options, including more therapeutic foster homes, to meet the long term needs of children in state care. The ongoing use of hotels as placement resources for children is not acceptable.
- **Provide Funding for Software Applications to Streamline Foster Care Licensing Process.**
Software applications are available that are designed to alleviate the shortage of foster parents and find the best family for every child. These products speed up the foster care licensing process by automating steps that are now completed manually and allow applicants, references and caseworkers to complete forms from a computer or phone. These kinds of tools could include a public recruiting site, online applicant portal, approvals module and placement module. The agency dashboard would let workers track progress on the license application, supporting documents, training hours, background checks, health screens, references, and documents for other adults in the home and enables faster approval of foster care licensing. Caseworkers are also able to find the best placement matches for children based on distance to school, preferences and the ability to keep siblings together.³⁶
- **Expand Programs that Support Foster and Kinship Families and Prevent Placement Disruptions.**
Many of the hotel stays involve children who were placed in a foster home and the placement disrupted. Services to support foster parents and help them meet the needs of children in their

³⁴ In 2017 NAVOS closed 15 BRS beds in King County, having lost nearly \$3 million between 2014 and 2016. More information in "Foster Kids Sleep in Hotels and Offices as 15 more Beds Disappear". Anna Boiko-Weyrauch. *KUOW*. October 27, 2017. <http://archive.kuow.org/post/foster-kids-sleep-hotels-and-offices-15-more-beds-disappear>

³⁵ Families First Prevention Services Act of 2017.

³⁶ One example of foster care recruitment and licensing software is "Binti". More information at <https://binti.com/>

care can improve stability and reduce the number of children experiencing a placement crisis. Our child welfare system must enhance efforts to: expand respite care; provide case aides to temporarily assist foster parents; and identify a system of support services for foster parents including counseling, educational assistance, respite care, and hands-on assistance for children with high risk behaviors.

➤ **Ensure that Children in State Care Receive Appropriate Mental Health Services.**

The vast majority of children placed in hotels have behavioral issues and/or mental health needs which contribute to placement instability. Our child welfare and behavioral health systems must ensure that children receive treatment and services tailored to their needs. The impact of providing necessary mental health services go far beyond efforts to reduce placement exceptions. These services are essential to child well-being and improved outcomes. When a child's behavioral and psychological problems are effectively treated, the prospects of attaining a safe, stable, and permanent home increase.

➤ **Recruit, Train and Compensate “Professional Therapeutic Foster Parents”.**

Policymakers should explore recruiting, training and compensating a select group of therapeutic foster parents, to devote their full time and attention to the care of high needs children and youth with mental health conditions and or challenging behaviors. These foster parents would be required to complete additional training and be expected to take on greater responsibilities in caring for these children. This would provide a family-like placement for these children, decrease the need for congregate care, and increase placement stability.³⁷

Many of the children who experience placement exceptions have significant mental health needs and/or challenging behavioral issues which exceed existing resources within our foster care system. Even with the current tiered levels of maintenance payments, foster parents are not fully compensated for the cost of providing for these children or for the work involved in meeting their needs.

The solutions described above require a significant investment of time and money and will not happen overnight. Until placement resources exceed the varied needs of children in state care, OFCO believes additional resources should be provided to manage the negative effects of placement disruptions and hotel stays by better equipping staff and reducing the chaotic and constantly changing environment for the youth. OFCO recommends DCYF:

➤ **Ensure All Staff Who Supervise Children Overnight are Adequately Trained**

The Department currently offers “Right Response” training to staff interested in developing skills to work with children in possibly volatile situations.³⁸ The Department should increase the number of After Hours caseworkers completing this training and certification as they frequently supervise youth overnight in hotels. The Department should also consider other staff training options addressing: behavior management and crisis intervention techniques; conflict resolution or problem solving skills; youth supervision requirements; managing sexually aggressive and

³⁷ “The Foster Care Recruitment and Retention Crisis”, (August 2016) Dee Wilson. <http://www.uwcita.org/the-foster-care-recruitment-and-retention-crisis/>

³⁸ Right Response focuses on de-escalation techniques and is currently available to all staff who wish to take this training. It is a certification program that requires recertification every 1-2 years. Please see: <https://rightresponse.org/de-escalation-skills>

physically aggressive/assaultive behavior; and effects of trauma on children.³⁹ Existing training for group home and residential treatment staff may serve as a model to minimize aggressive behaviors, assaults on peers and DCYF staff, and property destruction, and give staff the tools to feel empowered when supervising these children and increase their own sense of security.⁴⁰

➤ **Provide Appropriate Structured Programs and Activities.**

Expand opportunities for youth to participate in activities, structured programs, and educational options when they are awaiting placement, rather than sitting in the DCYF office all day. Research shows youth who are disengaged from community and school activities are at risk for a range of negative outcomes, such as school dropout, self-destructive and anti-social behaviors and chemical dependency use.⁴¹ Youth who spend extended time in the office often become bored or anxious, which can lead to disruptive behaviors or running away. Additionally, when youth are housed in agency offices simply awaiting placement, staff are taken away from important casework activities to supervise them.

Because many of these youth require a higher level of supervision that make participating in community outings and other activities more challenging, the Department should consider assigning staff to take children on community outings (e.g. movies, parks, swimming, shopping). Additionally, DCYF should partner with local youth organizations to create opportunities for children awaiting placement to be able to attend structured activities like day camps, teen nights, and athletics. When a youth comes into care or disrupts from a placement, all efforts should be made to continue facilitating that child's participation in any extracurricular activities in which they are already enrolled.

³⁹ Minimum Licensing Requirements for Group Care Facilities. DSHS Division of Licensed Resources. June 2018.

<https://www.dcyf.wa.gov/sites/default/files/pdf/WAC-388-145.pdf>

⁴⁰ This recommendation is in part informed by comments from an Area Administrator and supervisor who noted it was staff with experience working in residential care facilities that interacted best with youth who exhibited difficult behaviors and were physically aggressive. Many of these youth may also be going through mental health crises and training may help staff recognize signs of a mental health crisis and know how to respond.

⁴¹ For a summary of this research see: "Structured Extracurricular Activities Among Adolescents: Findings and Implications for School Psychologists". Rich Gilman. *Psychology in the Schools*, Volume 4, Number 1, January 2004, pp. 31-41.

FOSTER CARE AND THE CRIMINAL JUSTICE SYSTEM

The criminalization of youth in foster care refers to practices, policies, and discrimination that funnels youth from the child welfare system into the criminal justice system.⁴² Children with a history of involvement with the child welfare system have a high likelihood of coming into contact with the juvenile justice system. In 2010, nearly 44 percent of Washington youth who were referred to the juvenile justice system had a history of contact with DCYF (then DSHS Children's Administration).⁴³ Youth involved with the juvenile justice system who had a history of child welfare experience were referred to the juvenile justice system an average of 1.5 years earlier than youth with no child welfare history.⁴⁴ This correlation lasts well beyond childhood - one in four youth who exit foster care without permanency will be involved in the criminal justice system within two years of leaving foster care.⁴⁵

Frequent placement changes while in foster care are associated with an increased risk of juvenile delinquency.⁴⁶ This is exacerbated by placement in a group home. One study found the risk of juvenile delinquency is two and a half times greater for youth with at least one group home placement compared to youth in foster care settings who have not been placed in a group home.⁴⁷

In 2017, OFCO received a series of complaints about children placed in a state-licensed group home. The complaints raised concerns that these children were at risk of harm by being placed with peers who frequently run away and engage in criminal behavior. Attorneys representing children have voiced similar concerns that their client's criminal history began or worsened once they were placed in a group home.⁴⁸ Researchers found that children in group homes are separated from non-delinquent and positive role model peers and instead are surrounded by those with behavioral problems and juvenile justice histories.⁴⁹ They concluded exposure to anti-social peers exacerbated deviant behaviors including but not limited to smoking, problems in school, physical aggression, substance abuse, and delinquency.⁵⁰

⁴² "The Foster Care to Prison Pipeline: What It Is and How It Works." Rachel Anspach. *Teen Vogue*, May 2018.

<https://www.teenvogue.com/story/the-foster-care-to-prison-pipeline-what-it-is-and-how-it-works>

⁴³ "Prevalence and Characteristics of Multi-System Youth in Washington State." *Washington State Center for Court Research*. April 2014. This study found that 56.1% of youth referred to juvenile justice system had no history with CA; 31.3% had at least one referral and investigation by CPS; and 12.7% had legal activity and/or out of home child welfare placement.

⁴⁴ Ibid.

⁴⁵ "Toolkit for Jim Casey Youth Opportunities Initiative Sites". 2nd edition. Jim Casey Youth Opportunities Initiative. 2013.

<http://www.aecf.org/m/resourcedoc/aecf-JimCaseyInitiativeToolkit.pdf>

⁴⁶ "Child Maltreatment and Juvenile Delinquency: Investigating the Role of Placement and Placement Instability". Joseph Ryan and Mark Testa. *Children and Youth Services Review*. Volume 27, Issue 3. March 2005.

⁴⁷ "Juvenile Delinquency in Child Welfare: Investigating Group Home Effects." Joseph Ryan, et. al. *Children and Youth Services Review*, September 2008. <https://www.sciencedirect.com/science/article/pii/S0190740908000418>

⁴⁸ "The Long Way Home: When the State of Washington Gave up on Him, a Boy with No Home Took Matters into His Own Hands." Wilson Criscione. *The Pacific Northwest Inlander*. April 2017. <https://www.inlander.com/spokane/the-long-way-home/Content?oid=3864168>

⁴⁹ "Juvenile Delinquency in Child Welfare: Investigating Group Home Effects." Joseph Ryan, et.al. *Children and Youth Services Review*.

⁵⁰ "Testing Peer Contagion in Youth Mental Health Services". Bethany Renee Lee. Dissertation submitted to George Warren Brown School of Social Work. 2007.

Youth living in group homes are more likely to be exposed to incidents involving law enforcement. Group homes, like foster homes, are required to notify law enforcement when youth run away. One county court commissioner commented that group homes are more likely to involve police for something that in a family setting might result in a child being grounded, such as throwing food.⁵¹

In reviewing information on hotel stays, OFCO observed several occasions where law enforcement was called such as: when a child threw a pot of food; a child refused to leave the hotel room in the morning to return to the DCYF office; when a youth gained access to a secure area in a DCYF office; and when a youth knocked a phone out of a caseworker's hands and refused to give it back. There were also examples of law enforcement and medical personnel being called when youth were experiencing a mental health crisis, assaulted caseworkers or peers, or caused significant property damage.

Department calls law enforcement to control a youth's behavior

OFCO received a complaint alleging the Department repeatedly called and threatened to call law enforcement as a means of controlling a 13 year old African American child's behavior, rather than using other interventions or behavior modifications. The complainant believes the child is adversely impacted by exposure to police officers in the context of behavior management and believes that the Department should have better methods for handling children with challenging behaviors.

