OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

An Independent Voice for Families and Children

ANNUAL REPORT
2023

Patrick Dowd, Director
ofco.wa.gov

Table of Contents

EXECUTIVE SUMMARY 4

SECTION I: IMPROVING THE SYSTEM 7

THE FENTANYL CRISIS - ACCIDENTAL INGESTION OF DRUGS AND OVERDOSES BY CHILDREN 8

PLACEMENT EXCEPTIONS DATA 12

STAFF SAFETY AND TRAUMA-INFORMED SUPPORT 19

SECTION II: LISTENING TO FAMILIES AND CITIZENS 21

INQUIRIES AND COMPLAINTS 22

COMPLAINT PROFILES 23

COMPLAINT ISSUES 26

SECTION III: TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES 29

INVESTIGATING COMPLAINTS 30

OFCO'S ADVERSE FINDINGS 33

APPENDICES 35

APPENDIX A: COMPLAINT INVESTIGATIONS BY REGION AND OFFICE 36

APPENDIX B: SUMMARIES OF OFCO'S ADVERSE FINDINGS 39

Report prepared by Elizabeth Bokan and Sherry Saeteurn

STATE OF WASHINGTON
OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS
6840 FORT DENT WAY, SUITE 125
TUKWILA, WA 98188
(206) 439-3870 • (800) 571-7321 • FAX (206) 439-3877

November 2023

To the Residents of Washington State:

I am pleased to submit the 2023 Annual Report of the Office of the Family and Children's Ombuds (OFCO). This report provides an account of the OFCO's activities from September 1, 2022, to August 31, 2023. We thank the parents, youth, relatives, foster parents, professionals, and others who brought their concerns to our attention. We take their trust and confidence in our office most seriously.

During this reporting period, OFCO completed 786 investigations regarding 1,158 children. As in past years, concerns about agency conduct and the separation and reunification of families were 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. For several years, we have described the ongoing placement crisis and the use of hotels, leased facilities staffed by the Department of Children, Youth and Families workers, and temporary night-to-night foster care as emergency placements for children. This reporting year, 358 children spent a combined total of 4,570 nights in hotels, night-to-night foster homes, or other placement exceptions. As discussed in this report, these placements also contribute to circumstances that endanger youth, DCYF staff, and other professionals. Current efforts to expand resources and eliminate placement exceptions include implementation of a settlement agreement of a class action lawsuit filed on behalf of children with behavioral health needs and/or developmental disabilities who experienced placement exceptions.

Our state child welfare system is implementing new laws and initiatives to safely reduce the number of children entering state care and address racial bias that has contributed to the disproportionate removal of Black and Indigenous children from their families. As a result, the number of children in state care has fallen. These efforts, however, coincide with a fentanyl crisis that is creating significant risk of harm to children. To preserve families and protect children, we must ensure that needed family support services, and in particular substance use disorder treatment, are available throughout our state.

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,

P.K. Dowd

Patrick Dowd, JD
Director Ombuds

EXECUTIVE SUMMARY

The OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS (OFCO) works 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 state agencies serving children, adolescents, and families, and recommends and facilitates broad-based systemic improvements. The Ombuds carries out its duties in an independent manner, separate from the Department of Children, Youth and Families (DCYF). The Director Ombuds is appointed by, and reports directly to, the Governor. The appointment is subject to confirmation by the Washington State Senate.

This report provides an account of OFCO's complaint investigation activities from September 1, 2022, through August 31, 2023.

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, 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. Key features of OFCO's investigative process include:

- **INDEPENDENCE.** OFCO reviews and analyzes complaints in an objective and independent manner.
- **IMPARTIALITY.** The Ombuds acts as a *neutral investigator* and not as an advocate for individuals who file complaints or for the government agencies investigated.
- **CONFIDENTIALITY.** OFCO must maintain the confidentiality of complainants and information obtained during investigations.
- **CREDIBLE REVIEW PROCESS.** Ombuds staff have a wealth of collective experience and expertise in child welfare law, social work, mediation, and clinical practice, and are qualified to analyze issues and conduct investigations.

SYSTEM OVERSIGHT AND IMPROVEMENT:

- Monitor the procedures as established 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 to ensure children's health and safety;
- Periodically review the facilities and procedures of state institutions serving children and state-licensed facilities or residences;

[1] RCW 43.06A and RCW 26.44.030.

- 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 DCYF 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 12-month period involving the same child or family.

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]

WORKING TO MAKE A DIFFERENCE

The ongoing fentanyl crisis and impact on families leaves children at significant risk. In addition to situations of child neglect secondary to a parent's substance use disorder, there has been an increase in the accidental ingestion of drugs and overdoses by children; over the past year, the majority of these incidents have involved fentanyl. The rising impact of fentanyl on our communities coincides with efforts in our child welfare system to support families and protect children from maltreatment, while preventing the removal of children from their home.

In 2021, the legislature passed the Keeping Families Together Act (KFTA) to safely reduce the number of children entering state care and address racial bias in the child welfare system which has contributed to the disproportionate removal of Black and Indigenous children from their families. Key provisions of this act changed the legal standard required for a child's removal from the home and went in effect on July 1, 2023. Before ordering a child removed from the home, the court must now find that removal is necessary to prevent "imminent physical harm" to the child, due to child abuse or neglect. Since this provision took effect, there has been nearly a 25% decrease in the number of children entering care, compared to 2022. Other initiatives aimed at safely maintaining children in their homes, along with implementation of the KFTA, have particularly reduced the out-of-home placement of infants and toddlers. The ultimate success of the KFTA rests on ensuring a sufficient array of family supports and services to remedy circumstances that would otherwise result in out-of-home placement of a child, and particularly substance use disorder treatment and services.

Due to a chronic lack of placement resources, particularly for children with complex needs, DCYF has continued to house children in unlicensed placements, including hotels and leased facilities staffed and managed by DCYF. This year, OFCO documented 4,570 overnight placement exceptions involving 358 children. This is a slight decrease in the number of placement exceptions from last year, but an increase in the number of children experiencing a placement exception. DCYF expanded the use of leased facilities which has resulted in a 50% drop in overnight hotel stays. In most cases, a placement exception is temporary, and a suitable placement is obtained within five or fewer days. A relatively small number of children continue to make up the majority of placement exceptions. This year, 64 children spent 20 or more nights in placement exceptions, accounting for 75% of all placement exceptions. Many of these

[2] Child Fatalities and Near Fatalities in Washington State, September 2023. Available at: https://ofco.wa.gov/reports-and-data.

children have significant treatment, supervision, and placement needs, and current placement resources are insufficient to meet them.

Current efforts to eliminate placement exceptions include implementation of a settlement agreement of a class action lawsuit filed on behalf of children with behavioral health needs and/or developmental disabilities who experienced placement exceptions. Key provisions of DCYF's implementation plan will: establish an emerging adulthood housing program; establish professional therapeutic foster parenting; establish a statewide hub home model program; revise foster care licensing standards; and enhance family group planning. Additionally, DCYF has requested additional funding to increase rates and expand emergent placement services to provide short-term licensed care for children.

Housing children in hotels and temporary facilities is disruptive for children and often traumatic. These placements also contribute to circumstances that endanger youth, DCYF staff, and other professionals. Of the 57 reports involving physical assault or endangerment, forty-nine incidents involved youths experiencing temporary placement in a hotel or leased facility. Most of these incidents did not result in injury or physical harm, however, they illustrate the vulnerability of DCYF staff responsible for supervising children in placement settings ill equipped to meet their needs. To protect both children and DCYF staff, the Department must develop and implement strategies to enhance safety and prevent physical assaults and other behaviors that endanger others.

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2022, and August 31, 2023, OFCO completed 786 investigations regarding 1,158 children. Issues involving the conduct of DCYF staff and other agency services were the most frequently identified complaint issues. Issues involving the separation and reunification of families comprised the next highest category of issues identified in complaints.

OMBUDS IN ACTION

OFCO acts when necessary to avert or correct a harmful action, oversight, or avoidable mistake by DCYF. Thirty-seven complaints prompted intervention by OFCO in 2023. OFCO provided assistance in an additional 62 complaints to resolve either the complaint issue or a concern identified by OFCO in the course of its investigation.

In 2023, OFCO made 34 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 or rescission of the finding. This process provides transparency for OFCO's work as well as accountability for DCYF.[3]

[3] An inter-agency agreement between OFCO and DCYF was established in November 2009.

SECTION I: IMPROVING THE SYSTEM

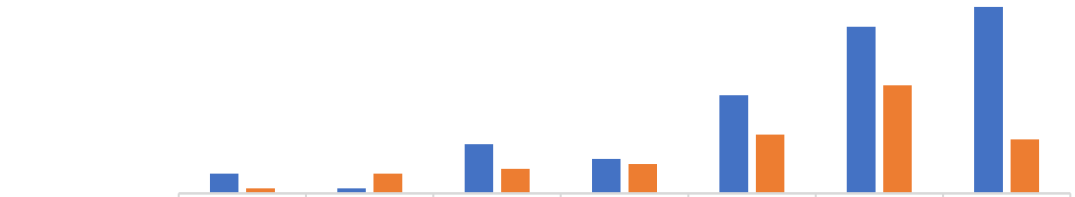
- The Fentanyl Crisis - Accidental Ingestion of Drugs and Overdoses by Children
- Placement Exception Data
- Staff Safety and Trauma-Informed Support

THE FENTANYL CRISIS - ACCIDENTAL INGESTION OF DRUGS AND OVERDOSES BY CHILDREN

Throughout the last four years, OFCO has seen a significant increase in critical incidents involving accidental ingestion of drugs and overdoses by children. Over a quarter of the child fatalities and more than half of the child near fatalities examined by OFCO in 2022 were cases of accidental ingestions and overdoses, and over 67% of these incidents involved fentanyl.[4] Thus far in 2023, OFCO has examined 38 near fatalities and 11 fatalities involving accidental ingestions and overdoses; all but five incidents involved fentanyl.[5] The critical incidents described in this section only include child fatalities or near fatalities where the family was involved with the child welfare system within the preceding 12 months. Furthermore, OFCO is not notified of all child fatalities or near fatalities, only those recorded in the DCYF reporting system.[6] Fentanyl's impact is much broader than this.

The fentanyl crisis' impact on child fatalities and near fatalities is a national problem. A 2023 study reviewing child death review reports in forty states from 2015 to 2018 found that opioids are the most common substance contributing to fatal poisonings among young children. The study noted that in recent years, children have been exposed to new opioid sources, such as heroin, fentanyl, and opioids used in medication-assisted treatment, and that opioid poisoning-related child fatalities increased from 24% in 2015 to 52% in 2018. Children aged 5 years and younger have the highest rate of emergency department visits for unintentional drug-related poisonings.[7] In 2021, 40 infants and 93 children ages one to four years died from accidental fentanyl poisoning in the United States, a sixfold increase among children younger than five years since 2018. Those numbers have only since increased. Adolescent drug overdose deaths have also increased since 2021 and 77% of these deaths involved fentanyl.[8]

Figure 1: **Critical Incidents Involving Accidental Ingestions and Overdoses, 2017-2023**



	2017	2018	2019	2020	2021	2022	2023
Near Fatalities	4	1	10	7	20	34	38
Fatalities	1	4	5	6	12	22	11

[4] Child Fatalities and Near Fatalities in Washington State, September 2023. Available at: https://ofco.wa.gov/reports-and-data.

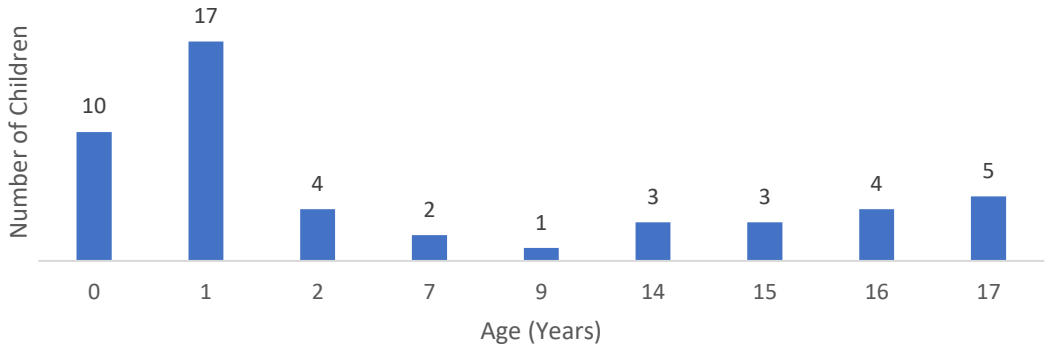
[5] Critical incidents counted for 2023 are as of 9/30/2023.

