The Washington State Office of the Family and Children’s Ombuds Investigation Report regarding Oakley Carlson

Given the public interest in the circumstances that led to Oakley’s disappearance and questions about the Department of Children, Youth and Families involvement with her family, the Ombuds is releasing the following report.

As publicly reported, in December 2021, five-year-old Oakley Carlson was declared missing following a law enforcement child welfare check. According to law enforcement, the parents had no explanation for her disappearance and said the last time they saw Oakley was on November 30, 2021. Statements by community members indicated that the child was known to the Washington State Department of Children, Youth, and Families (DCYF), and that Oakley was in foster care between 2017 to 2019, when she was returned to her parents’ care.

Members of the community have joined together advocating for justice for Oakley. Their efforts have included requests to the Office of the Governor and the DCYF Oversight Board for a public and independent investigation into the DCYF’s handling of Oakley’s case. While the demand for information, transparency and accountability is understandable, federal and state laws mandate confidentiality of child welfare and juvenile justice records. Public disclosure is permissible only in limited circumstances, such as a child fatality or near fatality caused by abuse or neglect. The confidentiality requirements in federal and state laws are not designed to shield child welfare agencies from scrutiny, but rather to protect the rights of the child and the child’s parents or guardians.

Child fatality reviews are conducted, in cases where the fatality of a child is suspected to be caused by abuse or neglect and the family received services from the department within one year preceding the child’s death. The review is conducted by a multidisciplinary team which includes individuals with professional expertise relevant to

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1. RCW 13.50.100; RCW 74.13.500; Child Abuse Prevention and Treatment Act (CAPTA)
2. CAPTA
3. RCW 74.13.640
the specific issues of the case such as service providers, foster parent representatives, child advocates, medical professionals, law enforcement, the ombuds and DCYF staff. The purpose of the child fatality review is to: increase understanding of the circumstances surrounding the child’s death; examine DCYF policies and procedures to determine the need for policy development or revision, or recommend legislative change; evaluate DCYF services and community response to the identified needs of the family and to identify areas for education and training; and build community alliances, expertise and commitments for program improvements, policy, and procedural changes, and improved multi-disciplinary collaboration. Child fatality review reports are completed and posted on the DCYF’s public website within 180 calendar days of a child’s death. Unless a child is officially declared deceased, cases of a missing child under suspicious circumstances do not meet the legal requirements permitting a child fatality review.

The Washington State Office of the Family and Children’s Ombuds (OFCO) is an independent and impartial state agency providing oversight of the DCYF to ensure the Department carries out its duties both to appropriately preserve families as well as to protect children from maltreatment. OFCO’s specific duties include informing the public about the child welfare system and the rights and responsibilities of individual’s receiving services from the DCYF, investigating complaints alleging administrative acts by the DCYF that are contrary to laws or policies, and identifying systemic issues and recommendations to strengthen the child welfare system. The OFCO was established in response to tragedies involving child fatalities and calls for independent oversight and transparency in our state child welfare system.

The OFCO investigates, upon his or her own initiative or upon 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 a complaint. When conducting investigations, the OFCO has full access to the DCYF’s case management system and all relevant information, records, or documents in the possession or control of the Department. The OFCO is prohibited from disclosing or disseminating information obtained during the course of an investigation. The OFCO is also required to maintain the confidentiality of individuals submitting a complaint for investigation. In this way, individuals can bring their concerns to the OFCO’s attention without fear of repercussions.

The OFCO employs an objective, impartial and credible review process and acts as a fact finder and not as an advocate. Once OFCO establishes that an alleged agency action (or inaction) appears to be true, the Ombuds analyzes whether the Department’s conduct violated law, policy, or procedure. When the ombuds finds that the Department’s action did not comply with laws and was harmful, we notify the Department so that appropriate corrective steps can be taken.

The legal requirements governing the DCYF’s duties and responsibilities, and specifically those related to Oakley Carlson’s case are summarized below.