This child also spent a total of 41 nights in hotels over the past year, has had multiple group home placements and was noted to have difficult behaviors as well as symptoms of Post-Traumatic Stress Disorder. The child had a history of being physically aggressive in placements and towards Department or group home staff. In one incident in which he was accused of assaulting group care staff, the police were called and the child was arrested. The child claimed he simply pushed the staff's hand away in response to being touched. He was later charged in juvenile court. On another occasion, the Department called law enforcement when the child refused to go to school.

When contacted by OFCO, the Area Administrator asserted that staff only contact law enforcement when necessary, such as when a child is a threat to others or has seriously damaged property. The Area Administrator indicated that numerous staff on different shifts have felt it necessary to contact law enforcement for assistance with this child.

OFCO did not make any adverse findings in this case.

https://kb.osu.edu/bitstream/handle/1811/32090/20_2lee_paper.pdf;jsessionid=A3D2C1213258DBC628D50BD76372FD2B?sequence=2

⁵¹ "The Long Way Home", Walter Criscione, ibid.

OFCO RECOMMENDATIONS

- **DCYF should develop policy to standardize practice about situations that would require a law enforcement response to assist with a child's conduct.**

There are situations where contacting law enforcement may be necessary to protect youth and staff from physical harm and/or to prevent serious property damage. Clearly defined policies and procedures will help agency staff identify the situations where involving law enforcement is necessary and appropriate, and which situations may be better resolved with alternate de-escalation and behavior management techniques. The utilization of law enforcement as a tool to control behavior, particularly with younger children, should be rare, and only as an absolute last resort.

- **DCYF should provide caseworker training on trauma informed strategies to de-escalating conflict situations and behavior management of children and youth.**

The Department should evaluate training that is currently available and assess whether all caseworkers are sufficiently trained in de-escalation and behavior management. In 2019, DCYF will also manage Juvenile Rehabilitation Services. This could provide an opportunity to cross train DCYF caseworkers and utilize training resources currently available.

PLACEMENT INSTABILITY AND EDUCATION CHALLENGES

Children in foster care are a vulnerable and mobile student population. They typically experience more unscheduled school changes than peers not in foster care. One study found that 75 percent of children in foster care had at least one unplanned school change in the school year, compared to 40 percent for those not in foster care.⁵² Unexpected school changes are detrimental to a child's education.⁵³ Children in foster care experience lower graduation rates; lower scores on academic assessments; and higher rates of grade retention, absenteeism, suspensions and expulsions.

Recognizing the importance of supporting education and school success, state and federal law as well as DCYF policies set forth requirements for meeting the educational needs of children in foster care.⁵⁴ DCYF policy states "children who enter out-of-home care or change placements will remain at the school they were attending, whenever it is practical and in the best interest of the child". Policy also mandates that all school-aged children in out of home placement attend public school, unless they are court approved for a different educational setting. Some of the responsibilities of caseworkers relating to a child's education are to:

- coordinate with a child's school district with the goal of keeping the child enrolled in the school they were attending, including transportation planning;
- confirm the child is enrolled and attending school within three days of initial out-of-home placement;
- request education information and records as needed;
- advocate for services to meet the child's academic needs; and
- notify all legal parties when a school disruption occurs.⁵⁵

While keeping the child in a placement where they can maintain their school enrollment is a high priority, a shortage of available placements means that youth may have to be placed far away from their school. This means they must enroll in a new school or spend a significant portion of time commuting from the new placement to their original school. When a child's placement is disrupted and/or they are moving to new placements on a nightly basis there is a unique set of challenges to transporting and maintaining a child in school. A child may also be going through a mental health crisis or have otherwise unstable behaviors that are contributing to the placement disruption and/or need for hotels as

⁵² "Foster youth stability: A study of California foster youths' school and residential changes in relation to education outcomes." Kristine Frerer, et al. *Institute for Evidence-Based Change*. (2013). <http://www.voced.edu.au/content/ngv%3A74049>

⁵³ "Non-Regulatory Guidance: Ensuring Educational Stability for Children in Foster Care". *U.S. Department of Education and U.S. Department of Health and Human Services*. 2016. <https://www2.ed.gov/policy/elsec/leg/essa/edhhsfostercarenonregulatorguide.pdf>

⁵⁴ A comprehensive list of laws relating to education for children in foster care can be found on the Washington State Office of Superintendent of Public Instruction (OSPI) website at: <http://www.k12.wa.us/FosterCare/Laws.aspx>. DCYF policies around education can be found in CA Practices and Procedures Guide 4302A. Educational Services and Planning: Early Childhood Development, K-12 and Post-Secondary.

⁵⁵ CA Practices and Procedures Guide 4302A. Educational Services and Planning: Early Childhood Development, K-12 and Post-Secondary.

placement that may also make it more difficult to keep a child safe at school. Planning for the child's education should include contact with the school district foster care liaison who is responsible for ensuring that students in out-of-home care are enrolled in and regularly attending school.⁵⁶

Through reviews of placement exceptions as well as complaint investigations, OFCO observed several instances of youth experiencing frequent placement disruptions in which the youth did not appear to be attending school. In some cases, youth were not enrolled or attending school for an extended period of time prior to the Department's involvement, and frequent placement disruptions further delayed enrollment. In other cases, youth were enrolled in school but chose not to attend or were missing from care. Three examples of youth with multiple short term placements and hotel stays highlight the work of the Department and the challenges of enrolling and keeping these youths in school.

Youth maintains school attendance despite placement instability

A 15-year-old youth entered DCYF care after being discharged from a behavioral health hospital and a determination it would not be safe for her to return home. A placement was not immediately available and the youth spent several nights in hotels and other short term placements. While reviewing the circumstances surrounding the hotel stays, OFCO noted the caseworker was making extensive efforts to keep the youth enrolled in school despite not having a stable placement.

Department staff transported the youth from the hotel and DCYF office to school as needed. When the youth began engaging in self-harming behaviors at school the caseworker requested and attended multiple meetings with the school administrator and counselor to develop a safety plan that would keep the youth safe while continuing to attend school. The youth however frequently ran away from school, and expressed suicidal ideation. The caseworker and the school eventually decided the youth could not be kept safe at this school, and recommended an alternative program. The youth did not want to attend this program, and did not go to school for a brief period. When a foster home was located, the youth was immediately enrolled in a new school near the foster home. The youth was only in this home for a brief period when an out of state group care facility was identified and the child was moved. The facility has an on-site school.

⁵⁶ Information about the Foster Care Education Program and School District Foster Care Liaisons is available at: <http://www.k12.wa.us/FosterCare/>

Youth experiences significant schooling disruption due to multiple placements

OFCO initiated an investigation after receiving multiple notices about a nine-year-old child who had been staying in hotels, multiple foster homes, and a group home over a period of several months. The child spent a total of 46 nights in hotels this past year and did not attend school for a significant period of time. OFCO reviewed the case file and contacted the supervisor and caseworker for additional information.

After the child was discharged from group care he experienced a series of short term foster homes interspersed with spending nights in hotels. During this time the caseworker tried to enroll him in a local school. The school district however did not believe it could meet his needs as identified in his Individualized Education Program (IEP). The caseworker contacted a nearby school district, which declined to enroll this youth. The caseworker then went back to the original school district and this time the school agreed to serve the child.

Soon after the local school agreed to enroll the child, he was moved to a group home across the state. This move occurred a few weeks before winter break and the school near the group home said it could not enroll the youth until after the holidays. Just before school resumed the youth was hospitalized for suicidal ideations and aggressive behaviors, delaying his start of school by another week. The youth attended school for two weeks until the group home asked for him to be removed.

The youth was then placed in a foster home and was enrolled in school by the foster parent. However, a month later, the foster parent asked for the child to be removed. With no alternative placements, the child returned to his home region staying in hotels and night-to-night foster homes. The caseworker again contacted the original school district to re-enroll the youth. The district agreed, but updating his IEP and yet another school vacation delayed his enrollment; in the interim, however, the district offered a tutor. The district eventually made a plan with the department to transport the youth to a therapeutic school program 45 minutes away from the foster home. As of this writing the youth is in a non-permanent foster home and is enrolled and attending school.

Due to placement instability described above, this youth spent six months not attending school consistently. OFCO did not make an adverse finding against the department in this case as the caseworker made continuous and diligent efforts to enroll the youth in school.

Failure to meet young child's educational needs during hospitalization

OFCO investigated a complaint alleging that DCYF refused to pick up a dependent child from a hospital emergency department after being brought there due to assaultive behaviors toward the foster parents and children in his foster home. Despite OFCO's advocacy to have the child moved to a suitable placement, this seven-year-old child spent just over one month in an adult psychiatric unit, where among many other concerns, the child was unable to attend school.

The hospital contacted CPS intake to request that the child be removed from the hospital as not only did the facility have no beds available for a seven-year-old child, a medical evaluation of the child indicated that he did not meet criteria for inpatient hospitalization. Over the course of a month, hospital staff continued to express concerns about the child and requested the Department pick him up. They stated that the adult psychiatric unit was a physically and emotionally unsafe place for a child for any amount of time, let alone an extended period. OFCO contacted the Area Administrator who noted that DCYF was attempting to find a suitable placement for the child that would meet his special needs. Throughout the child's stay in the hospital, the child did not attend school and there was no record of any effort by DCYF to meet the child's educational needs.

OFCO made two adverse findings in this case:

1. OFCO found it clearly unreasonable under the circumstances to leave a seven-year-old child in an adult psychiatric emergency department against medical advice for 32 days. A hospital emergency department, unless medically advised, is not a recognized placement for children in DCYF care. According to the medical staff this situation was harmful to the child; furthermore, it soured relations between the facility and the Department.
2. OFCO found that the Department's lack of efforts to provide schooling for this child was a violation of DCYF policy.⁵⁷ OFCO could not find any record of attempts to enroll or transport the child to school, or otherwise meet his educational needs while in the hospital.

The Department disputed the finding about the placement being unreasonable, citing its difficulty in finding a placement that could meet the child's needs. OFCO nevertheless upheld this adverse finding. The Department did not dispute the finding that the child did not receive educational services while in the hospital.

⁵⁷ CA Practices and Procedures Guide, Section 4302A Educational Services and Planning: Early Childhood Development, K-12 and Post-Secondary.