[6] OFCO receives notice through the DCYF's Administrative Incident Reporting System (AIRS).

[7] Gaw CE, Curry AE, Osterhoudt KC, et al. *Characteristics of Fatal Poisonings Among Infants and Young Children in the United States.* Pediatrics. 2023;151(4): e2022059016.

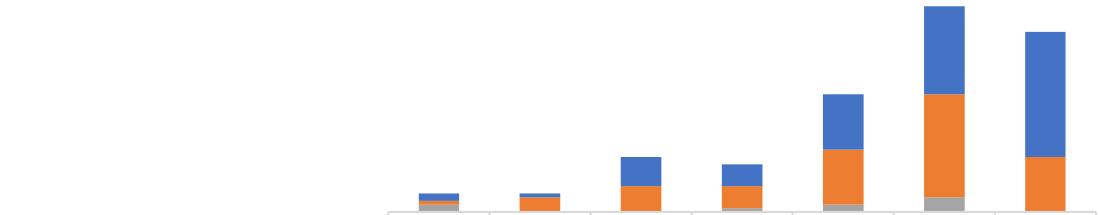
[8] Gaither JR. *National Trends in Pediatric Deaths From Fentanyl*, 1999-2021. JAMA Pediatr. 2023;177(7):733–735.

Figure 2: **Age of Children Involved in Accidental Ingestions and Overdoses, 2023**



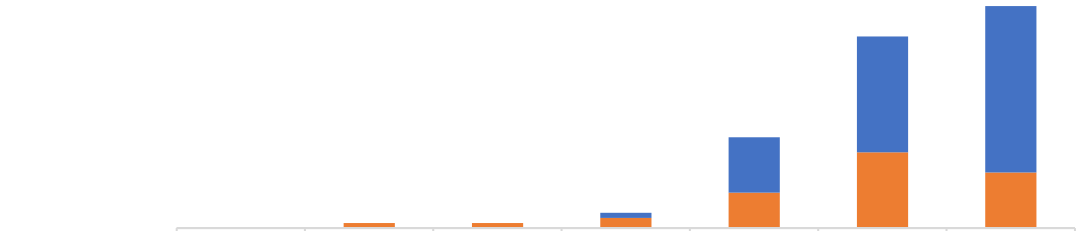
All 11 child fatalities OFCO examined in 2023 involving accidental ingestions and overdoses involved fentanyl. Younger children were at the greatest risk. Of the 49 critical incidents of accidental ingestions and overdoses examined in 2023, 31 involved children under three years of age.

Figure 3: **Accidental Ingestions and Overdoses, 2017-2023**



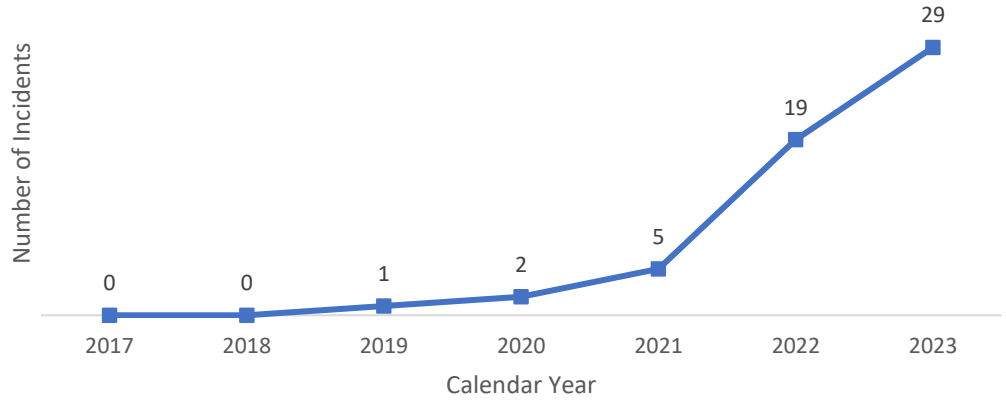
	2017	2018	2019	2020	2021	2022	2023
Accidental Ingestion, Ages 0 to 11	2	1	8	6	15	24	34
Accidental Overdose, Ages 11 to 22	1	4	7	6	15	28	15
Intentional Overdose, Ages 12 to 20	2	0	0	1	2	4	0

Figure 4: **Critical Incidents Involving Fentanyl, All Children and Youth, 2017-2013**



	2017	2018	2019	2020	2021	2022	2023
Near Fatalities	0	0	0	1	11	23	33
Fatalities	0	1	1	2	7	15	11

Figure 5: **Critical Incidents Involving Accidental Ingestion of Fentanyl by Children Ages 0-11, 2017-2023**



PREVENTING CHILD MALTREATMENT AND PRESERVING FAMILIES

Different, and at times conflicting, policy goals are inherent to the child welfare system. DCYF is charged with both preventing child abuse and neglect, as well as preserving and supporting families. DCYF performance outcome measures include reducing the number of children entering out-of-home care, reducing the length of time children spend in care, and increasing family reunification, while also reducing the number of children re-entering care after family reunification[9]. To prevent child abuse and neglect while preserving and strengthening families, the legislature passed the Keeping Families Together Act (KFTA) in 2021. The act also aims to safely reduce the number of children in foster care and address racial bias in the child welfare system which has contributed to the disproportionate removal of Black and Indigenous children from their families.

Key provisions of the KFTA include changes to the legal standard required for a child's removal from the home.[10] Before ordering a child removed from the home, the court must now find that removal is necessary to prevent "imminent physical harm" to the child, due to child abuse or neglect. Previously, the standard for removal was broader and allowed the court to issue an order if it found the child's health, safety, and welfare would be seriously endangered if not taken into custody, and that the child was at risk of imminent harm. At the shelter care hearing, the court must also find a causal relationship between the conditions in the home and imminent physical harm to the child. The KFTA specifically states that factors including family poverty, inadequate housing, substance abuse, prenatal drug or alcohol exposure, and mental illness by itself do not constitute imminent physical harm.

Additionally, to strengthen families and protect children while preventing child welfare involvement, DCYF, the Department of Health, the Health Care Authority, and the Washington State Hospital Association recently created "Plan of Safe Care,"[11] a new pathway to engage parents and infants that are born substance exposed but without safety concerns. Through the Plan of Safe Care, hospitals and care

[99] RCW 43.216.015.
[10] KFTA changes the standard for law enforcement placing a child in protective custody, a hospital administrative hold on a child, and a court order directing DCYF or law enforcement to place a child in custody.
[11] https://www.dcyf.wa.gov/safety/plan-safe-care, https://www.dcyf.wa.gov/sites/default/files/pdf/SignedCrossAgencyLetter.pdf.

providers connect parents with voluntary wraparound services from community organizations without reporting the family to Child Protective Services.

Since the KFTA went into effect on July 1, 2023, DCYF has recorded a 24.6% decrease in the number of children entering care. The largest reduction in out-of-home placements (49%) was among infants and toddlers, ages zero to three years.[12] Additionally, the number of substance-exposed infants entering care has also decreased in the past year, as DCYF has taken additional steps to prevent removal and support a safety plan for a family, when feasible.

RECOMMENDATIONS:

The implementation of the KFTA coincides with the rising fentanyl crisis straining our child welfare system. Because the "imminent physical harm" standard may be interpreted more narrowly, it is essential that child welfare professionals and judicial officers develop an objective framework to thoroughly and consistently evaluate all the factors present when considering causality between the parent's conduct and the circumstances leading to DCYF's involvement with the family, and the necessity of out-of-home placement to prevent imminent physical harm to the child. Factors relevant to causality include, but are not limited to, the extent of the caregiver's substance use disorder (SUD), the caregiver's understanding of risk to the child, whether the caregiver is engaged in treatment and support services, and the child's age, vulnerability, and reliance on the caregiver to meet basic needs.

Keeping children safe and preserving families is only possible if there are adequate services and resources to support families. A qualitative study of people in Washington State who use fentanyl found that 70% were interested in reducing or stopping their fentanyl use but identified lack of services as a barrier to recovery.[13] Navigating SUD diagnosis and treatment is significantly more difficult for Black, Indigenous, and other people of color.[14] Washington State must establish a robust continuum of SUD treatment services including medical assisted treatments, as well as counseling and behavioral therapies accessible in all regions of our state.

DCYF, DOH, and HCA should engage in rigorous data collection and analysis to evaluate the implementation and outcomes of Plan of Safe Care and determine if parents and infants receive services necessary to provide for the safety and healthy development of the child and prevent future involvement with the child welfare system. This information is critical to identify any gaps in connecting families with services, as well as additional resources that are needed.

[12] Number of children entering care from July 1, 2023, through September 29, 2023, compared to July 1, 2022, through September 2022. DCYF Webinar, October 15, 2023.

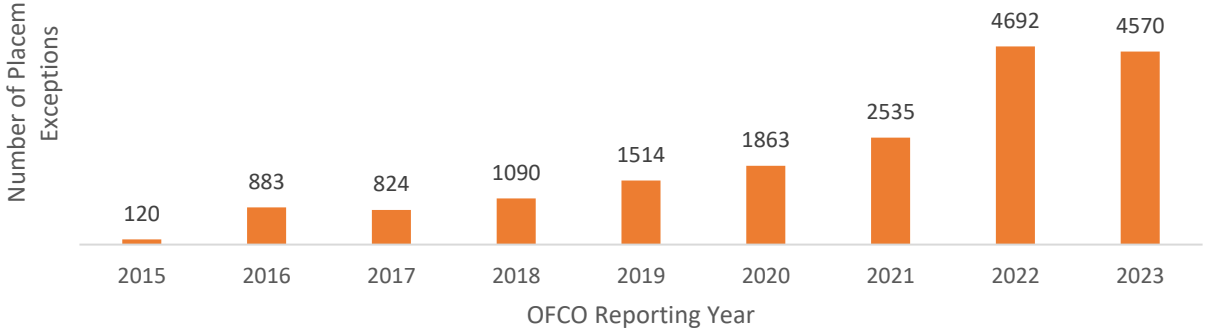
[13] Teresa Winstead, PhD, MA; Alison Newman, MPH; Everett Maroon, MPHc; Caleb Banta-Green, PhD, MPH, MSW, Unmet Needs, Complex Motivations, and Ideal Care for People Using Fentanyl in Washington State: A Qualitative Study, June 2023. Fentanyl Qualitative Report, June 2023 (uw.edu).

[14] Caroline Le, Sarah Coombs, Substance Use Disorder Hurts Moms and Babies, National Partnership for Women & Families, June 2021, substance-use-disorder-hurts-moms.pdf (nationalpartnership.org).