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4 RCW 43.06A
CPS Intake and Investigation
The DCYF Child Protective Services (CPS) intake receives and processes reports of child abuse and neglect. The CPS intake worker interviews the referrer, and gathers collateral information related to the report. A report is screened in for CPS intervention when: the alleged victim is under the age of 18 years old; the allegation, if true, meets the definition of child abuse or neglect, or describe circumstances that place the child at imminent risk of serious harm; and the alleged subject has the role of a parent. The intake supervisor reviews all intakes and makes a final screening decision based on all information obtained during the intake process and critical thinking that balances child safety, risk and mitigating factors. When a report is accepted for CPS intervention, the caseworker attempts to conduct an initial face to face meeting with the children within 24 hours for “emergent response” or 72 hours for “non-emergent response.” In addition to interviewing the children and parents, the CPS case worker interviews other individuals who may have knowledge of the children or youth, parents or the allegations of child maltreatment including school personnel, neighbors, relatives, and medical providers. A CPS case is closed when all components of the investigation have been completed, services are not needed or have been declined, court intervention is not necessary or appropriate and there is no identified active safety threat.

Reasonable Efforts to Reunite Families
When a child is removed from a parent’s care pursuant to a dependency proceeding, federal and state laws require the DCYF to make reasonable efforts to return the child to the parent’s care. These efforts include offering services to address safety threats and eliminate the need for out-of-home placement. Family reunification services are reviewed and approved by the court and are included in the Dependency Dispositional order and Dependency Review orders. At subsequent review hearings, based on reports from the Department and service providers, the court determines whether or not the parents are in compliance with and making progress in court ordered services.

Permanency
Laws and policies also recognize that children should not languish in out-of-home care, and permanency planning goals should be achieved at the earliest possible date, preferably before the child has been in out-of-home care for 15 months. Additionally, the court must order the department to file a petition seeking termination of parental rights if the child has been in out-of-home care for 15 of the last 22 months unless the court makes a good cause exception as to why the filing of a termination of parental rights petition is not appropriate. A strict adherence to permanency timelines is not required and “good cause exceptions” include a parent’s positive response to offered services and efforts to reunite the family. Providing guidance on interpreting and applying federal laws, the U.S. Department of Health and Human Services wrote “[w]hile we are mindful of the length of time children spend in foster care, and do not want to unnecessarily prolong that, timeliness should not be the primary driver when considering how to best achieve permanency for children and youth.”

Decision to Return a Child Home
The parents’ successful compliance with services is a key factor in the decision to return a child to the parents’ care. Prior to returning a child home, the Department completes a Safety Assessment addressing the child’s safety, permanency, and well-being and assessing the parents for any additional services. Additionally, the Department conducts a Family Team Decision Making (FTDM) meeting before reunification occurs. The FTDM process enables family members and individuals involved with the family to participate in critical decisions in the child’s case. Participants invited to attend the FTDM include: caseworker; parents; foster parents; attorneys (AAG, parents’ attorney, youth’s attorney); GAL/CASA; service providers; extended family; and other individuals supporting the parent.

Post Reunification Supervision
Once a dependent child is returned home, the court maintains jurisdiction for six months and the Department continues to provide case management services to ensure the child’s safety and that the parents comply with court orders related to the care and supervision of the child, including: “[t]he continued participation of the parents, if applicable, in available substance abuse or mental health treatment if substance abuse or mental illness was a contributing factor to the removal of the child.” A parent’s noncompliance with the department’s case plan, services or court order may be grounds for removing the child from the home. The Department’s case supervision after a child is returned home also includes two in-home health and safety visits every calendar month when children age five or younger reside in the home.

OFCO Investigation Findings and Conclusions
The OFCO investigation included a full review of all relevant records and documents and interviews with individuals with direct involvement or information about the Department’s handling of this case. Our investigation particularly focused on family reunification efforts, permanency planning, and the Department’s response to any identified child safety or risk factors prior to and after Oakley was returned home. We found that Department’s actions and conduct in this case were consistent with laws, policies and court orders. Our investigation however identified opportunities to improve services to families, and specifically to preserve and strengthen the parent-child bond when a child is removed from the home. “Family time” or parent-child visits, are critical to promoting bonding, attachment, healthy child development and successful family reunification. Our elected officials and agency leaders must ensure that adequate resources are dedicated to family time services so that parents and children receive the maximum visitation possible. Furthermore, reunification planning should not only focus on a parent’s successful compliance with services but should also address parent-child bonding and attachment issues.

We have documented the issues and findings raised in this investigation and will include them in our annual report to the Governor and to the Legislature.

6 RCW 13.34.138