PARENT-CHILD AND SIBLING VISITATION

Visits between parents and children help maintain the parent-child bond and are necessary for parents to regain custody of their children after they are placed in out-of-home care. Research shows consistent and frequent visitation between parents and children can reduce children's trauma and is associated with improved child well-being, less time in out-of-home care and faster family reunification.⁵⁸

“Visitation is the right of the family, including the child and the parent, in cases in which visitation is in the best interest of the child. Early, consistent, and frequent visitation is crucial for maintaining parent-child relationships and making it possible for parents and children to safely reunify. The department shall encourage the maximum parent and child and sibling contact possible, when it is in the best interest of the child, including regular visitation and participation by the parents in the care of the child while the child is in placement.” RCW 13.34.136

Concerns about visitation are one of most frequent complaints submitted to OFCO. In the 2017-2018 reporting year, OFCO received 116 complaints alleging the Department was not providing appropriate visitation for parents and/or other relatives of the child, as well as thirteen complaints that the Department was not ensuring appropriate contact between siblings in out-of-home care.⁵⁹ Additionally, parents frequently complain that their court order requires supervised visits which they feel is unnecessarily restrictive. OFCO intervened or provided substantial assistance in 21 complaints involving these issues and monitored cases in three complaints to ensure a resolution.

OFCO made three adverse findings relating to parent-child and/or sibling visits not occurring. In two of the findings, visitation between a parent and a dependent child were not occurring as specified in the court order.⁶⁰ In both of these complaints, visits were not occurring at least in part, because the caseworker was unable to locate a contracted visit provider to supervise the visits. In one of these cases after being contacted by OFCO with concerns about the visits not happening, the caseworker supervised one visit per week until a contracted provider could be arranged.

⁵⁸ “Family Visitation in the Child Welfare System.” Policy brief written by Partners for Our Children. January 2017. <https://partnersforourchildren.org/sites/default/files/POCFamilyVisitationBrief%20FINAL.pdf>

⁵⁹ Five complaints identified both contact between parent and child and between siblings as issues.

⁶⁰ For a further summary of these findings see Appendix D.

Example One: Lack of visitation providers results in a mother not having visits with her child

A 13-year-old entered DCFS care due to physical abuse by the parent. The shelter care order provided monitored visits between the youth and parent at a minimum of two times a week for two hours, as well as liberal monitored phone contact. OFCO received a complaint that these visits were not occurring. Initially visits were monitored by the youth's caregiver for a few months until conflicts with the parent arose and the caregiver was no longer willing to facilitate visits. The Department arranged for a visit provider and visits occurred for a couple of months. The parent's attendance at these visits was sporadic and the provider eventually cancelled the visitation contract.

Visits did not occur for the next three months. The parent periodically asked about visits and was reportedly told by the caseworker that arrangements were in process. Though in-person visitation was not occurring the caregivers were facilitating phone contact between the youth and parent during this period. When contacted by the Ombuds, the Department acknowledged the parent's right to visitation and said that the caseworker had been making diligent efforts to find a provider to pick up the visitation contract. The Department agreed to provide visits monitored by a caseworker until a contracted provider was arranged.

While recognizing that a shortage of contracted visit providers contributed to the lack of parent-child visits in this case, OFCO made an adverse finding that the agency failed to provide court-ordered visitation. OFCO noted that the failure to provide visits was due to inadequate resources to supervise visits and not attributed to a lack of diligence by the caseworker.

Example Two: Lack of visitation providers results in a mother not having visits with her child

OFCO investigated a complaint that a parent did not receive several hours of visitation because the Department was having difficulties locating a visitation supervisor. The complainant recognized that the Department was actively seeking a contracted provider to supervise the visits but felt that the caseworker or other Department staff should supervise visits until a provider was found.

OFCO contacted the supervisor who acknowledged that not only was there a delay in locating a contracted provider, but that the provider found could only supervise some of the court ordered visits, necessitating a search for a second provider. Eventually another provider was located and the Department agreed to provide an additional three hours of visitation per week to make up for the missed visits.

OFCO made one finding about the lack of visitation between two dependent siblings placed in separate placements. In this case the Department arranged only three sibling visits over a three-year period. Department policy states that siblings placed apart “will have two or more monthly face-to-face visits or contacts, unless there is an approved exception”.⁶¹ While OFCO acknowledged that the siblings were placed significantly far from each other, in-person contact with siblings is nevertheless vital for maintaining family connections.

OFCO intervenes to set up sibling visits

OFCO received a complaint alleging two siblings in separate foster homes were not receiving in-person visits with each other. The siblings were participating in Skype visits two times a week during the mother’s in-person visits with the younger child. OFCO contacted the DCFS supervisor assigned to the case to ask whether in-person visits could be arranged for these siblings. The supervisor arranged for the caseworker to facilitate a sibling visit. Soon after, the children returned to the mother’s care.

Siblings visit with one another after OFCO intervention

OFCO received a complaint stating two dependent siblings, ages four and eight, are placed in separate homes and are not having visitation with one another. These children entered state care in 2014. They remained together through multiple placements until April 2015, when the younger child was placed with her father. In August 2015, this child sustained significant injuries by her father and was placed in residential care able to meet her medical needs. The older sibling remained in licensed foster care and then was placed with a relative. The Ombuds found that the Department had only arranged three sibling visits over a three-year period. The first visit was in July 2016, and the next two visits occurred in March and May 2017. Department policy states that siblings placed apart “will have two or more monthly face-to-face visits or contacts, unless there is an approved exception.” In this case there was no approved exception, and the Department’s failure to facilitate consistent sibling visits prevents these children from preserving and maintaining their relationship.

OFCO made an adverse finding regarding the lack of sibling visitation. After OFCO’s finding, the siblings were able to have an electronic, FaceTime visit and the Department noted that they are working to acquire wireless tablets for the children to ensure more regular visitation. OFCO did note however that this response does not address a plan to arrange in-person visitation between the siblings.

⁶¹ CA Practices and Procedures Guide. Section 4254. Parent, Child, Sibling, and Relative Visits.

Importance of Family Visitation in the Least Restrictive Setting While Ensuring Child Safety

Current agency policies provide that parent-child visits must be in the least restrictive setting, in the child's community whenever possible and unsupervised unless the presence of threats and danger to the child requires the constant presence of an adult to ensure the safety of the child.⁶² Factors necessitating supervised visits include: injury to the child from abuse or neglect that require medical attention; cases of sexual abuse or involving a law enforcement investigation; risk of emotional or psychological harm to the child; or danger that the parent will flee with the child.

When completing the parent and child visit plan, the caseworker determines whether visits will be:

- **Unsupervised** – the parent is able to safely care for and protect the child during the visit;
- **Monitored** – the parent is the primary caregiver and an approved adult periodically observes and intervenes if needed; or
- **Supervised** – an approved adult maintains line of sight and sound supervision and intervenes if needed.

Visit plans and the level of supervision are reviewed and reassessed at least monthly during supervisory case reviews.

While agency policies describe various tiered levels of visits based on child safety factors, **child welfare professionals report an over reliance on supervised visits** and that dependency court partners are often unaware of agency policy and are not implementing its provisions.⁶³ To address this issue a team of state and community partners⁶⁴ involved with dependency proceedings designed and provided a one day Visitation Forum stakeholder training in select counties.⁶⁵ The forum provides education about the Department's policy and an opportunity for court partners such as attorneys, CASA/GALs judicial officers and caseworkers, to develop a shared improvement plan to facilitate a more meaningful discussion of parent-child visits, enhance the quality of court hearings, and ensure child safety while protecting the rights of the family. Visitation data in these counties indicates that these forums have been successful in reducing reliance on supervised visits.⁶⁶

⁶² DCYF Practices & Procedures Section 4254.

⁶³ Dependent Children in Washington State: Case Timeliness and Outcomes, 2017 Annual Report, Washington State Center for Court Research. <https://www.courts.wa.gov/subsite/wscrr/docs/2017DTR.pdf>. Report to the Legislature Parent Child Visitation, Children's Administration DSHS, January 2016.

<https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/Supervised%20Visits%202015.pdf>

⁶⁴ Washington State Administrative Office of the Courts, Court Improvement Training Academy, Washington State Office of Public Defense, and DCYF.

⁶⁵In 2017- 2018, Visitation Forums have been held in Grant, Grays Harbor, Island, Mason, Skagit, Thurston and Whatcom counties.

⁶⁶ For example, in Grays Harbor County, supervised visit rates dropped from 91% to 56% following the Visitation Forum and shared improvement plan.

OFCO RECOMMENDATIONS

- **Continue Stakeholder Training Efforts on Child Safety and Parent-Child Visitation**
Judges, attorneys, CASA/guardians ad litem, caseworkers and others involved in the dependency process should receive training on Department policy, child safety planning in the context of visits, and the best use of supervised visits.

- **Establish a Framework to Identify Families that do not Require Supervised Visits**
In collaboration with other stakeholders, the Department should establish a statewide framework to review visit plans and identify families where circumstances do not require supervised visits. This framework would assist in the consistent application of agency policy and ensure the effective distribution of funds for families requiring supervised visits.

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES OVERSIGHT BOARD

On July 1, 2018, Children’s Administration and the Department of Early Learning combined to form the Department of Children, Youth, and Families (DCYF). During the coming year, the governor and legislature will review recommendations whether the Juvenile Rehabilitation division and the Office of Homeless Youth Prevention should be integrated into the DCYF by July 2019.

This realignment of state agencies represents a fundamental change in the delivery of child welfare services to **protect children from harm**, and promote healthy development by providing high quality **prevention, intervention and early education services**. Included in the design of the DCYF is a focus on measurable outcomes, transparency and oversight with the goal of improving public accountability for the child welfare agency. To ensure transparency, the DCYF is required to make performance and outcome data available to the public. Enhanced oversight of the DCYF includes the creation of the DCYF Oversight Board.

This past year, OFCO has been engaged with establishing the DCYF Oversight Board for Children Youth and Families. The board’s diverse membership includes legislators, subject matter experts,⁶⁷ and representatives from stakeholder groups involved in child welfare. In order to measure DCYF’s progress in meeting performance goals, and system oversight, the board has broad authority to: obtain data and information from the DCYF, request investigations by OFCO and access relevant OFCO records, meet with and receive feedback from stakeholders, and review DCYF contracts with service providers. The oversight board is further empowered to review, overturn, modify or uphold child care licensing compliance agreements that do not involve a violation of health and safety standards⁶⁸. The first meeting of the oversight board was held on August 30, 2018 and the initial annual report to the legislature and the governor is due December 1, 2019.⁶⁹ The Oversight Board will monitor and guide the development of this agency and its impact on Washington’s citizens.

⁶⁷ Legislation requires a total of four subject matter experts, one for each for the following fields: early learning; child welfare; juvenile rehabilitation and justice; and reducing disparities in child outcomes by family income and race and ethnicity. Chapter 6, Laws of 2017 (SESSH 1661), Section 101(10)(a).

⁶⁸ Id.

⁶⁹ Interested Individuals may sign-up to receive email notices regarding Board meetings at: https://public.govdelivery.com/accounts/WAGOV/subscriber/new?topic_id=WAGOV_128

DCYF OVERSIGHT BOARD

The DCYF Oversight board is tasked with monitoring and ensuring that the DCYF achieves the stated outcomes and complies with laws, rules, policies and procedures pertaining to early learning, juvenile rehabilitation, juvenile justice, and children and family services.