PLACEMENT EXCEPTIONS DATA

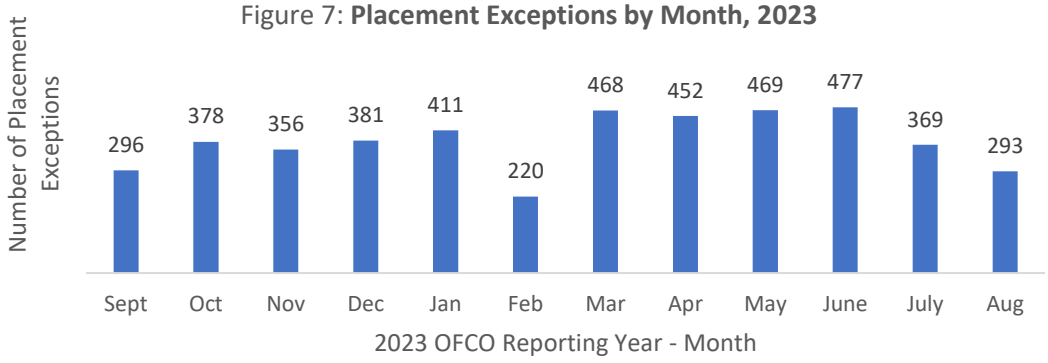
PLACEMENT EXCEPTIONS FOR FOSTER CHILDREN

Figure 6: **Placement Exceptions, 2015-2023**



Due to a chronic lack of placement resources, particularly for children with complex needs, for years DCYF has housed children in unlicensed placements such as hotels or night-to-night licensed foster homes until an appropriate placement became available.[15] From September 1, 2022, to August 31, 2023, OFCO received notice of 4,570 placement exception events involving 358 children. This is a slight decrease in the number of placement exceptions from last year, but an increase in the number of those children experiencing a placement exception. In 2022, DCYF included night-to-night foster care stays when reporting placement exceptions. While technically these are not placement exceptions in the strictest sense, as the placement is a licensed foster home, the lack of stability and the transient nature of these placements results in a similar experience for the child. Additionally, this past year, the Department expanded the use of leased facilities providing temporary placement that are managed and staffed by DCYF employees. This has led to a 50% drop in placement exceptions occurring in hotels from 2022. This reporting year, 44% of placement exceptions were in hotels, 39% in leased facilities, and 17% in night-to-night licensed foster homes. No placement exceptions occurred in DCYF offices, compared to 771 "office stays" in 2021.

Figure 7: **Placement Exceptions by Month, 2023**



[15] Child welfare systems across the country also struggle to secure appropriate placement for children in care. Kids housed in casino hotels? It's a workaround as U.S. sees decline in foster homes Jazmine Orozco Robriguez, June 14, 2023 https://www.npr.org/sections/health-shots/2023/06/14/1181975688/foster-kids-in-casino-hotels-decline-in-foster-homes.

Table 1: **Location of Placement Exceptions by Region, 2023**

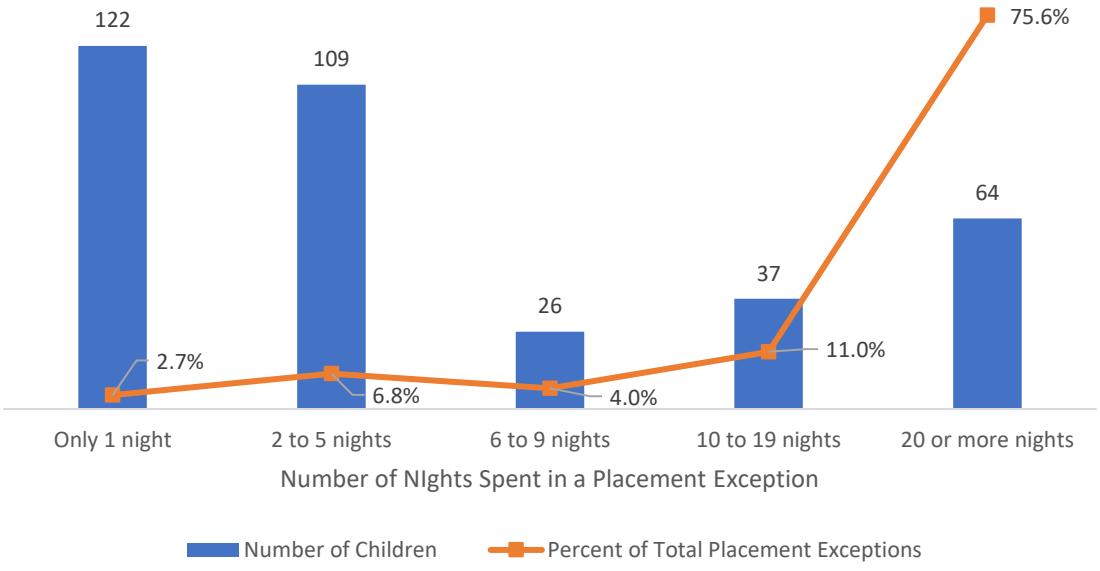
DCYF Region	Hotel	Night to Night	Leased Facility	Total Number of Placement Exceptions
Region 1	9	--	--	9
Region 2	--	--	--	--
Region 3	121	81	6	208
Region 4	10	54	1094	1158
Region 5	53	234	--	287
Region 6	1795	421	692	2908

Sixty-four percent of placement exceptions occurred in DCYF Region 6 (Clallam, Jefferson, Mason, Grays Harbor, Thurston, Pacific, Lewis, Wahkiakum, Cowlitz, Skamania, and Clark Counties) and 25% were in Region 4 (King County). The vast majority of hotel stays also occurred in Region 6, while Region 4 primarily utilized the Lake Burien leased facility.

DCYF typically locates a placement within a few days for most children who experience placement exceptions. This year, DCYF identified a suitable placement for 65% of children within five days or less of a placement exception occurring, nearly identical to last year. However, these children accounted for less than 10% of all reported placement exceptions.

Sixty-four children (18%) were reported to have spent 20 or more nights in placement exceptions and accounted for over 75% of all placement exceptions, with a combined total of 3,453 nights. Of these 64 youth, 29 spent 45 or more nights in a placement exception and accounted for over half of all reported placement exceptions (2,365 nights).

Figure 8: **Number of Placement Exceptions, per Child, 2023**



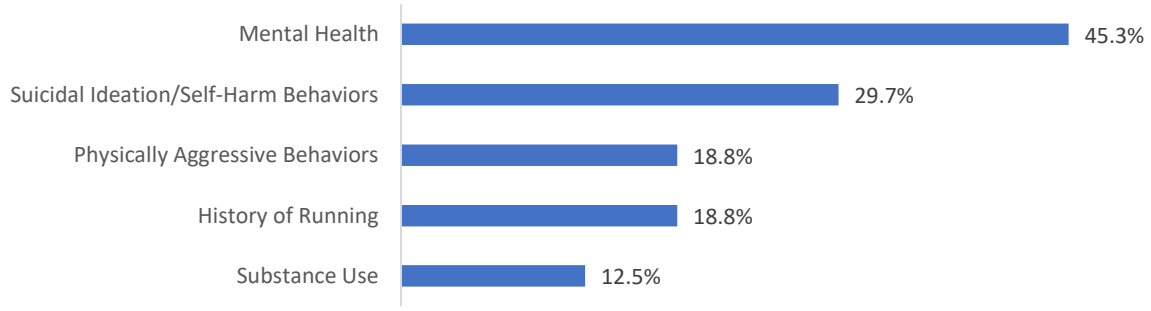
WHO ARE THE SIXTY-FOUR YOUTH WHO SPENT TWENTY OR MORE NIGHTS IN PLACEMENT EXCEPTIONS?

- The highest number of nights in placement exceptions reported for a single child was 272 nights.
- Six youth stayed over 100 nights in a placement exception. Four of these six youths have significant mental health needs, such as mental health disorders and/or past psychiatric stays.
- Over 92% of these youth were aged 10 years or older, with the majority (61%) being between the ages of 15 and 17.
- As of October 2023, placement has been located for 50 of these youth.[16] Five remain in a DCYF leased facility, four were placed in juvenile detention, two aged out of foster care without electing to participate in the Extended Foster Care program, and three youth are currently missing from care.

Table 2: **Current Placement for the 64 Youth Experiencing 20 or more Nights in Placement Exceptions**

Current Placement	Number of Youths
BRS Placement or Group Home	18
Returned Home to Parent	9
Relative or Suitable Other Placement	6
Foster Home	5
Extended Foster Care Independent Living	5
Extended Foster Care Foster Home	3
Out of State Residential Treatment Center	2
CLIP Placement	2
DCYF Leased Facility	5
Juvenile Detention	4
Aged out of Foster Care	2
Missing from Care	3

Figure 9: **Characteristics and Behavior of Children Who Spent 20 or More Nights in Placement Exceptions, 2023**



[16] Placement information as of 10/17/2023.

Table 3: **Age, Race, Gender of Children Who Spent 20 or More Nights in Placement Exceptions, 2023**

	Number of Children	Percent of Children Who Spent 20 or More Nights in Placement Exceptions
Age		
0-4 years	1	1.6%
5-9 years	4	6.3%
10-14 years	20	31.3%
15-17 years	39	60.9%
Race/Ethnicity[17]		
American Indian or Alaska Native	12	18.8%
Asian or Pacific Islander	--	--
Black/African American	16	25.0%
Hispanic/Latino	6	9.4%
Multiracial, Other	1	1.6%
White/Caucasian	29	45.3%
Gender/Sex[18]		
Female	22	34.4%
Male	32	50.0%
Transgender Female	1	1.6%
Transgender Male	3	4.7%
Other	6	9.4%

DEMOGRAPHICS OF CHILDREN EXPERIENCING PLACEMENT EXCEPTIONS

Of the 358 children who spent at least one night in a placement exception, 52.8% were male and 41.6% were female. The remaining 5.6% identified as transgender or other gender.[19]

Although children ages 10 to 17 years of age make up approximately 29% of the total out-of-home care population in Washington State,[20] they comprise 69% of the children experiencing placement exceptions. As shown in Figure 11, and consistent with previous years, children who experience placement exceptions tend to be older than the total out-of-home care population.[21] Children ages 10 to 14 spent an average of 12 nights in placement exceptions, and children ages 15 to 17 spent an average of 21 nights.

The majority of the children (77%) experiencing placement exceptions this year were assigned to a DCYF office in Regions 4 or 6.

[17] This report reports race and ethnicity categories according to DCYF's WSRDAC/M standard. American Indian/Alaska Native, Multiracial has been combined with American Indian/Alaska Native, and Black/African American, Multiracial has been combined with Black/African American.

[18] While the DCYF documents the legal and preferred name, and reported pronouns and gender identity of the child, some children may not feel comfortable sharing this information. See, DCYF Policies and Procedures Section 6900.

[19] While the DCYF documents the legal and preferred name, and reported pronouns and gender identity of the child, some children may not feel comfortable sharing this information. See, DCYF Policies and Procedures Section 6900.

[20] Department of Children, Youth, and Families. Number and Percent of Children/Youth Who Experienced Out-of-Home Care, by Age, SFY 2022. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

[21] Ibid.