Powers of the DCYF Oversight Board

The powers exercised by a majority vote of the Board include:

- Select officers and adopt rules for orderly procedure.
- General oversight over the performance and policies of the DCYF and provide advice and input to the DCYF and governor.
- Receive quarterly reports from the Office of Innovation, Alignment, and Accountability regarding the implementation of the DCYF (July 1, 2018 to July 1, 2019).
- Request investigations and receive reports from OFCO.
- Obtain access to all relevant records in OFCO's possession.
- Request and receive information, outcome data, documents, etc., from DCYF.
- Determine whether the DCYF is achieving its performance measures.
- Review DCYF decisions regarding licensing compliance agreements that do not involve a violation of health and safety standards, with the authority to overturn, change, or uphold DCYF's decision.
- Conduct annual reviews of a sample of DCYF contracts for services to ensure they are performance based and assess measures included in contracts.

DCYF Oversight Board's Duties and Responsibilities

- The first meeting will be on or after July 1, 2018.
- The Board will immediately assume the duties of the Legislative Children's Oversight Committee (LCOC).
- Assumes the full function of the LCOC by July 2019.
- Convene stakeholder meetings at least twice a year to allow feedback regarding contracting with DCYF, the use of local, state, private and federal funds, and other matters related to DCYF's duties. The oversight board's meetings are open to the public (RCW 42.30).
- Review existing surveys of providers, customers, parent groups, and external services to assess whether DCYF is effectively delivering services, and conduct additional surveys as necessary.
- Issue an annual report to the governor and the legislature reviewing DCYF's progress towards meeting performance measures and outcomes, and review DCYF's strategic plan, policies and rules.

LIST OF DCYF OVERSIGHT BOARD MEMBERS⁷⁰

Annie Blackledge, Mockingbird Society	Representative of an organization that represents the best interest of the child
Anne Lee, Team Child	Subject matter expert in reducing disparities in child outcomes by income, race, and ethnicity
Ben de Haan, UW School of Social Work	Child welfare subject matter expert
Bobbe Bridge, Center for Children & Youth Justice	Juvenile rehabilitation and justice subject matter expert
Charles Loeffler, Department of Children, Youth, and Families	Child welfare caseworker representative
Jess Lewis, Office of the Superintendent of Public Instruction (OSPI)	Foster parent representative
Judge Frank Cuthbertson, Pierce County Superior Court	Judicial representative over child welfare proceedings or other children’s matters
Kevin Fuhr, Moses Lake Police Chief	Law enforcement representative
Lois Martin, Community Day Center for Children	Early childhood program practitioner representative
Loni Greninger, Jamestown S’Klallam Tribe	Western Washington tribal representative
Rep. Ruth Kagi, House of Representatives	Early learning subject matter expert
Rep. Tana Senn, House Democrats	Legislator
Rep. Tom Dent, House Republicans	Legislator
Sen. Jeannie Darneille, Senate Democrats	Legislator
Sen. Steve O’Ban, Senate Republicans	Legislator
Shrounda Selivanoff, Office of Public Defense	Parent stakeholder group representative
Sydney Forrester, Governor’s Policy Office	Governor’s Office representative (non-voting)
Wendy Thomas, Kalispel Tribe	Eastern Washington tribal representative

⁷⁰ List of members is current as of October 11, 2018.

IV. APPENDICES

APPENDIX A:

Complaints Received by Region and Office

APPENDIX B:

Adverse Findings by Office

APPENDIX C:

Summaries of OFCO's Adverse Findings

APPENDIX A

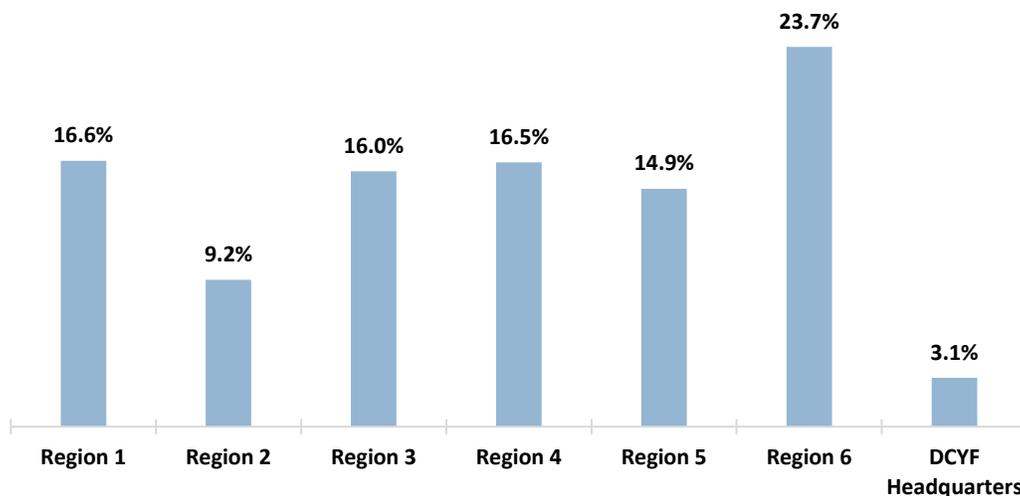
COMPLAINT INVESTIGATIONS BY REGION AND OFFICE

The following section provides a breakdown of DCYF regions and offices identified in OFCO complaints.

Table 8: Populations by DCYF Region⁷¹

DCYF Region	Children Under 18 Years Residing in Region	Percent of Washington State Children Under 18 Years
Region 1 (Spokane)	208,855	13.2%
Region 2 (Yakima)	175,566	11.1%
Region 3 (Everett)	263,539	16.6%
Region 4 (Seattle)	418,141	26.4%
Region 5 (Tacoma)	256,552	16.2%
Region 6 (Vancouver)	264,157	16.6%

Figure 16: OFCO Complaint Investigations Completed by DCYF Region, 2018



⁷¹ Partners for Our Children Data Portal Team. (2017). [Graph representation of Washington state child welfare data 9/20/2017]. Count of All Children. Retrieved from <http://www.vis.pocdata.org/maps/child-populationregions> .

Table 9: OFCO Complaint Investigations Completed by Office, 2018

REGION	OFFICE		REGION	OFFICE	
1	Spokane DCFS	73	4	King South DCFS	56
	Moses Lake DCFS	22		King East DCFS	31
	Wenatchee DCFS	19		Martin Luther King Jr. DCFS	20
	Colville DCFS	15		King West DCFS	19
	Omak DCFS	6		Office of Indian Child Welfare	17
	Newport DCFS	6		White Center DCFS	3
	Colfax DCFS	5		DCFS Central Office (Region 4)	3
	Clarkston DCFS	4		DLR (Region 4)	3
	DLR (Region 1)	2			
2	Richland/Tri-Cities DCFS	24	5	Tacoma DCFS	41
	Yakima DCFS	21		Bremerton DCFS	36
	Walla Walla DCFS	14		Lakewood DCFS	27
	Goldendale DCFS	8		Puyallup DCFS	25
	Ellensburg DCFS	6		DCFS Central Office (Region 5)	4
	Toppenish DCFS	5		DLR (Region 5)	3
	White Salmon DCFS	3		Vancouver DCFS	83
	Sunnyside DCFS	1		Tumwater DCFS	33
	DCFS Central Office (Region 2)	1		Kelso DCFS	27
	DLR (Region 2)	1		Aberdeen DCFS	22
3	Alderwood/Lynnwood DCFS	33	6	Centralia DCFS	19
	Everett DCFS	28		Shelton DCFS	18
	Bellingham DCFS	25		Port Angeles DCFS	4
	Mount Vernon DCFS	22		Stevenson DCFS	2
	Arlington/Smokey Point DCFS	15		Port Townsend DCFS	1
	Monroe/Sky Valley DCFS	8		South Bend DCFS	1
	Oak Harbor DCFS	7		Forks DCFS	1
	DCFS Central Office (Region 3)	1		Long Beach DCFS	1
	DLR (Region 3)	7		DCFS Central Office (Region 6)	2
				DLR (Region 6)	3
		Central Intake Unit	11		
		DCYF Headquarters	8		
		Other DLR-CPS	7		
		Adoption Support Services	2		
		Complaints about non-DCYF agencies	9		

APPENDIX B

ADVERSE FINDINGS BY OFFICE

The following section provides a breakdown of DCYF offices identified in adverse findings.

Table 10: Adverse Findings by Office, 2018

REGION	OFFICE	#
Region 1	Spokane DCFS	5
	Moses Lake DCFS	1
	Region 1 DLR	1
Region 2	Ellensburg DCFS	1
	Yakima DCFS	1
	Region 2 DLR	1
Region 3	Mount Vernon DCFS	3
	Sky Valley (Monroe) DCFS	2
	Lynnwood DCFS	1
Region 4	King South-West DCFS	3
	King South-East DCFS	2
	King East DCFS	2
	MLK Jr. DCFS	1
Region 5	Region 5 DLR	2
	Puyallup DCFS	1
	Tacoma	1
Region 6	Kelso DCFS	3
	Tumwater DCFS	2
	Aberdeen DCFS	1
	Shelton DCFS	1
	Region 6 DLR	1
DCYF Headquarters	DCYF Headquarters	4

APPENDIX C

SUMMARIES OF OFCO'S ADVERSE FINDINGS

Inadequate CPS Investigations and Assessment of Child Safety

CPS did not contact collateral sources as required and missed the opportunity to obtain medical records regarding a child's injuries.

CPS received an intake from a physician reporting concerns for a two-year-old child with suspicious marks and bruises. CPS conducted the initial face-to-face assessment with the child two days later and did not observe any marks or bruises. A few days later, CPS received another intake from a medical professional reporting the child had swelling of one eye and a small facial abrasion. When asked if "someone hit" her, the child answered "yes." CPS conducted an initial face-to-face contact with the child later that day and observed a dark mark under the child's eye. No further investigative activities occurred for a month. Approximately six weeks after receiving the initial intake, CPS contacted the custodial parent's sister, and the child's pediatrician who had not seen the child since March. The Ombuds concluded that CPS did not contact collateral sources as required, and should have obtained additional information regarding the nature of the child's injuries from the two medical professionals who reported concerns to CPS intake and requested medical records.

- *Violation of CA Practices and Procedures Guide, Section 2331.* While conducting a CPS investigation, the caseworker must interview professionals and other persons who may have knowledge of the child abuse and/or neglect allegations or of the family.

DCYF Response:

In response to OFCO's adverse finding, DCYF acknowledged that collateral contacts were missed. The Department stated that both the CPS caseworker and the supervisor involved were no longer employed at DCYF, and that policies regarding appropriate and significant collateral contacts to make during an investigation had been reviewed with the entire office.

CPS did not conduct subject interviews, complete a timely Safety Assessment, contact collateral sources, or complete an investigation within 60 days.