Figure 10: **Gender of Children in Placement Exceptions, 2023**

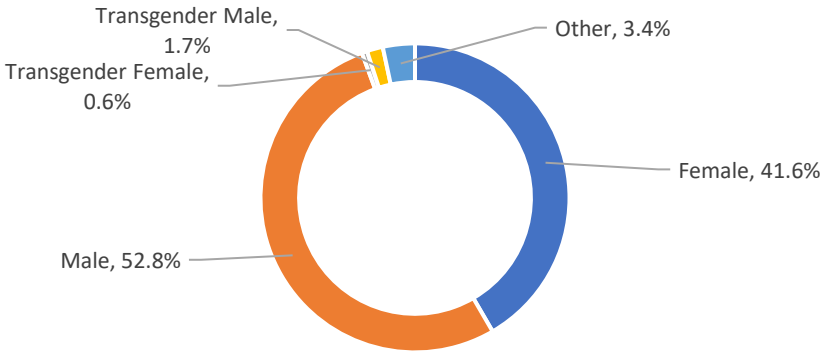


Figure 11: **Age of Children in Placement Exceptions, 2023**

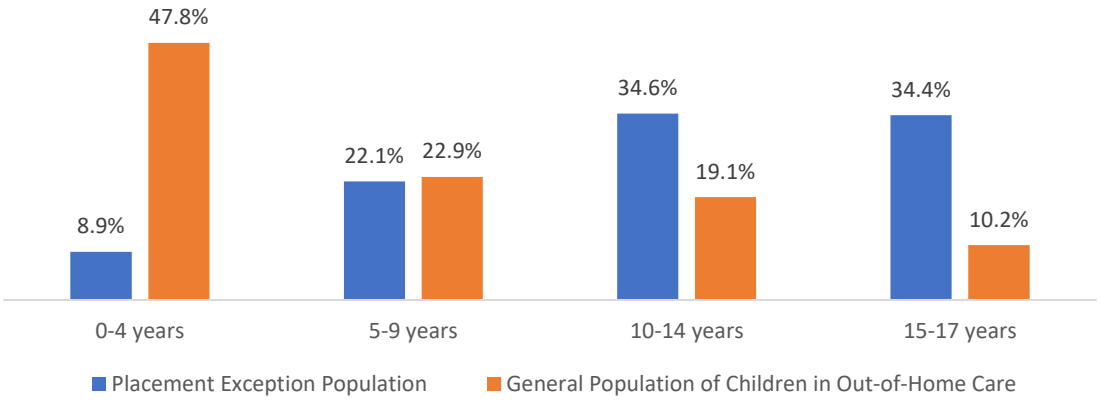


Figure 12: **Average Number of Placement Exceptions by Age, 2023**

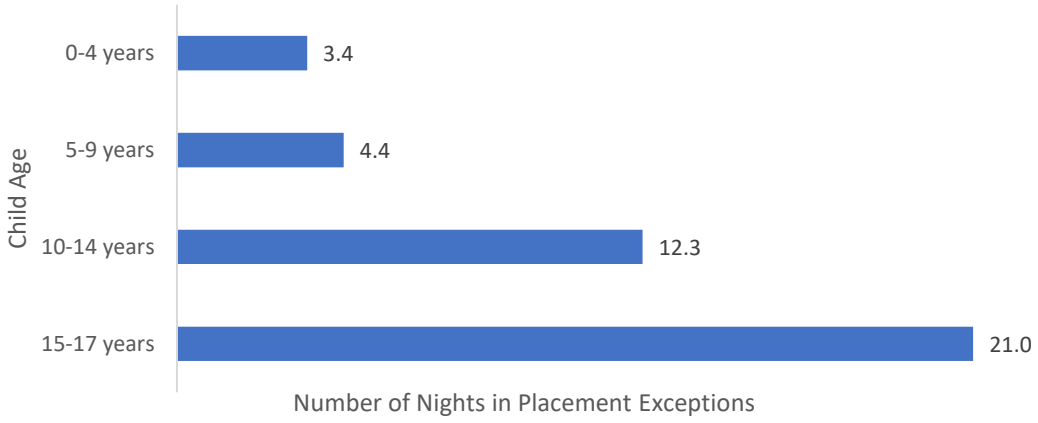


Table 4: **Child Race and Ethnicity, 2023**

Child Race/Ethnicity	Placement Exception Population	Washington State Out-of-Home Care Population[22]
American Indian or Alaska Native	12.6%	18.0%
Asian or Pacific Islander	1.7%	1.0%
Black/African American	21.2%	16.0%
Hispanic/Latino	11.5%	16.0%
Multiracial, Other	2.8%	2.0%
White/Caucasian	48.6%	46.0%
Unknown	1.7%	--

Table 5: **Number of Children Who Experienced Placement Exceptions by Region, 2023**

DCYF Region	Number of Children	Percent of Total Placement Exceptions
Region 1	2	0.6%
Region 2	--	--
Region 3	50	14.0%
Region 4	90	25.1%
Region 5	32	8.9%
Region 6	184	51.4%

STRATEGIES TO ELIMINATE PLACEMENT EXCEPTIONS

D.S. Settlement Agreement

In January 2021, Disabilities Rights Washington (DRW) filed a lawsuit on behalf of Washington children in foster care who have behavioral health needs and/or developmental disabilities and who spent significant periods of time in single night placements, Department offices, or hotels. The parties entered a Settlement Agreement in June 2022, and, in May 2023, DCYF issued an implementation plan[23] for the following system improvements and alternatives to night-to-night foster care and placement exceptions:

- Emerging Adulthood Housing Program: Develop and implement an array of supported statewide housing for young people ages 16 – 20 years who prefer to live independently.
- Professional Therapeutic Foster Parenting: Develop and implement a contract and licensing category for therapeutic foster parent professionals to support children with developmental disabilities or behavioral health needs and their families.
- Statewide Hub Home Model Program: Develop and implement a statewide Hub Home Model Program focused on caring for youth with current, or a history of, behavioral health needs. A licensed foster parent with experience caring for young people who qualified for Wraparound with Intensive Services (WISe) or Behavioral Rehabilitative Services (BRS) serves as a "Hub Home" and supports up to ten Satellite Homes.

[22] Department of Children, Youth, and Families. Children in Care by Race/Ethnicity, Last Day of SFY 2016-2022. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.
[23] D.S. Implementation Plan, May 31, 2023, revised August 2, 2023. https://dcyf.wa.gov/sites/default/files/pdf/FinalDSImplementationPlan.pdf.

- Revising Licensing Standards: Amend contracts and policies and engage in negotiated rulemaking to amend requirements for foster care placements to be more developmentally appropriate and flexible to meet the needs of individual youth.
- Family Group Planning: Review the Shared Planning Meeting policies and practices for improvements and revise those policies and practices in response to stakeholder input. A contracted stakeholder process is assisting with the development, implementation, and evaluation of this System Improvement.
- Referrals and Transitions: Develop and implement referral and transition protocols in response to feedback from lived experience experts and other stakeholders. A contracted stakeholder process is assisting with the development, implementation, and evaluation of this System Improvement.
- Qualified Residential Treatment Programs (QRTP): Increase the frequency of, and improve the process for, assessments of youth to determine if placement in a Qualified Residential Treatment Program (QRTP) is, or continues to be, the best treatment option for youth who are referred.

Expand Emergent Placement Services

Placement exceptions often occur under emergent circumstances when the department is unable to place the child in an ongoing placement. Emergent Placement Services (EPS) provide short term (up to 15 days) care for children with high levels of support needs. This program was established in 2018 and provider rates are outdated. DCYF is resting funds to expand EPS resources and increase rates to providers.[24] Increasing EPS beds will help reduce reliance on placing children in hotels or DCYF staffed leased facilities.

[24] DCYF 2023-25 First Supplemental Budget Session, Emergent Placement Needs Decision Package, https://ofm.wa.gov/about/news/2023/09/agency-budget-requests-2024-supplemental-now-available-online.

STAFF SAFETY AND TRAUMA-INFORMED SUPPORT

Since September 1, 2022, OFCO has documented 57 reports involving physical assaults or conduct by youth that endangers DCYF staff or other professionals including medical staff, therapists, and security guards. Forty-nine of these 57 incidents involved youth experiencing a placement exception in a hotel or DCYF-managed temporary placement facility (Ryan's House, now named Aspire House, or Lake Burien).

Most of these incidents (27) occurred while the youth was at Aspire House or Lake Burien, or at a hotel and supervised by DCYF staff. Thirteen incidents occurred at a DCYF office, and nine incidents took place while the youth was transported in a vehicle operated by DCYF staff.

Most of these incidents did not involve law enforcement intervention or result in injury requiring medical attention, and DCYF staff successfully deescalated these situations.

However, even these "minor incidents" of youth acting out underscore the vulnerability of the DCYF staff and the potential risk to others. For example, some of these reports describe a youth striking or grabbing caseworkers while they are driving a vehicle. The incidents did not result in an accident or injury, but the potential risk is present.

Other incidents do result in injury, and sometimes in significant injury. In other instances, though no physical assault occurred, youth committed serious offenses against staff. In one such event, a youth held scissors to the throat of a worker who was transporting the youth, took the worker's cell phone, demanded the worker drive them to a location where they met up with another individual, and forced the worker to cover their face with a pillow as the youth departed.

Thirty-three youths were identified as responsible for the 57 incidents of threatening or injuring staff. This number represents a small percentage of children in placement exceptions. (In 2023, 358 children were placed in a hotel or another placement exception for one or more nights.) These youth frequently have special needs and are some of the most challenging children for DCYF to appropriately place. They are frequently candidates for, or are also receiving services from, Developmental Disability Administration, Health Care Authority, and Juvenile Rehabilitation. These incidents of assault and threats are a direct result of multiple systems' lack of appropriate resources, placements, and services for these youths.

One of the 33 youth referenced above engaged in physical assaults and verbal abuse of staff in three instances over three weeks while experiencing placement exceptions in hotels. In the first instance, the youth broke down a door and frame in a hotel room while attempting to access a DCYF staff person and a security guard. The youth rammed and kicked the door and then stuck a fire extinguisher through a crack in it, spraying both adults, before setting off a fire alarm; the youth then ran out and onto the highway. In the next instance, the youth became escalated during transport and began yelling at the staff person who was driving, saying that they hoped she would be raped in front of her family, that the youth would have people they knew rape her, murder her, and cut up her body, and that the youth was going to throw the worker out of the moving car. The youth then threatened to kill the worker if she did not stop the car. The worker attempted to comply, but while the car was moving and on the off-ramp from the freeway, the youth took the keys out of the ignition and threw them out of the car. The youth then took the worker's phone and called law enforcement

regarding their own behavior, who responded. In the third instance, the youth became escalated while in a hotel room and pulled the supervising worker's hair, then dragged her across the room, and kicked her several times in the face. The youth also hit a security guard who was present. The assault was reported to last for 10 to 15 minutes before law enforcement arrived. The worker who was dragged by the hair was diagnosed with contusions, a broken nose, and a concussion. This youth has since been admitted to a children's psychiatric facility.

In addition to dealing with situations that present a direct threat to their physical safety, such as assaultive behavior or possible exposure to drugs including fentanyl, DCYF staff are also exposed to secondary traumatic stress as an occupational hazard through working with individuals with acute needs and witnessing and attempting to mitigate the negative experiences of children and families on their caseloads. DCYF staff are also impacted by critical incidents such as child fatalities, near fatalities, and other traumatic events. The cumulative effect of threats to safety and exposure to trauma may also negatively impact staff performance, as the impact of these experiences may disrupt one's ability to think clearly while assessing risk and safety, as well as one's ability to make fair and objective decisions. Additionally, workplace trauma contributes to high turnover of staff which harms DCYF's ability to serve children, youth, and families.[25]

RECOMMENDATIONS:

Develop and implement strategies to enhance staff safety and prevent physical assaults and other behaviors that endanger staff or others. Efforts should include:

- Increase children to staff ratios when supervising placement at a hotel or leased facility and when transporting a child.
- Ensure that all staff assigned to supervise youth have sufficient training and supervision, including in de-escalation techniques.

Develop and implement interventions to support individual staff; develop organizational interventions to create a trauma-informed work environment.

- Interventions for staff could include: critical incident debriefing to help mitigate the effects of a traumatic event;[26] individual or group therapy at no cost to staff; caseload coverage, adjusted work hours, and/or caseload management following a critical incident.
- DCYF organizational development efforts could include utilizing established tools such as the Secondary Traumatic Stress-Informed Organization Assessment to examine whether resilience-building activities and physical and psychological safety are promoted; policies, leadership, and practices are secondary traumatic stress informed; and secondary traumatic stress policies are appropriately evaluated and monitored.[27]

[25] Secondary Traumatic Stress: Definitions, Measures, Predictors, and Interventions, Anita Barbee, PhD, MSSW, Lisa Purdy, MSSW, & Michael Cunningham, PhD, University of Louisville (September 2023).
[26] Secondary Traumatic Stress in Child Welfare Practice: Trauma-Informed Guidelines for Organizations, The Chadwick Trauma-Informed Systems Dissemination and Implementation Project (December 2016) available at https://cblcc.acf.hhs.gov/wp-content/uploads/stsinchildwelfarepractice-trauma-informedguidelinesfororganization.pdf.
[27] Secondary Traumatic Stress-Informed Organization Assessment (STSI-OA) available at http://www.uky.edu/CTAC/STSI-OA.