In July 2017, CPS received an intake from a child care provider reporting marks and bruises on a 20-month old child who was in the care of the grandmother. The intake screened in for CPS investigation and an initial face-to-face contact with the child occurred at the child care center the same day. Photos taken by the CPS investigator showed red marks and scratches on the child's arms, though law enforcement officers who accompanied the grandmother and child to the

hospital reported they did not observe any marks. From early September 2017 to mid-January 2018 there was no documentation of investigative activities, when the case closed with an unfounded finding for physical abuse. OFCO found that the CPS investigation was inadequate.

- *Violation of CA Practices and Procedures Guide, Section 2331.* Specifically, in this case CPS did not:
 - Conduct interviews with the alleged perpetrators/subjects and inform them of the allegations as required.
 - Complete the Safety Assessment within thirty days of the intake.
 - Conduct collateral interviews (e.g. child care provider, medical provider).
 - Complete the CPS investigation within 60 days.

DCYF Response:

In its finding, OFCO noted that this CPS unit was very short staffed, having only one investigator at the time. Staffing and workload issues likely contributed to the inadequate CPS investigation. In its response to OFCO's adverse finding, DCYF noted that measures had been taken to minimize the reoccurrence of inadequate CPS investigations, including closer monitoring of directives made during supervisory case staffings, issuing performance memos when appropriate, and providing additional training on child safety.

CPS did not interview the alleged child victims or complete the Safety Assessment in a timely manner.

CPS received an intake reporting that the mother of four children, ranging in ages 6 to 13 years old, was using drugs, and that the drugs were left within the children's reach. The next day, the CPS investigator went to the home and although unable to locate the mother, observed three of the four children playing outside. This observation was considered the initial face-to-face contact with the children. Interviews of the children did not occur until two months after the CPS report was received. Department policy requires that child interviews occur within ten calendar days from the date of the CPS intake, if the interviews are not completed during the initial face-to-face contact. Additionally, CPS is required to complete a Safety Assessment within 30 days of receiving the intake. The Safety Assessment in this case was not completed until two months after the CPS intake was received.

- *Violation of CA Practices and Procedures Guide, Sections 2310 and 2331.* CPS caseworkers must conduct an investigative interview with alleged child victims within ten calendar days from the date of the intake if the interview was not already completed during the initial face-to-face contact.
- *Violation of CA Practices and Procedure Guide, Sections 1120 and 2331.* A Safety Assessment must be completed within 30 calendar days from the date of the intake.

DCYF Response:

The Department did not dispute OFCO's findings.

CPS acted unreasonably by failing to complete health and safety visits in a case that remained opened over 90 days.

CPS received a report alleging a four-year-old child sustained a broken wrist while inadequately supervised, and was living in a generally unsafe environment due to possible drug use by the parent. CPS conducted an initial face-to-face interview with the child within 24 hours and over the next month CPS completed a home visit and observed the parent with the child, contacted collateral sources, and requested a law enforcement welfare check. When the CPS investigator attempted to contact the mother again, she said she left the child with a friend for the time being and refused to share their name or address. The mother refused further services. The friend later contacted the worker to provide further information, and the worker learned that she was the subject in a FAR case that closed a year earlier, stemming from physical abuse allegations. The caregiver admitted to previous drug use and physical discipline of her own child. The CPS investigator made no attempts to see the child again. The Investigative Assessment was closed within required timeframes, yet the case remained open for over 90 days without a documented reason, in violation of RCW 26.44.030(12)(a). The agency should have completed a health and safety visit each subsequent 30 days the case was open beyond the initial 60 days. These additional visits did not occur.

DCYF Response:

OFCO initially made an adverse finding based on violations of law and policy. The Department contested these findings on the basis that the case only remained open because of a technical glitch preventing the supervisor from closing the case in FamLink. OFCO acknowledged that a technical issue may have prevented case closure but still felt that the lack of health and safety visits with the child in an open CPS case in which the parent had left her child with an unsafe caregiver and was actively avoiding contact with CPS, was clearly unreasonable and warranted the adverse finding.

The CPS Investigative Assessment was not completed in a timely manner and health and safety visits did not occur.

CPS did not conduct an adequate investigation into suspicious burn and/or welt marks on a one-year-old child. The initial face-to-face contact with the child was completed within 24 hours, along with an interview of the mother, who denied the allegations of intentional injury and said that she took the child to the doctor to assess the injuries. There was no documented case activity for the next three months, until a new CPS report alleging further maltreatment was accepted for investigation. During this three-month period, CPS should have: contacted collateral sources such as the child's medical provider to confirm the diagnosis and treatment; completed an Investigative Assessment within 60 days; and completed a health and safety visit with the child after the case had been open beyond 60 days. When investigative activities resumed after the second intake was accepted for investigation, CPS was unable to locate the mother and child despite numerous attempts and the investigation was closed as "Unable to Complete Investigation."

- *Violation of CA Practices and Procedures Guide, Sections 2540 and 2331; and RCW 26.44.030(12)(a). DCYF policy requires that an investigative assessment be completed*

within 60 calendar days, and state law requires that an investigation shall not extend longer than 90 days from the date the intake is received unless certain exceptions apply.

- *Violation of CA Practices and Procedures Guide, Sections 4420 and 2331.* Health and safety visits must be conducted with children identified in a CPS investigation open longer than 60 days.

DCYF Response:

DCYF did not request a modification of the finding but did provide information to demonstrate steps taken to improve practice and service delivery. During the period with no documented casework, the CPS unit was without a voluntary services worker and three other employees left the unit, which led to increased caseloads. Policy timelines and requirements were reviewed with the assigned caseworker and supervisor. The Area Administrator developed an action plan intended to increase case closures within required timeframes.

The CPS investigation was inadequate and required health and safety visits did not occur.

CPS did not conduct an adequate investigation into alleged sexual abuse of two children ages five and one year. CPS screened in for investigation a report based on statements made by the five-year-old child, alleging inappropriate sexual conduct by the father toward the one year old. Although CPS conducted an initial face-to-face visit with the one-year-old in a timely manner, CPS did not interview the five year old child until five months after the report was accepted for investigation. The Safety Assessment was only completed after this interview. The investigation was completed 162 days after the intake was received. CPS did not conduct health and safety visits as required by agency policy while this case remained open. These delays not only left the children at risk of harm, but could have impacted the quality of the interview with the young child witness.

- *Violation of CA Practices and Procedures Guide, Section 2331.* CPS is required to make face-to-face contact with all non-victim children who reside in the home to assess each child's safety prior to completing the Safety Assessment. The Safety Assessment must be completed on all children no later than 30 calendar days from the date of the intake. This policy and RCW 26.44.030(12)(a) mandate that CPS investigations must be closed within 60 and 90 days respectively from the date the intake is received.
- *Violation of CA Practices and Procedures Guide, Sections 4420 and 2331.* Health and safety visits must be conducted with children identified in a CPS investigation open longer than 60 days.

DCYF Response:

The Department concurred with the adverse findings and noted the Area Administrator is working with supervisors to track monthly health and safety visits with children in open cases. The Area Administrator submitted a request to the Department's Quality Assurance team asking for FamLink-generated reminders to be sent to caseworkers regarding upcoming required health and safety visits.

CPS investigation was not completed in a timely manner, a Safety Assessment was not completed, and health and safety visits did not occur.

CPS received two intakes in one day, alleging neglect of two children, ages one and six. OFCO received a complaint three months later expressing concerns about how CPS was conducting its investigation. OFCO found that the family had prior history of CPS reports alleging neglect of the children. CPS had conducted an initial face-to-face contact with the one-year-old the day after the intake was received, finding the child in the care of a relative for the day. The child appeared significantly underweight and the investigator asked the relative to take the child to the pediatrician that day. The relative agreed, and the investigator accompanied them to this doctor's visit. The doctor found the child had lost weight since the last medical appointment and expressed concern that the child was not eating enough, had chronic head lice, and an unaddressed speech delay. The doctor provided vouchers to assist the family with nourishment for the child, and informed the investigator that monthly appointments would be set up with the mother to monitor the child's weight. The investigator met with the mother and the six-year-old a week later and verified that there was food in the home. At this contact the child reported regular spankings with a belt. Three weeks later, the investigator contacted the doctor who confirmed that the mother was bringing the child to appointments, and the child was making satisfactory weight gain. A Family Team Decision Meeting was held to formulate a plan with the family to address the concerns about neglect of the children. The plan included regular visits by a public health nurse. OFCO monitored the case over the next month and a half, and contacted a supervisor when health and safety visits had not been conducted as required. However, when neither these visits nor a Safety Assessment had been completed in the six months following the CPS intakes and the CPS investigation still remained open, OFCO notified the Department of an adverse finding.

- *Violation of CA Practices and Procedure Guide, Section 2331 and RCW 26.44(12)(a).* DCYF policy and state law mandate that CPS investigations must be closed within 60 calendar days and 90 calendar days respectively.
- *Violation of CA Practices and Procedure Guide, Sections 1120 and 2331.* A Safety Assessment must be completed within 30 calendar days from the date of the intake.
- *Violation of CA Practices and Procedure Guide Sections 4420 and 2331.* When a CPS case is open longer than 60 days, the Department must conduct monthly health and safety visits with the children.

DCYF Response:

DCYF acknowledged the CPS investigation and Safety Assessment were not completed within policy timeframes. They noted that the family was working with numerous medical providers and a Public Health Nurse throughout the course of the investigation who did not report further concerns about neglect. The Department's response indicated the assigned CPS investigator would complete a relevant in-service training and the supervisor would continue to review laws and agency policies with the worker during monthly supervisory meetings and trainings.

FAR case was not closed within the required time frame and monthly health and safety visits did not occur.

An intake reporting a nine-year-old child presented with a bruise on their hip and expressed fear of the mother was screened in to the CPS Family Assessment Response (FAR) pathway. The CPS/FAR caseworker met with the child two days later but made no further contact until five months later when the only health and safety visit occurred. The FAR case was open for over five months and there was no documentation that the parent consented to an extension, or explanation why the case should remain open this long. In fact, it appeared to OFCO that for several months no work was completed on this case.

- *Violation of CA Practices and Procedures Guide, Section 4420.* The Department must conduct monthly health and safety visits with children identified in a CPS case open longer than 60 days.
- *Violation of CA Practices and Procedures Guide, Section 2332 and RCW 26.44.030(13).* CPS FAR cases must be closed within 45 days, though with parental agreement they may be kept open up to 90 days.

DCYF Response:

The Department responded that the social worker and supervisor assigned to this case were no longer employed at DCYF. The office added time to their monthly unit meetings to discuss policies and procedures. Additional training was provided to help staff understand CPS/FAR policies and the importance of timely case notes and conducting monthly health and safety visits in cases open longer than 60 days. The Area Administrator sends weekly data reports to supervisors asking for their unit's plan to close cases. Supervisors also have had one-on-one discussions with CPS/FAR social workers on performance measures during their monthly case reviews. These efforts resulted in a decrease in the average length of time cases are open.

Child safety was not assessed in a timely manner.

CPS did not assess the safety of two young children in a timely manner. A hospital social worker called CPS to report that a mother tested positive for amphetamines after giving premature birth to a baby. The mother admitted to recent use of methamphetamine. The mother's two older children, ages one and three, were also listed in the report. This intake was screened in for a CPS "Risk Only" investigation. Within 72 hours, as required by policy, the CPS caseworker completed the initial face-to-face contact with the infant, who was hospitalized and in critical condition due to being significantly premature. A few days later, the CPS caseworker met with the mother who admitted to relapsing while pregnant. The mother confirmed that the two older children were in her care. However, the CPS caseworker did not make face-to-face contact with the two older children until two months after the CPS intake report was received. The Safety Assessment was only completed three months after the CPS intake, leaving these two young children at risk of harm in the care of their parent who recently relapsed.

- *CA Practices and Procedures Guide, Sections 2331 and 1120.* CPS must make face-to-face contact with children who are not identified as a victim or identified child in the intake,

but who reside in the home in order to assess his or her safety and gather information to complete the Safety Assessment. The Safety Assessment must be completed on all children no later than 30 calendar days from the date of the intake to identify safety threats and determine when a child is safe or unsafe.

DCYF Response:

The Department did not request a modification. The Area Administrator noted that the issue was discussed with the caseworker and supervisor.

The safety of all children in the household was not assessed.

CPS did not assess the safety of all children in the home in the course of an investigation. CPS investigated an allegation of neglect of an eleven-year-old child. Two adolescents, ages thirteen and sixteen, also resided in the home. The investigator completed the initial face-to-face assessment with the eleven-year-old in a timely manner. The Safety Assessment and Investigative Assessment were completed in FamLink within three weeks and the investigation determined the allegation of neglect to be Founded. The case remained open for child welfare services. Despite the founded finding of neglect made by CPS, the adolescent children were not interviewed until approximately seven weeks after the Investigative Assessment had been completed, leaving their safety unassessed during this period of time.

- *CA Practices and Procedures Guide, Sections 2331 and 1120.* CPS must make face-to-face contact with children who are not identified as a victim or identified child in the intake, but who reside in the home in order to assess his or her safety and gather information to complete the safety assessment. The Safety Assessment must be completed on all children no later than 30 calendar days from the date of the intake to identify safety threats and determine when a child is safe or unsafe.

DCYF Response:

The Department acknowledged the error made in this case and said the relevant policies and procedures were reviewed by caseworkers.

The safety of all children in the household was not assessed.

CPS did not assess the safety of all children in the home in the course of an investigation. CPS received a referral alleging that a baby born prematurely was exhibiting respiratory distress. The mother had not received prenatal care, tested positive for marijuana and heroin at the child's birth, and admitted to use of both drugs. The referral also stated there were three other children in the household, ages two, four and nine. The next day, CPS completed the initial face-to-face contact with the newborn. Two weeks later, the agency removed the newborn and filed a petition for dependency. However, there were no further efforts to see and assess the safety of the other children until a month later when CPS received a new report alleging medical neglect of one of the older children, leading to two more children being removed from the home. Because CPS did not assess the other three children in the home within the required 30 day timeframe, it missed an

opportunity to provide services and support around the older child's medical needs that could potentially have rendered later removal of the children unnecessary.

- *CA Practices and Procedures Guide, Sections 2331 and 1120.* CPS must make face-to-face contact with children who are not identified as a victim or identified child in the intake, but who reside in the home in order to assess his or her safety and gather information to complete the safety assessment. The Safety Assessment must be completed on all children no later than 30 calendar days from the date of the intake to identify safety threats and determine when a child is safe or unsafe.

DCYF Response:

In response to OFCO's finding, training and coaching were offered to all staff in this particular office. A veteran supervisor recently joined the CPS investigation unit in the office to support new staff in ensuring compliance with policy in all cases.

Parent's Rights

A four-year-old dependent child was placed on psychotropic medication without parental consent or court order.

A four-year-old child was removed from a parent's care due to allegations of neglect related to suspected parental drug use. After being placed in foster care, the child was prescribed medication to treat Attention Deficit Hyperactivity Disorder. Case records described the child as having some developmental delays and difficulties with self-regulation. The child reportedly has difficulty interacting with other children and hits, bites, and yells when he does not get his way. The child also reportedly struggles with sleep, waking up several times throughout the night. The parents did not learn of the child's prescription until they found a bottle of the medication during a parent-child visit. OFCO contacted the supervisor who confirmed that the child was taking psychotropic medication, though the supervisor could not confirm exactly which medication it was or how long the child had been taking it. The supervisor confirmed that the caseworker was aware the child was taking this medication but that she had not obtained parental consent for its use or a court order as required by policy. Although the caseworker later obtained the parent's consent, OFCO did not find clear evidence that the parent was provided sufficient information about the medication, its potential side effects, and expected results to meet the standard for giving "informed consent".

- *CA Practices and Procedures Guide Section 4541.* The parent of the child in DCYF custody must provide informed consent for the administration of psychotropic medications to the child, unless the child is age 13 or older and competent to provide consent in his or her own behalf. If the parent is unavailable, unable, or unwilling to consent to the administration of medically necessary psychotropic medications, the caseworker shall obtain a court order before the medications may be administered.

DCYF Response:

DCYF sent the policy on psychotropic medication management to all supervisors in the particular DCFS office with an instruction to review the policy with caseworkers at the next unit meeting. The policy was also reviewed during the office's all staff meeting.

CPS did not notify the subject of an investigation that the allegation of child maltreatment was "founded".

CPS concluded that an allegation of neglect was founded regarding the mother's care of her seven-year-old child. State law and Department policy require CPS to notify the subject of a substantiated allegation of the finding, and their right to request a review of the finding. The mother only learned of the neglect finding after applying to be a paid caregiver for a disabled adult, one year after the CPS investigation was completed. After bringing this error to the Department's attention, the mother received a letter notifying her of the finding, and informing her of her right to request administrative and judicial review of this decision. The letter, however, provided the wrong mailing address to submit the review request. As a result, two letters sent by certified mail requesting review of the CPS finding were returned as "not deliverable as addressed." The mother then tried to contact the CPS supervisor, but the phone number listed in the findings letter was not a working number. At OFCO's request, the Department agreed to contact the subject directly and accept her telephonic request for review.

- *RCW 26.44.125 and CA Practice and Procedures Guide 2559B.* DCYF staff must notify subjects of CPS investigative findings in writing and provide the required information regarding the steps to request a DCYF founded finding review.

DCYF Response:

DCYF agreed with OFCO's adverse finding and corrected the error by informing the mother that it would review the founded finding.

A caseworker disclosed a parent's confidential information.

A mother was involved in a dependency proceeding for her child and was also on probation for an unrelated criminal offense. As part of the dependency case, DCFS asked the mother to take a urinalysis test. The test was completed and results came back positive for methamphetamine. The caseworker forwarded the results to the prosecuting attorney's office who submitted the positive test result to the court in a motion to revoke the mother's suspended sentence for her criminal offense. OFCO found that the CFWS caseworker violated state law by disclosing confidential information to the criminal justice system. Disclosure of this information resulted in additional conditions placed on the mother by the criminal court and could have resulted in revocation of the mother's suspended sentence and jail time.

- *RCW 13.50.100.* Records retained or produced by any juvenile justice or care agency may be relayed to other participants in the juvenile justice or care system only when there is an investigation involving a juvenile.

DCYF Response:

The Department responded that the caseworker and supervisor did not fully understand the limitations on sharing information with the prosecutor, and re-training in confidentiality will be provided to all staff in the DCFS office.

CPS did not notify a non-English speaking parent that he had been reported to CPS, did not provide an interpreter as required, and did not notify the parent of the CPS finding.

CPS received an intake alleging that a father was intoxicated and unable to adequately care for his medically fragile two-year-old child. The father spoke Spanish and during the investigation the CPS caseworker used a language line interpreter to attempt to interview the father by phone, but the father reportedly hung up at the start of the conversation. Based on other information gathered during the investigation, CPS made a founded finding of neglect by the father. OFCO found that DCFS did not notify the father in writing of the finding and his right to appeal, as required. There was a draft letter to the father written in English uploaded to FamLink but it was never mailed to him, and the letter was never translated into Spanish. OFCO contacted the CPS supervisor who advised that the letter would be translated and sent to the father.

Sometime later, a second CPS report was received alleging that the father threw one of the children into the car while intoxicated, and previously engaged in domestic violence. This report screened in to the FAR pathway. Two months after this intake came in, a caseworker attempted to contact the father by phone and left two messages. An interpreter was not used when leaving these messages. The FAR case was closed the same day the messages were left. The failure to make timely contact with the father through a Spanish interpreter and allow a reasonable amount of time for him to respond, precluded any efforts to engage him in the FAR process.

- *CA Practices and Procedures Guide Section 2559B and RCW 26.44.100.* DCYF staff must notify subjects of all approved CPS investigative findings in writing and orally, whenever possible, whether founded or unfounded and provide required information regarding the steps necessary to request a founded finding review.
- *CA Practices and Procedures Guide Section 2332 and RCW 26.44.100.* DCYF must notify the parent of any allegations of child abuse or neglect made against them at the initial point of contact. Parents must be notified of a FAR referral and the Department must explain FAR and inform the parent of their rights.
- *WAC 388-271-0020.* The Department must provide an interpreter if a parent has trouble speaking and/or understanding English and a bilingual worker is not available.

DCYF Response:

The Department had the findings letter translated and mailed to the father after being alerted by OFCO.

Family Contact and Visitation

The Department did not provide consistent visitation between a parent and dependent child.

The Department did not provide “frequent and consistent” visits between a parent and dependent child as required. A 13-year-old youth was removed from the mother’s care. The shelter care order stipulated monitored visits between the youth and mother at a minimum of two times per week for two hours each, as well as liberal monitored phone contact. The youth’s caregiver facilitated visits for a few months until conflicts between the caregiver and parent arose, resulting in the caregiver’s unwillingness to continue with this arrangement. The Department arranged a contracted visitation provider and visits occurred for approximately two months. The mother’s attendance however was sporadic and the provider canceled the visit contract. For the next three months parent-child visits did not occur despite the mother’s regular contact with her caseworker and her request for visits. When initially contacted by the Ombuds, the Department acknowledged the parent’s right to visitation and agreed to provide visits monitored by a Department social worker until a contracted provider was arranged. In its findings notification letter, OFCO noted that a shortage of contracted visit providers contributed to the lack of parent-child visits.