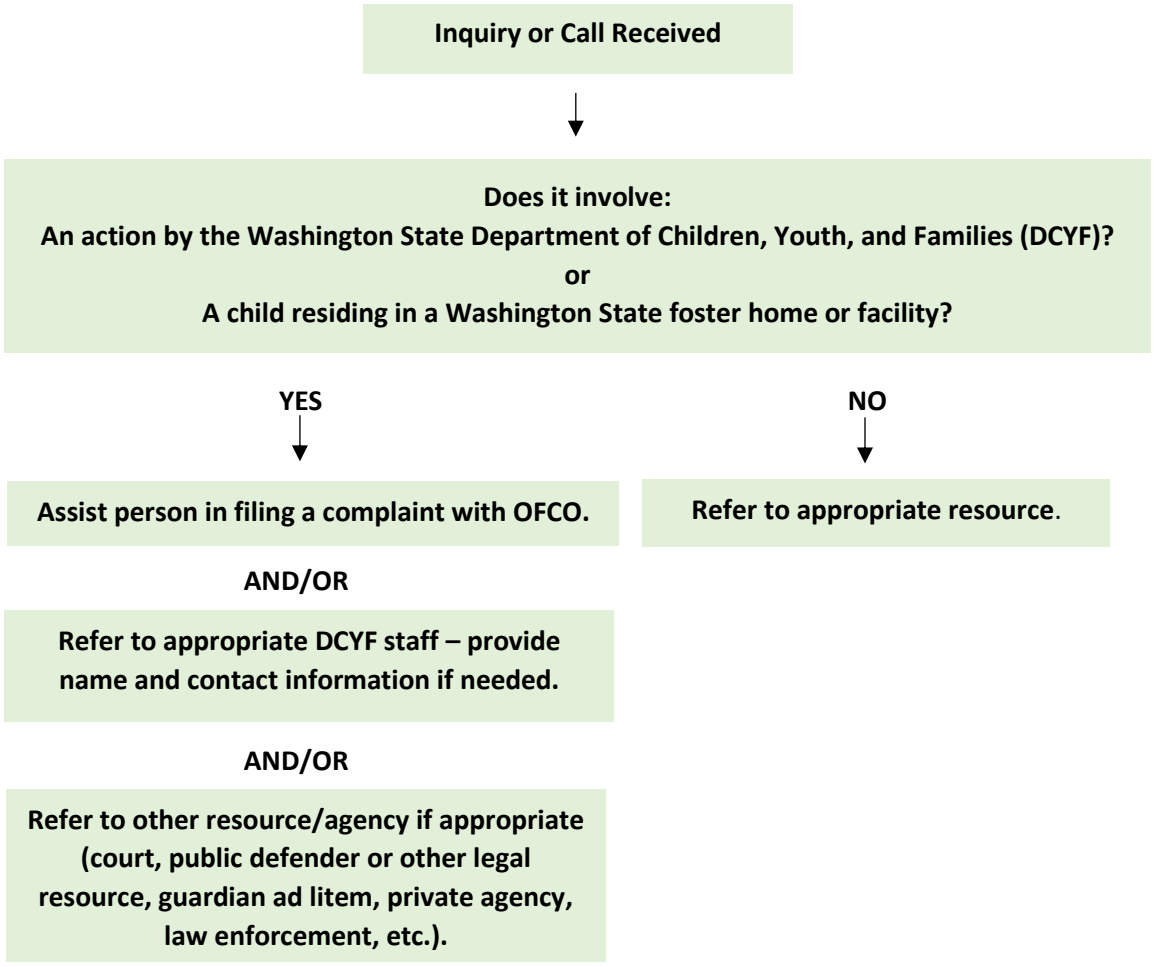
SECTION II: LISTENING TO FAMILIES AND CITIZENS

- Inquiries and Complaints
- Complaint Profiles
- Complaint Issues

INQUIRIES AND COMPLAINTS

OFCO listens and responds to people who contact the office with questions or concerns about services provided through the child welfare system. Callers may simply need information about DCYF's' processes and/or services, or they may want to know how to file a complaint with OFCO. If OFCO cannot address a caller's concerns, the caller will be referred elsewhere for information or support.

Figure 13: **What Happens When a Person Contacts OFCO?**



COMPLAINT PROFILES

This section describes complaints filed during OFCO's 2023 reporting year: September 1, 2022, to August 31, 2023. OFCO received 746 complaints during this reporting year. Most complaints received by OFCO were submitted via OFCO's website.

Figure 14: **Complaints Received by Year**

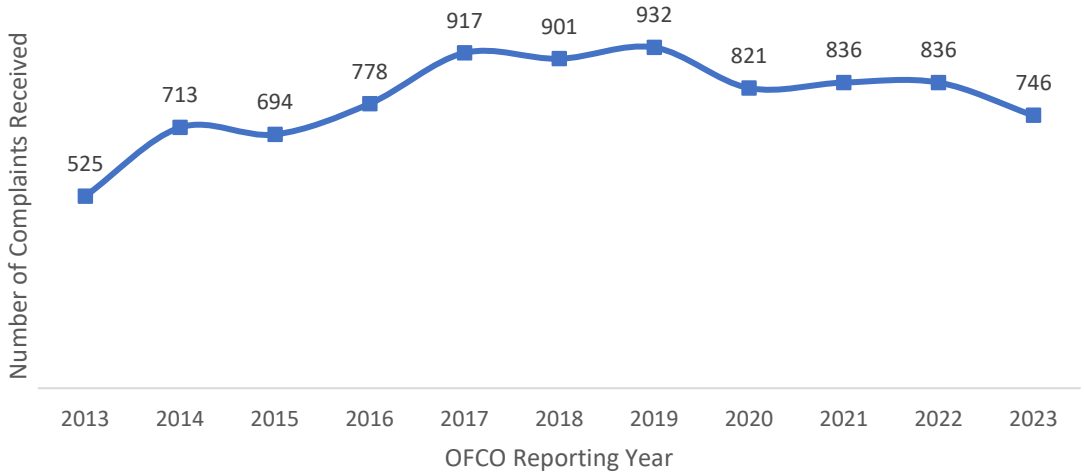
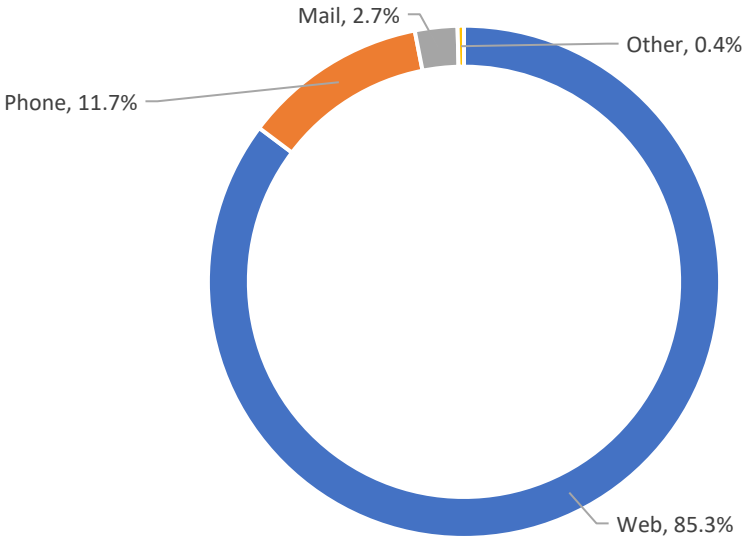


Figure 15: **How Complaints Were Received, 2023**



PERSONS WHO COMPLAINED

Consistent with previous years, parents, grandparents, and other relatives of a child whose family is involved with DCYF filed most of the complaints investigated by OFCO (76.5%).

Table 6 displays the race and ethnicity of this year's complainants.

Figure 16: **Complainant Relationship to Children, 2023**

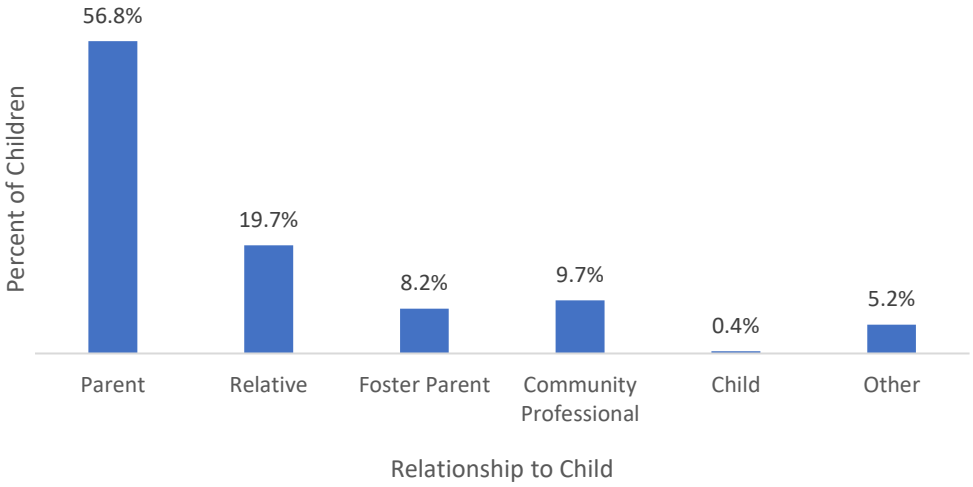


Table 6: **Complainant Race and Ethnicity, 2023**

Complainant Race/Ethnicity	OFCO Complainants	Washington State Population[28]	Children in Out-of-Home Care through DCYF[29]
American Indian or Alaska Native	5.6%	1.8%	18%
Asian or Pacific Islander	2.3%	10.4%	1%
Black/African American	8.7%	4.3%	16%
Hispanic/Latino	6.0%	13.4%	16%
Multiracial, Other	0.5%	5.2%	2%
White/Caucasian	60.6%	78.3%	46%
Declined to Answer/Unknown	16.2%	--	--

[28] Office of Financial Management. Population by Race, 2020. https://ofm.wa.gov/washington-data-research/statewide-data/washington-trends/population-changes/population-race.

[29] Department of Children, Youth, and Families. Children in Care by Race/Ethnicity, Last Day of SFY 2016-2022. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

CHILDREN IDENTIFIED IN COMPLAINTS

Of the 1,158 children identified in complaints this year, approximately 67% were nine years of age or younger. 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 placed in out-of-home care through DCYF.

Table 7: **Age of Children in Complaints to OFCO, 2023**

Age of Child	Percent of Children in OFCO Complaints	Percent of Children in Out-of-Home Care through DCYF[30]
0-4 years	35.5%	47.8%
5 to 9 years	31.0%	22.9%
10 to 14 years	22.9%	19.1%
15 to 17 years	8.8%	10.2%
18+ years	1.8%	--

Table 8: **Race and Ethnicity of Children in Complaints to OFCO, 2023**

Child Race/Ethnicity	Percent of Children in OFCO Complaints	Percent of Children in Out-of-Home Care through DCYF[31]	Percent of Washington State Children[32]
American Indian or Alaska Native	13.6%	18%	2.4%
Asian or Pacific Islander	1.5%	1%	9.9%
Black/African American	16.2%	16%	5.1%
Hispanic/Latino	13.6%	16%	21.9%
Multiracial, Other	2.8%	2%	10.4%
White/Caucasian	51.2%	46%	72.2%
Declined to Answer	1.0%	--	--

[30] Department of Children, Youth, and Families. Number and Percent of Children/Youth Who Experienced Out-of-Home Care, by Age, SFY 2022 . https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

[31] Department of Children, Youth, and Families. Children in Care by Race/Ethnicity, Last Day of SFY 2016-2022. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

[32] Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2020. https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin.

COMPLAINT ISSUES

Complaints can often be complex, and complainants may identify multiple issues or concerns they would like investigated. Figure 17 displays the categories of issues identified by complainants.

This year, issues involving the conduct of DCYF staff and other agency services were the most frequently identified in complaints made to OFCO. Half of the complainants expressed these concerns. The most frequently identified concerns included:

- Unwarranted, unreasonable, or inadequate CPS interventions (166 complaints);
- Unprofessional conduct by agency staff, such as harassment, discrimination, bias, dishonesty, or conflict of interest (106 complaints); and,
- Communication failures, such as caseworkers not communicating with parents or relatives (63 complaints).

Issues involving family separation and reunification were the next most identified concerns. The most frequently identified concerns included:

- Unnecessary removal of child from parental care (82 complaints);
- Failure to provide contact between child and parents or other family members (45 complaints);
- Failure to reunite family (44 complaints); and
- Failure to place child with a relative (27 complaints).