- *RCW 13.34.136.* Visitation is the right of the family, including the child and the parent, in cases in which visitation is in the best interest of the child. Early, consistent, and frequent visitation is crucial for maintaining parent-child relationships and making it possible for parents and children to safely reunify. The Department shall encourage the maximum parent and child and sibling contact possible, when it is in the best interest of the child, including regular visitation and participation by the parents in the care of the child while the child is in placement. Visitation shall not be limited as a sanction for a parent's failure to comply with court orders or services where the health, safety, or welfare of the child is not at risk as a result of the visitation. Visitation may be limited or denied only if the court determines that such limitation or denial is necessary to protect the child's health, safety, or welfare.

DCYF Response:

The Department noted that a caseworker was currently conducting visits between the mother and child once per week while they continued to search for a contracted visitation provider or other relatives willing to facilitate visits. The office provided training to caseworkers to understand the importance of following laws and policies regarding providing consistent and frequent visitation. Supervisors engaged in discussions with caseworkers about the visitation policy during monthly case reviews. The issue of visitation policies and concerns was added as a standing discussion item in the Area Administrator’s meetings with supervisors.

The Department did not provide court ordered visits between three dependent children and their mother for over two months.

OFCO was contacted with concerns that court ordered visitation between three dependent children and their mother was not occurring. Coordinating and maintaining consistent parent-child visits has been difficult throughout the life of the case due to various factors including: lack of transportation; the mother missed visits on occasion; and the three children were in separate placements, sometimes across the state from one another. At one point, the court also ordered that an entity other than the Department supervise visits. For two months after the court entered this restriction, the Department was unable to secure a visit supervisor, despite diligent efforts by the caseworker. The lack of consistent visits significantly disrupted reunification efforts, as Triple P Parenting Program services were cancelled because of the lack of parent-child contact.

OFCO noted its finding was not a reflection of the efforts made by the Department to comply with court ordered visits, but rather that this case illustrates an apparent lack of sufficient visitation resources, which had a tangible negative impact on timely reunification.

- *RCW 13.34.136.* Visitation is the right of the family, including the child and the parent, in cases in which visitation is in the best interest of the child. Early, consistent, and frequent visitation is crucial for maintaining parent-child relationships and making it possible for parents and children to safely reunify. The department shall encourage the maximum parent and child and sibling contact possible, when it is in the best interest of the child, including regular visitation and participation by the parents in the care of the child while the child is in placement. Visitation shall not be limited as a sanction for a parent's failure to comply with court orders or services where the health, safety, or welfare of the child is not at risk as a result of the visitation. Visitation may be limited or denied only if the court determines that such limitation or denial is necessary to protect the child's health, safety, or welfare.

DCYF Response:

The Department requested reconsideration of this finding, citing the caseworker's multiple attempts to get visitation set up and that phone contact between the mother and children was occurring during the two-month period. In this specific case there was a court order that prevented the Department from supervising the mother's visits and once this court order was lifted, visitation occurred.

DCYF fails to facilitate visits and other contact between two siblings in out of home care

Two dependent siblings, now ages four and eight, entered state care in 2014. They remained together through multiple placements until April 2015, when the younger child was placed with her father. In August 2015, this child was again removed from parental care and placed in residential care and then in a group home that could meet the child's medical needs. The other sibling remained in licensed foster care and was later placed with a relative. The Ombuds found that the Department had only arranged three sibling visits over a three-year period. The first visit was in July 2016, and the next two visits occurred in March and May 2017. Department policy

states that siblings placed apart “will have two or more monthly face-to-face visits or contacts, unless there is an approved exception.” In this case there was no approved exception, and OFCO made an adverse finding that the Department’s failure to facilitate consistent sibling visits prevents these children from preserving and maintaining their relationship.

- *CA Practices and Procedures Guide, Section 4254.* DCYF will ensure that siblings placed apart will have two or more monthly face-to-face visits or contacts, unless there is an approved exception.

DCYF Response:

DCYF responded that after being contacted by OFCO, one electronic (FaceTime) visit was facilitated for the siblings. The Department stated it was working with each placement to acquire a wireless tablet to use the Skype application for the siblings to see each other on a more frequent basis. OFCO noted the Department’s response did not address a plan to arrange face-to-face visitation between the siblings. Two months after the Department’s response to this finding, only the initial FaceTime visit was documented as having occurred.

Caregiver Issues

DLR did not fully assess a foster parent’s character and suitability.

DLR failed to conduct an adequate home study on foster parents who subsequently failed an adoption home study due to history that predated their initial foster care license. The foster parents had been licensed since 2013. In 2015, two siblings were placed in this foster home and in 2017, a third sibling joined the older children. The foster parents were identified as possible adoptive parents for these three children, and in 2018, were referred for an adoption home study update. The DLR caseworker assigned to the home study update reviewed Department records pre-dating licensing of these foster parents in 2013. These records revealed allegations of physical abuse and medical neglect by the foster mother and concerns of sexual and physical abuse by the foster father. The foster father had a biological child who was adopted by family friends/neighbors when the child was six years old. Based on these records, the siblings were removed from this home and the adoption home study denied. The Department violated department policy by not reviewing readily available records and thoroughly assessing the character, suitability and competence of these caregivers before licensing the home in 2013 and placing children there.

- *CA Practice and Procedures Guide, Sections 5110 and 6800.* A home study for those wishing to be licensed as a foster parent must include an assessment of the competence and suitability of the applicants. This includes gathering and assessing an individual’s background information and other information contained in DCYF’s electronic system and hard files.

DCYF Response:

The Department agreed with OFCO's finding. The Area Administrator noted that the Department has taken steps to provide training for licensors on the appropriate use of archived FamLink files to assess character and suitability of foster care applicants.

The Department did not adequately assess a non-licensed caregiver's history prior to placing children in their care.

DCFS did not adequately assess a non-licensed caregiver prior to placing five children in this person's care. Although DCFS completed a criminal background check, and reviewed some agency records, it missed this person's foster care licensing history. After the children were placed in this home, the caregiver applied for a foster care license. Through the foster care license application process, the Department learned this person had previously been licensed, and had several valid licensing infractions for inappropriate discipline, lack of supervision, boundary issues, and concerns about her ability to meet the needs of foster children. Licensing records indicated this person had struggled with significant mental health issues and resigned as a foster parent. DCFS violated department policy by not reviewing readily available records and properly assessing the character, suitability and competence of this caregiver before placing children in her home.

- *CA Practice and Procedures Guide, Section 45274 & Operations Manual Section, 5522.* DCYF must assess the character, competence and suitability of a placement before placing a child with an unlicensed caregiver.

DCYF Response:

The Department acknowledged the facts of OFCO's finding and said the office casework staff would receive additional training regarding pre-placement FamLink history searches.

The Department did not complete a home study in a timely manner.

A three-year-old child was placed with her grandparents following a Shelter Care hearing. DCFS did not refer the relative caregivers for a home study until over one year after the initial placement. Due to several changes in home study workers, it took DLR 14 months after the referral for the home study to be completed, at which point the home study was denied due to concerns about the grandparents' character and suitability, relating to their CPS history over an extensive period of time. Because the home study was not completed in a timely manner, the child resided in this home for over two and a half years before concerns regarding this relative placement were identified. The child now faces the possibility of being removed. OFCO made an adverse finding that there was an unreasonable delay (over a year) by DCFS in referring the relatives for a home study, and further unreasonable delay by DLR in completing the home study once it was referred.

- *CA Practices and Procedures Guide, Section 45274.* The Department must refer relatives for a home study within thirty days of placement in order to further assess the character, competence and suitability of the caregivers.

DCYF Response:

The Department noted that staff turnover was a significant factor contributing to the delay in the home study. During this period, DLR in this region of the state experienced almost a 100 percent turnover rate and there were three different home study workers assigned to this case. DCFS stated that following OFCO's finding, it has revised the case transfer process to ensure that caregivers are referred for home studies at the time of case staffing.

Unreasonable delay in the foster care licensing process resulted in prospective foster parents withdrawing their application.

Prospective foster parents submitted a Family Home Study Application to DLR, in December 2017. The applicants were previously licensed through a private agency from November 2004 until August 2006, when they moved out of state. The private agency documented the foster parents left in "good standing" and they "would welcome them back should they wish to reapply in the future". In January 2018, a DLR licensor contacted the applicants and let them know she would schedule a home visit once the required paperwork was submitted. The licensor also informed the prospective foster parents they were "12th on her list" of pending applications. Later in January, the prospective foster mother followed up with the licensor to confirm that all the required paperwork except the Tuberculosis test and physical exam reports had been received. The licensor confirmed receipt of the paperwork. In February 2018, the licensor completed a home inspection and indicated the home was "almost ready to license." Two days later the prospective foster mother followed up with the licensor on a few issues, confirming their dog's vaccines and licensing were up to date. In March 2018, the licensor conducted a second home inspection and concluded the home met all licensing requirements. However, due to workload issues, the licensor was not able to complete the written home study in a timely manner. In June 2018, DLR notified the prospective foster parents that they needed to update their CPR and First Aid training as it had now expired. Also missing from their file were their medical reports, which the prospective foster parents reported had been submitted and presumably either lost or misplaced by DLR. Frustrated by this seven-month delay and still not being licensed, the prospective foster parents withdrew their application in July 2018.

- *OFCC finds that the delay in the licensing process was clearly unreasonable. Due to workload, the licensor was not able to write up the licensing home study until five months after DLR received the family's application. It took five months for DLR to inform the prospective foster parents of missing paperwork, and subsequently expired training, after the prospective foster parents had asked several times whether there was anything else DLR needed. The adverse impact of this outcome is the loss of a foster family resource, a particular blow to a child welfare system desperately short of foster homes. Given the agency's concerted efforts to recruit foster families, the loss of these applicants who seemingly could have been quickly and seamlessly licensed given their past foster care experience, is especially unfortunate.*

DCYF Response:

DCYF noted that the foster care licensing team was sad and discouraged when this prospective foster family withdrew their application. They noted that the assigned DCYF licensor was experiencing a backlog at the time the application was received. The Department resolved to have

staff and managers monitor pending applications more closely to ensure timely mitigation of possible issues.

Four dependent children were placed in a foster home that was already at its capacity for foster children.

The Department requested placement of four siblings in a foster home that was already at its license capacity of three children. The foster parents agreed to take these four additional children. This placement error was in part due to confusion over whether the foster parents were a relative placement for these four siblings. As a result, a records review did not identify them as foster parents or recognize the licensing capacity issue. The overcapacity continued for seven months before the Department took action, even though health and safety visits noted there were up to eight children in the home, and identified the caregivers as foster parents. Ultimately, all children were removed from this home. Foster parents have a duty to only accept placements within the parameters of their license and to inform their licensor of individuals moving into the home. However, the Department also has a duty to assess caregivers prior to placement. Had the Department identified these caregivers as licensed foster parents and realized they were at capacity, these foster parents would not have been placed in the difficult position of refusing to accept relative/fictive kin children. Placement disruption for the children in this home may have been avoided.