Figure 17: **Categories of Issues Identified by Complainants**

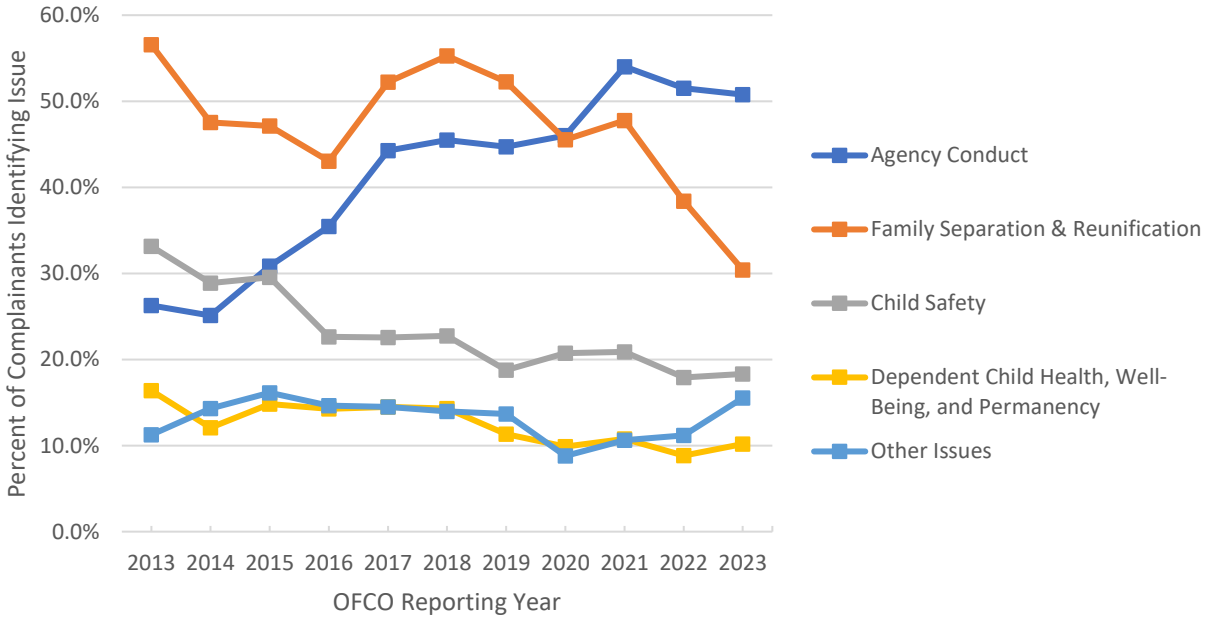


Table 9 on the following pages show the number of times specific issues within these categories were identified in complaints.

Table 9: **Issues Identified by Complainants**

	2023	2022	2021
COMPLAINTS ABOUT AGENCY CONDUCT	399	420	396
Unwarranted/unreasonable/inadequate CPS intervention	166	167	158
Unprofessional conduct, harassment, conflict of interest or bias/discrimination by agency staff	106	110	100
Communication failures	63	72	80
Breach of confidentiality by agency	24	23	24
Unreasonable CPS findings	17	17	10
Poor case management, high caseworker turnover, other poor service	8	21	10
Inaccurate agency records	8	8	10
Family Assessment Response	3	9	6
Retaliation by agency staff (does not include complaints of retaliation made by licensed foster parents)	2	1	4

	2023	2022	2021
FAMILY SEPARATION AND REUNIFICATION	239	313	350
Unnecessary removal of child from parental care	82	104	81
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	45	70	89
Failure to reunite family	44	55	87
Failure to place child with relative	27	32	48
Other inappropriate placement of child	17	26	21
Unnecessary removal of child from relative placement	10	12	14
Failure to provide sibling visits and contact	7	8	4
Other family separation concerns	4	0	2
Failure to place child with siblings	3	4	2
Inappropriate termination of parental rights	2	2	2

	2023	2022	2021
CHILD SAFETY	144	146	153
Failure to protect children from parental abuse or neglect	48	58	57
Suspected child neglect	*23*	*27*	*32*
Suspected child abuse	*25*	*31*	*25*
Failure to address safety concerns involving children in foster care or other non-institutional care	35	37	53
Failure to address safety concerns involving children being returned to parental care	29	22	23
Child safety during visits with parents	11	18	9
Failure by agency to conduct 30 day health and safety visits with child	1	1	1
Safety of children residing in institutions/facilities	1	0	1

DEPENDENT CHILD HEALTH, WELL-BEING, AND PERMANENCY	2023 80	2022 72	2021 79
Unreasonable delay in achieving permanency	30	21	14
Failure to provide child with adequate medical, mental health, educational or other services	16	20	27
Other placement issues	10	3	0
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	6	11	25
Failure to provide appropriate adoption support services/other adoption issues	4	3	1
Extended foster care/independent living services	2	2	1
Placement instability/multiple moves in foster care	2	5	5
ICPC issues (placement of children out of state)	1	3	4

OTHER COMPLAINT ISSUES	2023 122	2022 91	2021 78
Failure to provide parent with services/other parent issues	27	26	28
Violation of parents' rights	22	22	20
Lack of support/services to foster parent/other foster parent issues	20	13	6
Lack of support/services and other issues related to unlicensed relative or fictive kin caregiver	8	14	11
Violations of ICWA	7	11	3
Foster care licensing issues	4	2	5
Foster parent retaliation	2	3	5

SECTION III: 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 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 nonetheless identifies legitimate concerns. In these cases, the Ombuds helps to resolve the concerns.

This reporting year, OFCO completed 786 complaint investigations. The majority of investigations were standard, non-emergent investigations (80%), and 20% met OFCO's criteria for initiating an emergent investigation. OFCO intervened or provided timely assistance to resolve concerns in 15% of emergent complaints and 11% of non-emergent complaints.

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
- During the course of the investigation, OFCO identified an agency error or other problematic issue, sometimes unrelated to the issue identified by the complainant, 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).

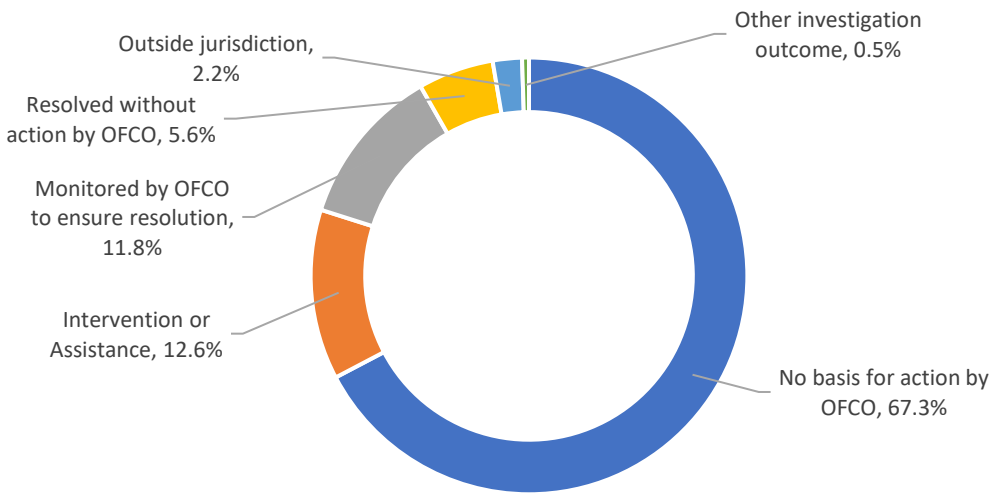
Outside Jurisdiction

- 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).

Figure 18: **Investigation Outcomes, 2023**



Investigation results have continued to remain consistent in recent years. In 2023, OFCO assisted or intervened to try to resolve an identified issue in 99 complaints (12.6%). OFCO monitored 93 complaints (11.8%) for a period until either the identified concerns were resolved or OFCO determined that there was no basis for further action. No basis for further action was found in the majority of complaints (67.3%).

OFCO'S ADVERSE FINDINGS

OFCO takes action when necessary to avert or correct a harmful oversight or avoidable mistake by DCYF. If OFCO substantiates a significant complaint issue, OFCO may make a formal finding against the agency after an investigation. In some cases, the adverse finding involves a past action or inaction, leaving OFCO with no opportunity to intervene before the harm occurs; in these instances, OFCO intervenes to protect against future violations. However, in situations where 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.

CRITERIA FOR ADVERSE FINDINGS AGAINST THE AGENCY

- The agency violated a law, policy, or procedure; or
- 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 2023, OFCO made 34 adverse findings in a total of 13 complaint investigations. OFCO provides written notice to 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. This year, DCYF provided a response to all findings. In addition to the 34 adverse findings, OFCO made two other findings that were withdrawn after DCYF provided more information to OFCO and requested a withdrawal. The number of adverse findings by region and office are broken down in Table 10.

Table 11 shows the various categories of issues in which adverse findings were made. Findings most often related to issues concerning child safety and parents' rights.

Table 10: **Adverse Findings in Complaint Investigations by DCYF Region and Office, 2023**

DCYF Region	DCYF Office (Number of Findings)	Total Number of Findings	Percent of Findings
Region 1	Colfax (4)	4	11.8%
Region 2	Yakima (2)	2	5.9%
Region 3	Lynnwood (1)	1	2.9%
Region 4	King South-East (5) King South-West (3) Martin Luther King, Jr (4)	12	35.3%
Region 5	--	--	--
Region 6	Kelso (6) Tumwater (2) Vancouver-Cascade (3) Vancouver-Clark (1) Vancouver-Columbia (2)	14	41.2%
DCYF Headquarters	DCYF Headquarters (1)	1	2.9%

Table 11: **Adverse Findings by Issue**

	2023	2022	2021
CHILD SAFETY	**14**	**6**	**11**
Failure to conduct required health and safety visits	9	3	4
Failure to complete safety assessment	5	--	1
Inadequate CPS investigation or case management	--	2	3
Inappropriate CPS finding (Unfounded)	--	1	2
Other child safety findings	--	--	1
PARENTS' RIGHTS	**14**	**7**	**6**
Delay in completing CPS investigation/CPS FAR or internal review of findings	11	5	4
Failure of notification/consent, public disclosure, or breach of confidentiality	3	2	1
Failure to communicate with or provide services to parent	--	--	1
POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY	**4**	**5**	**7**
Inadequate investigation	2	0	0
Inadequate documentation of casework	1	3	5
Other poor practice	1	2	2
FAMILY SEPARATION AND REUNIFICATION	**1**	**0**	**1**
Relative search issues	1	0	0
Failure to provide appropriate contact/visitation between parent and child	--	--	1
FOSTER PARENT/RELATIVE CAREGIVER ISSUES	**1**	**0**	**1**
Failure to assess caregiver	1	0	0
Licensing issues	--	--	1
DEPENDENT CHILD WELL-BEING AND PERMANENCY	**--**	**1**	**1**
Delay in achieving permanency	**--**	**1**	--
Unnecessary change of child's placement	**--**	**--**	1
OTHER FINDINGS	**--**	**1**	**1**

NUMBER OF FINDINGS	**34**	20	28
NUMBER OF CLOSED COMPLAINTS WITH FINDING(S)	**13**	10	16

APPENDICES

- Appendix A: Complaint Investigations by Region and Office
- Appendix B: 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:

Figure 19: **OFCO Complaint Investigation by DCYF Region, 2023**

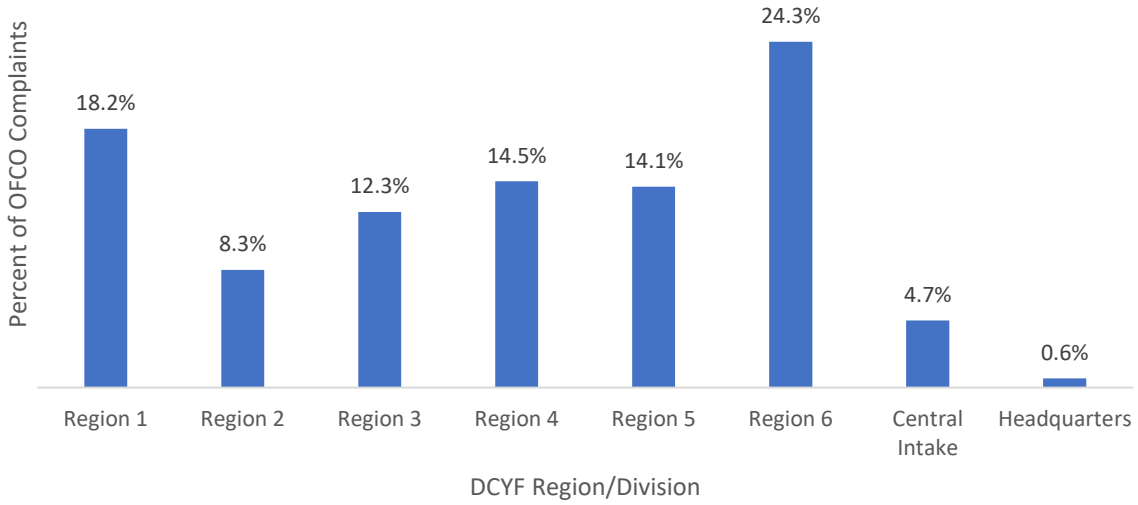


Table 12: **Number of OFCO Complaint Investigations Completed by DCYF Office, 2023**