- *CA Practices and Procedures Guide Sections, 45274 and 5172.* The Department has a duty to assess the character, competence and suitability of a caregiver prior to placement.

DCYF Response:

The Department acknowledged the errors made in this case and the Area Administrator followed up with casework, supervisory and clerical staff to ensure this issue does not arise again.

Unreasonable decision to place a dependent child in a foster home with two existing unstable placements.

OFCO found that the Department made an unreasonable decision to place a dependent child in a home that was over capacity and in which there were existing concerns about the care of foster children in the home. These foster parents were licensed to care for up to two children, ages 9 to 15 years old, and were caring for two siblings ages 8 and 13. At a case meeting, the Department identified concerns that the foster parents were not consistently meeting the two children's needs. Specifically, the children had missed multiple counseling appointments and school days, and the foster parents were not providing appropriate sleep environments for the children. The Department was planning to move the children to a different foster home. However, before these two siblings were moved, the Department placed a third child, age 9, in this foster home, without seeking the required administrative approval for an "overcapacity" placement. This third child had already experienced multiple placements and exhibited significant behavioral challenges at school and home including extreme defiance, and physical and verbal aggression. The decision to place this child in a foster home that exceeded its licensed capacity, while simultaneously seeking to remove two siblings because the foster parents were not adequately meeting their needs,

increased the risk of harm to all three children and signaled conflicting messages to the foster parents as to their ability to care for children with special needs. Had the required administrative approval for overcapacity placement been sought, it likely would have been denied under these circumstances, avoiding an additional unsuccessful placement for the 9-year-old child.

DCYF Response:

The Department agreed with OFCO's finding, and the Area Administrator noted the office will evaluate ways to improve communication and cooperation between case-carrying social workers and the placement desk staff who contact foster parents to identify placements. The placement coordinator will receive training to implement DCYF's placement policies.

Unreasonable delay in reimbursing foster parents for respite care services

OFCCO found that foster parents who provided respite care for dependent children experienced a five-month and a seven-month delay respectively in receiving reimbursement for the provision of respite care services on two separate occasions. The foster parents contacted the Department by phone and e-mail on multiple occasions to try to resolve the issue but were not successful. Timely reimbursement for respite care is essential to building an effective system of respite care support for foster parents, and improving foster parent recruitment and retention.

DCYF Response:

Once OFCCO brought this issue to the area administrator's attention it was quickly resolved and the foster parent received the reimbursements.

Other Findings

A five-year-old child in state care did not receive mental health counseling

A five-year-old child was removed from parental care due to allegations of physical abuse. The child was seeing a counselor prior to entering state care. A Child Health and Education Tracking (CHET) screen dated one month after entering care determined this child required further evaluation by a mental health professional, as well as clarification of whether the child could continue seeing his counselor or needed a new referral. Counseling services for the child were stopped entirely a couple of months later. Another couple of months later, the court ordered that the child receive mental health treatment as well as an updated developmental assessment. An appointment was promptly scheduled to take the child to his previous counselor for one more visit before transferring to a new provider. Approximately four months later, however, the foster parent reported that the child was not enrolled in any mental health services, nor had an updated developmental assessment been completed. The child was returned to the mother's care after almost a year in state care with a lengthy disruption of mental health treatment. The child's treatment resumed after the returned home. OFCCO found the lack of services to this child while in state care, to be clearly unreasonable.

DCYF Response:

The office's supervisory team discussed the need to thoroughly review CHET reports and court reports regarding services for children to make sure they are referred in a timely manner.

Seven-year-old dependent child is left in adult psychiatric facility for one month

OFCO found that a lack of suitable placement resources for foster children with special needs resulted in a highly inappropriate and medically unnecessary extended hospital stay for a seven-year-old dependent child, in an adult psychiatric unit. The child was taken to the hospital's adult emergency psychiatric unit due to assaultive behavior towards his foster parents and other foster children. The next day, hospital staff contacted the Department to inform that the child could not be treated in their adult psychiatric unit, and furthermore that this child did not meet the criteria for inpatient hospitalization. The Department began a diligent search for a suitable placement, but was unable to locate a placement for over a month. This seven-year-old child therefore remained in the adult psychiatric unit for 32 days before being moved to an out-of-state group care facility. Over this period, hospital staff continued to call the Department, voicing concerns for the child's safety, reiterating that the psychiatric unit was not designed to provide services to children; was not designed to be a long term care option for anyone; and as an acute care facility for adults with mental health crises, was a physically and emotionally unsafe place for a child.

The Department acknowledged these concerns but lacked an available placement for the child. In addition to the tremendous inappropriateness of this placement, the child's educational needs were completely unmet during his hospitalization. This child did not receive any kind of schooling during the month he was at the hospital. Hospital staff reported that the child was bored and lacked appropriate social interaction with peers and adults during his stay, as the hospital was unable to meet the child's social, emotional and educational needs.

- OFCO found it clearly unreasonable under the circumstances to leave a seven-year-old child in an adult psychiatric emergency department against medical advice for 32 days. This extended hospital stay without medical justification was not only harmful to the child according to the medical professionals involved, it does not represent a recognized placement for children in DCYF care. Furthermore, this situation soured relations between the hospital and the Department.
- *CA Practices and Procedures Guide, Section 4302A*. All school-aged children in out of home placement will attend public school, unless they are court approved for a different educational setting.

DCYF Response:

The Department disagreed with OFCO's adverse findings and requested a modification of both findings. The Department recounted its efforts to find alternate placements for the child, both in state and out of state. The agency recognized that the hospital was not a suitable placement for the child, but stated it did not have any other options that could meet the child's significant mental health needs. OFCO acknowledged these facts upheld its findings.

Mandated reporters experienced unreasonably long wait times when trying to report suspected child abuse or neglect to CPS intake

OFCO received a complaint from a mandated reporter who said that over the past two days, he had been on hold with CPS intake for two hours trying to report alleged physical abuse of a child with autism. This individual tried calling both the statewide intake line (1-888-END-HARM) and the local office but still could not get through. Two other complaints were made to OFCO by school officials about long wait times to make a report to CPS. The first school counselor told OFCO she was on hold trying to make a report for 45 minutes before hanging up. When she called back she waited 20 minutes before the call was answered. When the counselor told intake staff they had multiple reports to make, she was told that intake could only take one report at a time, so new calls needed to be made for each subsequent report. The second school counselor told OFCO he called CPS intake twice in one week in an attempt to make a report of suspected abuse and each time had to wait 45 minutes for the call to be answered.

In the notification of its adverse finding, OFCO cited its own experience calling CPS intake to report suspected child maltreatment. An Ombuds waited 25 minutes for the call to be answered. In addition, while investigating other complaints OFCO observed case notes from DCYF caseworkers who also had long wait times when making a CPS report. One caseworker waited 20 minutes before having to end the call without making the report due to a previous engagement, and the other waited on hold nearly an hour before reaching intake staff to make the report.

DCYF Response:

The Department responded that the number of calls made to Central Intake has increased substantially, particularly the number of emergent calls. Central Intake has not received the additional staffing necessary to respond to the increased call volume. However, they have taken the following steps in an attempt to improve call response times:

- Improve efficiencies to decrease time on the phone with the referent;
- Changing staffing patterns to have more staff available during high volume periods;
- Implemented a new automated phone system for receiving calls to Adult Protective Services, which is intended to reduce strain on calls to Child Protective Services; and
- Initiated a project to identify problem areas in the entire intake system to eliminate inefficiencies and increase productivity.

OFCO STAFF

Director Ombuds

Patrick Dowd is a licensed attorney with public defense experience representing clients in dependency, termination of parental rights, juvenile offender and adult criminal proceedings. He was also a managing attorney with the Washington State Office of Public Defense (OPD) Parents Representation Program and previously worked for OFCO as an Ombuds from 1999 to 2005. Through his work at OFCO and OPD, Mr. Dowd has extensive professional experience in child welfare law and policy. Mr. Dowd graduated from Seattle University and earned his J.D. at the University of Oregon.

Ombuds

Cristina Limpens is a social worker with extensive experience in public child welfare in Washington State. Prior to joining OFCO, Ms. Limpens spent approximately six years as a quality assurance program manager for Children's Administration working to improve social work practice and promote accountability and outcomes for children and families. Prior to this work, Ms. Limpens spent more than six years as a caseworker working with children and families involved in the child welfare system. Ms. Limpens earned her MSW from the University of Washington. She joined OFCO in June 2012.

Ombuds

Mary Moskowitz is a licensed attorney with experience representing parents in dependency and termination of parental rights. Prior to joining OFCO, Ms. Moskowitz was a dependency attorney in Yakima County and then in Snohomish County. She has also represented children in At Risk Youth and Truancy proceedings; and has been an attorney guardian ad litem for dependent children. Ms. Moskowitz graduated from Grand Canyon University and received her J.D. from Regent University.

Ombuds

Elizabeth Bokan is a licensed attorney with experience representing Children's Administration through the Attorney General's Office. In that position she litigated dependencies, terminations, and day care and foster licensing cases. Previously, Ms. Bokan represented children in At Risk Youth, Child In Need of Services, and Truancy petitions in King County. Prior to law school she worked at Youthcare Shelter, as a youth counselor supporting young people experiencing homelessness. Ms. Bokan is a graduate of Barnard College and the University of Washington School of Law.

Ombuds

Melissa Montrose is a social worker with extensive experience in both direct service and administrative roles in child protection since 2002. Prior to joining OFCO, Ms. Montrose was employed by the Department of Family and Community Services, New South Wales, Australia investigating allegations of misconduct against foster parents and making recommendations in relation to improving practice for children in out-of-home care. Ms. Montrose has also had more than five years of experience as a caseworker for social services in Australia and the United Kingdom working with children and families in both investigations and family support capacity. Ms. Montrose earned her MSW from Charles Sturt University, New South Wales, Australia.

Ombuds

Colleen Hinton is a licensed independent clinical social worker with broad experience working with children and families. Prior to joining OFCO in 2000, she provided clinical assessments of children in foster care through the Foster Care Assessment Program, and provided training on child maltreatment to community professionals through Harborview Medical Center. Prior to this work, Ms. Hinton provided child abuse evaluations and treatment at the Children's Advocacy Center of Manhattan, and worked as a therapist for the Homebuilders intensive family preservation program in King County. She is a graduate of the University of Natal in South Africa, and earned her MSW from the University of North Carolina at Chapel Hill.

Special Projects / Database Administrator

Jessica Birkliid is a public policy professional with experience in child welfare policy and research, health care, and organizational development. Prior to joining OFCO she helped hospital patients navigate the healthcare system and understand their rights and responsibilities. She also spent time conducting research and administratively supporting the Washington Commission on Children in Foster Care, with the goal of improving collaboration between the courts, child welfare partners and the education system. Ms. Birkliid is a graduate of Western Washington University and the University of Washington Evans School of Public Policy and Governance.