Region 1			
Clarkston	4	Region 1 - Licensing Division, Foster Care Licensing	1
Colfax	5	Region 1 - Licensing Division, Safety & Monitoring	1
Colville	8	Region 1 - Regional Intake	5
Moses Lake	5		
Newport	0		
Omak	7		
Republic	0		
Spokane Central	29		
Spokane ICW	13		
Spokane North	21		
Spokane Valley	30		
Wenatchee	14		
Region 2			
Ellensburg	15	Region 2 - Adoptions	1
Goldendale	6	Region 2 - Licensing Division, Foster Care Licensing	1
Richland (Tri-Cities)	18	Region 2 – Regional Intake	1
Sunnyside	2		
Toppenish	3		
Walla Walla	6		
White Salmon	0		
Yakima	12		
Region 3			
Bellingham	18	Region 3 - Adoptions	3
Everett	21	Region 3 - Licensing Division, Safety & Monitoring	3
Friday Harbor	1	Region 3 - Regional Intake	7
Lynnwood	8		
Mount Vernon	7		
Oak Harbor	5		
Sky Valley (Monroe)	10		
Smokey Point (Arlington)	14		
Region 4			
King East (Bellevue)	15	Region 4 - Adoptions	2
King South-East (Kent)	18	Region 4 - Licensing Division, Foster Care Licensing	2
King South-West (Kent)	23	Region 4 - Licensing Division, Safety & Monitoring	1
King West (Seattle)	22	Region 4 - Regional Programs	1
Martin Luther King Jr.	15		
Office of Indian Child Welfare	10		
West Seattle	5		

Region 5			
Bremerton	9	Region 5 - Adoptions	3
Lakewood	23	Region 5 - Licensing Division, Foster Care Licensing	2
Parkland	14	Region 5 - Licensing Division, Safety & Monitoring	2
Puyallup	25	Region 5 - Regional Intake	2
Tacoma	31		
Region 6			
Aberdeen	24	Region 6 - Adoptions	2
Centralia	15	Region 6 - DLR/CPS Safety & Monitoring	1
Forks	0	Region 6 - Exceptional Placements	3
Kelso	31	Region 6 - Regional Intake	3
Long Beach	2		
Port Angeles	8		
Port Townsend	6		
Shelton	12		
South Bend	1		
Stevenson	5		
Tumwater	39		
Vancouver-Cascade	10		
Vancouver-Clark	10		
Vancouver-Columbia	19		
Other			
Central Intake	37		
Headquarters	5		
Department of Early Learning	3		
Non-DCYF/Other	26		

APPENDIX B: SUMMARIES OF OFCO'S ADVERSE FINDINGS

Failure to Monitor Child's Safety and Delay in Completing CPS Investigation or Intervention

DCYF did not complete health and safety visits and a Family Assessment Response intervention timely.

In March 2022, an intake alleging potential abuse of a 13-year-old child screened in for a CPS Family Assessment Response (FAR). Two days after DCYF received the intake, the caseworker met with the child. In June 2022, the caseworker contacted the mother to discuss services and made a referral to Family Preservation Services (FPS). The mother later declined services.

In July 2022, OFCO contacted DCYF to request that a health and safety visit be completed, as the child had not been seen by the agency since the initial visit in March 2022. The worker completed the health and safety visit the following day.

The case was closed at the end of August 2022 following a final health and safety visit.

Violations:

- **DCYF Policies and Procedures Guide, 2332 (5)(a)(i) states that a FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or guardian receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030.**
  This FAR case was open for over 5 months. The mother was offered services after 45 calendar days and declined. The case was not closed until August 2022.
- **DCYF Policies and Procedures Guide, 2332 (3)(d) and 4420 (1)(a)(vii) requires that DCYF conduct monthly health and safety visits for all children identified in a CPS FAR case open longer than 60 days.**
  DCYF completed an initial face-to-face (IFF) meeting with the child in March 2022 and did not complete another health and safety visit until July 2022 after OFCO contacted the agency.

DCYF Response:

DCYF reported that increased intakes and case assignments impacted the worker's ability to complete necessary tasks. The Area Administrator (AA) reminded supervisors of the expectation that they review completion of health and safety visits during monthly clinical supervision with staff. The local office is identifying protected time for staff to close overdue cases. Policies related to timely case closure and required monthly health and safety visits were reviewed and addressed during an all-staff meeting.

DCYF did not complete required health and safety visits and did not close the Family Assessment Response intervention timely.

In November 2022, DCYF received an intake alleging medical neglect of a 10-year-old and physical abuse of a 16-year-old by their father. The intake screened in for CPS FAR. The worker completed an

IFF meeting with both children three days later, during which they reported they did not feel safe at their father's home and disclosed physical abuse. The mother obtained a temporary order protecting them from their father based on the disclosures.

In December 2022, an additional intake screened into CPS FAR. The worker saw the children for an IFF the following day and later spoke with the mother who reported that the court had ordered her to return the 10-year-old to the father's home. DCYF documented no additional FAR activities until April 2023, when OFCO contacted DCYF to request that the agency complete health and safety visits with the children as they had not been seen since December 2022. A worker attempted to go to the father's home but was unable to access the property. A third intake was also screened into CPS FAR at that time. The intake described concerns related to the 10-year-old not feeling safe with their father. When the caseworker met with the child, he disclosed not feeling safe and thoughts of self-harm. The worker did not document attempts to contact anyone regarding the child's disclosures. Additionally, no worker attempted to see the 16-year-old for a health and safety visit on the other two open FAR intakes from 2022.

OFCO again contacted DCYF in May 2023 regarding the need to complete a health and safety visit with the 16-year-old and complete follow up on the 10-year-old's new disclosures. DCYF reported that the local office was suffering from staff shortages, and that they would follow up on the health and safety visits, the new allegations, and offering services to the family. Following OFCO's contact, a health and safety visit with the 16-year-old and an interview with the mother were completed.

The FAR Family Assessment for the November and December intakes was approved for closure at the end of May 2023, and the FAR Family Assessment for the April intake was approved for closure at the end of June 2023.

Violations/Unreasonable Finding:

- **DCYF Policies and Procedures Guide, 2332 (3)(d) and 4420 (1)(a)(vii) requires that DCYF conduct monthly health and safety visits for all children identified in a CPS FAR case open longer than 60 days.**
  DCYF received the first intake in November 2022. The IFFs were completed in November 2022 and the children were seen twice in December but were not seen again until April and May 2023 following multiple OFCO contacts and a new intake.
- **DCYF Policies and Procedures Guide, 2332 (5)(a)(i) states that a FAR case must be closed within 45 calendar days from the date the intake was received, unless the parent or guardian receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030.**
  DCYF received the first intake in November 2022 and the second intake in December 2022. The FAR Family Assessment regarding these intakes was approved in May 2023 and the case was closed in June 2023. The parents did not consent to extending the FAR involvement.
- **DCYF acted clearly unreasonably by not informing parents, making any referrals, or otherwise following up on the child's disclosure of thoughts of self-harm.**
  During a meeting in April 2023, the 10-year-old disclosed that they were having thoughts of self-harm. There is no documentation that the agency informed anyone of this disclosure or offered services regarding the youth's mental health needs.

DCYF Response:

DCYF reported that at the time the local office only had four out of fifteen positions filled, and the assigned worker was no longer employed with DCYF. Due to the staff shortage, the case was transferred to another office. Staff were deployed from other parts of the region to assist with the intakes and field visits. The region also implemented a plan to assist with closing out old cases in March 2023. The local office has since been fully staffed.

The Department agreed with the lack of documentation related to what actions were taken with the child's disclosures of self-harm but reported that the worker did make a plan with the child and had discussions with the mother and school counselor.

The AA also planned to conduct a "Lessons Learned" debrief with staff to discuss foundations of best practice and what was learned specific to this case.

A CPS investigation was not completed in a timely manner.

In October 2022, DCYF received an intake alleging sexual abuse of a dependent child by a parent. The intake noted that the children were having supervised visits with their parents at that time. The intake screened in for a non-emergent CPS investigation and was sent to law enforcement later that day. Two days later, the CPS worker completed the IFF interview with the child, who did not make a clear disclosure. Following the IFF, there was no documentation of any investigative activities occurring for approximately six months.

In May 2023, OFCO contacted DCYF to inquire about the status of the investigation. The CPS investigation was subsequently reassigned to a CPS roving supervisor who completed the investigative activities, and the case was closed.

Violation/Unreasonable Finding:

- **DCYF Policies and Procedures Guide, 2331 (4)(d)(iv) and RCW 26.44 (12)(a) mandate that CPS investigations must be closed within 60 calendar days and 90 days respectively from the date that CPS receives the intake.**
  The CPS intake was received in October 2022 and the Investigative Assessment was submitted for approval and closure in May 2023.
- **OFCO found it to be clearly unreasonable that most of the investigative activities, with the exception of the IFF and the intake being sent to law enforcement, that are mandated by DCYF Policies and Procedures Guide, Section 2331, occurred in May 2023, approximately seven months after the intake was accepted for investigation.**

DCYF Response:

The Department reported that the local office was significantly short-staffed at the time of the intake. The office has since been fully staffed. Weekly closure goals were established for each worker, and they are provided formalized protected time on a rotational basis to close cases.

DCYF did not conduct required health and safety visits and did not close a CPS investigation within the required timeframe.

In January 2023, DCYF received an intake reporting that a 15-year-old youth disclosed additional details regarding abuse and neglect that had previously occurred when she was residing with her father. The intake screened in for an emergent CPS investigation. At the time the intake screened in, there was an open Family Reconciliation Services (FRS) case for an At-Risk Youth (ARY) request made by the father. The FRS social worker met with the youth for the IFF on the new intake the day it was received, and a CPS caseworker was assigned three days later. Meanwhile, the family court, addressing ongoing custodial conflict, ordered the youth to return to her father's care at the end of January. DCYF assisted with and facilitated placement of the youth back to her father.

In February 2023, the CPS worker conducted a subject interview over the phone with the father and interviewed the other children residing in the home. The FRS worker also met with the 15-year-old. In March 2023, the FRS worker closed out the FRS case and informed both parents via text that the case would remain open with CPS. Between early March and early June 2023, there was no documentation of any CPS investigative activities. In April 2023, OFCO contacted DCYF about the status of the investigation. DCYF initially reported that the youth remained in her father's care but later followed up and reported that the youth was now residing with her mother. In May 2023, OFCO inquired if a health and safety visit at the mother's home would occur. DCYF conducted one a month later in June 2023; the youth reported she had moved back to her mother's home in March 2023.

Violations:

- **DCYF Policies and Procedures Guide, 4420, Health and Safety Visits with Children and Monthly Visits with Caregivers and Parents, and 2331 (2)(c) mandates that monthly health and safety visits be conducted with children identified in a CPS case investigation open longer than 60 days.**
  Required health and safety visits did not occur. The case was open continuously since January 2023. There was no documentation of face-to-face contact, or attempts to contact, the alleged child victim in April or May 2023.
- **DCYF Policies and Procedures Guide, 2331 (2)(e)(i)(c) and RCW 26.44 (13)(a) mandate that CPS investigations must be closed within 60 calendar days and 90 days respectively from the date that CPS receives the intake.**
  The investigation of the January 2023 intake remained open as of June 2023.

DCYF Response:

DCYF reported that the case was assigned at a time the office was receiving an increased number of intakes, protective custody actions, and dependency filings. The worker deprioritized the health and safety visits, as there were no concerns present in the mother's home.

The supervisors in CPS/FAR reported they will place a stronger emphasis on health and safety visits during clinical supervision as a new data focal point. The AA will monitor CPS/FAR cases approaching closure and assist in reducing barriers to closure. The AA will monitor practice through the end of the year by conducting random case reviews.

DCYF did not complete investigative activities in a timely manner.

In May 2022, a CPS case was opened due to concerns regarding 1-year-old twins in the care of their mother. Between May 2022 and February 2023, CPS received multiple intakes involving the family. In August 2022, CPS received a report that the mother was found unresponsive with the children in her care. The intake screened in for a non-emergent investigation. CPS completed an IFF meeting with the twins the same day at the grandparent's home and asked if the grandparents would be willing to care for the twins. The grandparents indicated they would and were willing to obtain guardianship.

In January 2023, the grandmother brought the twins to DCYF for a health and safety visit. The grandmother confirmed that the children would remain in her care until the mother addressed her substance use disorder. In February 2023, CPS received a report alleging sexual abuse of two other children by the father of the twins. The intake screened in for CPS Risk Only investigation as it was unknown what contact was occurring between the twins and their father and whether the mother was protective. More than two weeks later, CPS attempted to complete the IFF contact with the twins, but the grandparents were uncooperative. The CPS worker subsequently went to the father's home and confirmed that the twins were not in his care and that he had not seen them since September 2022. A worker then observed the twins the following day in the grandparent's car. OFCO contacted DCYF in March 2023 regarding the August intake being open beyond required timeframes. DCYF reported the CPS unit was experiencing high caseloads due to vacancies and that the assigned worker had completed additional investigative activities that were not yet documented in the system. The investigations of the August 2022 and February 2023 intakes were subsequently closed in March 2023.

Violations:

- **The Safety Assessment for the intake received in August 2022 was not completed within 30 calendar days from the date of the intake per DCYF Policies and Procedures Guide, 2331, 2 (e)(i)(A).**
  The Safety Assessment for the intake was initiated and approved in February 2023.
- **DCYF Policies and Procedures Guide, 4420, Health and Safety Visits with Children and Monthly Visits with Caregivers and Parents, and 2331 (2)(c) mandates that monthly health and safety visits be conducted with children identified in a CPS investigation open longer than 60 days.**
  Required health and safety visits did not occur. The case had been open continuously since May 2022. There was no documentation of face-to-face contact or attempts to contact either child from September 2022 through December 2022, or February 2023.
- DCYF Policies and Procedures Guide, 2310 (1)(a) requires that DCYF meet in person with the victim or identified child within 72 hours for a non-emergent response.
  IFF contact or attempts to contact did not occur with the alleged victims within required timeframes for the February 2023 intake. The children were seen in person in March 2023.
- **DCYF Policies and Procedures Guide, 2331 (4)(d)(iv) and RCW 26.44 (12)(a) mandate that CPS investigations must be closed within 60 calendar days and 90 days respectively, from the date that CPS receives the intake.**
  The investigation of the August 2022 intake was closed in March 2023.

DCYF Response:

The Department reported that necessary tasks on this case were not completed due to workload and vacancies. The worker on this case will be working with the supervisor to establish a work plan to manage the backlog of this case.

DCYF did not complete investigative activities in a timely manner.

In December 2022, an intake alleging neglect of an 8-year-old child screened in to CPS FAR. The assigned worker completed the IFF with the child the following day; the child reported living with five siblings. The worker documented leaving a voice message on the mother's phone that day and also documented that they did not identify any safety concerns.

For two months following the IFF, the only documentation entered was monthly supervisor reviews. The January 2023 supervisor review noted that the worker still needed to interview the parents, complete the IFF on the other children in the home, walk through the home, and complete the Structured Decision Making Risk Assessment (SDMRA). In February 2023, the supervisor review indicated no progress had been made. In March 2023, a DCYF worker contacted the mother regarding early learning resources. The worker documented that the mother was not aware of the allegations or of the FAR case prior to that contact.

OFCO contacted DCYF in March 2023 regarding the status of the FAR case and whether there had been undocumented contact with the mother prior to March 2023. OFCO was informed that the worker had only attempted to contact the mother once prior to her interview in March and that there were multiple staffing issues at the local office.

Violations:

- **Per DCYF Policies and Procedures Guide, 2332 (1)(a)(i)(A) and (B), parents and alleged subjects are to be notified of any allegations of child abuse and/or neglect and to arrange a meeting.**
  The interview of the mother who was identified as the alleged subject in the intake did not occur timely. The mother was not interviewed until March 2023, over three months after the intake screened in.
- **DCYF Policies and Procedures Guide, 2332 (5)(a)(i)(A) mandates that CPS FAR cases must be closed within 45 calendar days from the date that CPS receives the intake, unless the parent is receiving services and consents to the case remaining open.**
  This FAR case remained open for over 90 days.
- **The Safety Assessment for the intake received in December 2022 was not completed within 30 calendar days from the date of the intake, per DCYF Policies and Procedures Guide, 2331 2(e)(i)(A).**
  The Safety Assessment for the intake was completed in March 2023.
- **DCYF Policies and Procedures Guide, 4420, Health and Safety Visits with Children and Monthly visits with Caregivers and Parents and 2332 (3)(d) mandates that monthly health and safety visits be conducted with children identified in a CPS FAR case open longer than 60 days.**

Required health and safety visits did not occur. The case had been open since December 2022 and there was no documented face-to-face contact or attempts to contact the children in the home until March 2023.

- **DCYF Policies and Procedures Guide, 2332 (1)(c)(x) requires workers to see all children in the home before the Safety Assessment is completed.**
  The youth reported to the worker that she lived with her five siblings during the IFF. There was no documentation that the worker completed an IFF with these siblings.

DCYF Response:

The Department reported that necessary tasks on this case were not completed due to workload and vacancies. The local office was actively working to recruit staff and supervisors were carrying cases to alleviate the workload.

DCYF did not complete investigative activities in a timely manner.

In May 2022, an intake alleging neglect of a five-year-old child screened into CPS FAR, alleging that the mother overdosed twice in front of the child and that the child observed domestic violence in the home. Two days following receipt of the intake, the worker went to the home and spoke with the mother and child. The mother reported that the domestic violence resulted in a no-contact order against her boyfriend and acknowledged that she had a history of substance abuse. The worker did not see any drugs in the home. There were no further documented activities other than supervisory case review notes in June and July 2022.

In July 2022, another intake screened in alleging physical abuse and neglect of the child. The worker completed the IFF interview with the child, found no bruising on the child, and documented that the allegations were false. The intake also expressed concerns of possible sexual abuse by the grandfather. However, there was no documentation that the worker spoke to the mother regarding the concerns raised about the grandfather. The mother informed the worker that she asked her parents to leave her home after they relapsed. There was no documentation that the worker followed up with the grandfather or spoke to the child's father. Following this, there were no documented activities through mid-November aside from monthly supervisory case review notes.

In November 2022, the mother had a second child and a CPS Risk Only investigation was opened, as the mother had relapsed on fentanyl. DCYF created a service plan with the family and the grandparents agreed to be part of it.

A monthly supervisory case note in January 2023 indicated that the worker would close out the older intakes as all intakes had similar allegations. In February 2023, the FAR intake from May 2022 was converted to a CPS investigation and the investigations as to the May and July intakes were closed. The children were placed in protective custody.

In reviewing the Investigative Assessments, OFCO did not find documentation that the worker addressed concerns raised regarding the grandfather. In addition, the mother was given a founded finding for physical abuse, despite the worker noting that there were no bruises on the child. OFCO contacted the agency in April 2023 regarding the investigation. The agency corrected the issues raised

regarding the Investigative Assessments and reported that the worker had investigated the concerns regarding the grandfather.

Violations:

- **DCYF Policies and Procedures Guide, 4420, Health and Safety Visits with Children and Monthly Visits with Caregivers and Parents, and 2331 (2)(c) mandates that monthly health and safety visits be conducted with children identified in a CPS case open longer than 60 days.**
  Required health and safety visits did not occur. An investigation was opened in May 2022 alleging neglect. The worker documented going to the home and seeing the alleged child victim within the required timeframes. In July 2022, an IFF was completed due to a new intake that screened in, however, no health and safety visits were completed in August, September, or October 2022.
- **DCYF Policies and Procedures Guide, 2331 (2)(e)(i)(C) and RCW 26.44 (12)(a) mandates that CPS investigations must be closed within 60 calendar days and 90 days respectively from the date that CPS receives the intake.**
  The intake that screened into CPS FAR in May 2022 was transferred to investigation in February 2023. The May and July investigations were not completed within the required timeframes as the investigation closed 267 days after the first intake was received and 208 days after the second.
- **DCYF Policies and Procedures Guide, 2331 2(e)(i)(A) mandates that a Safety Assessment must be completed within 30 days of the agency receiving the intake.** The Safety Assessments for the May and July 2022 intakes was completed in February 2023.

DCYF Response:

The Department reported that the local office was experiencing significant turnover, resulting in a shortage of workers and supervisors. Due to the workload, the worker was unable to complete the required work timely. The AA discussed the adverse finding with the supervisor. DCYF developed a plan to assist with closing out older cases, creating an opportunity for assigned staff to address backlogged cases by bringing in staff from other parts of the region to assist with incoming cases. The Quality Practice Specialist mentored new and existing staff in the office regarding compliance with practice expectations. Additional training was also provided by the Quality Practice Specialist.

A CPS FAR was not conducted within the required timeframes. A comprehensive assessment of the family did not occur in a timely manner, health and safety visits were not conducted, and DCYF did not complete adequate collaterals.

In January 2023, DCYF received an intake regarding a 6-year-old who was brought to the ER by their mother. The child was observed to have marks, and the mother reported that the stepfather spanked the child two days prior. The intake screened into CPS FAR. The IFF contact with the child occurred the following day at the mother's home. The worker also spoke with a 4-year-old sibling and observed a 1-year-old sibling. During the visit, the mother reported that she was unsure of what to do after the incident and asked the stepfather to leave the home, however, the stepfather had since returned, and she reported they were both willing to attend parenting classes.

Between the end of January and May 2023, there was no documentation of any CPS FAR-related activities except for supervisory reviews. The review notes indicated that the mother was a protective parent and that the subject interview had occurred the same day as the IFF in January 2023. Documentation indicated that the stepfather was engaged in recovery programs and parenting classes, and that the family wanted services from Positive Parenting Program (Triple P), but the provider wasn't available nights or weekends.

In early May 2023, CPS intake was contacted by law enforcement after the 4- and 6-year-old were placed into protective custody due to the mother presenting as suicidal. The mother reported that the stepfather relapsed on drugs and threatened her. The intake screened in for an emergent CPS investigation. The IFF with the two children occurred the following day when the CPS FAR caseworker met law enforcement at the children's school and transported the children to foster care. The worker also observed the 1-year-old at the office. Following a Family Team Decision Making (FTDM) meeting, the two older children were placed with their biological father.

At the end of May 2023, OFCO received a complaint raising concerns for the safety of the two older children as the mother recently picked them up from their father. DCYF had completed no documentation since the children were returned to the father, and placement information in DCYF's tracking system (FamLink) indicated that the children were still placed with him. OFCO contacted DCYF requesting an update on where the children were placed. OFCO also inquired about the January FAR and whether a subject interview and comprehensive assessment had occurred with the stepfather. DCYF reported the children had returned to their mother and that the mother reported to be back on her mental health medications she had previously stopped taking. DCYF also reported that the mother said she was engaging in individual and couple's counseling, and that the stepfather was also engaged in counseling and parenting classes. The worker subsequently scheduled a meeting with the stepfather the following week.

OFCO again contacted the supervisor in June 2023 to inquire if the stepfather had been interviewed regarding the January CPS FAR intake, whether there was a plan for the mother and children to be seen in person, and if there was a plan to verify with collaterals that the parents were engaged in services. The supervisor reported that the worker was late in interviewing the stepfather but that they had just completed the FAR intervention. The worker also had recent face-to-face contact with the parents and completed health and safety visits with the children the prior week. The worker later documented that she had met with the stepfather and interviewed him about the allegations from the January CPS FAR intake and the May CPS intake.

OFCO again contacted the supervisor in July 2023 to clarify as to whether the two older children were seen for a monthly health and safety visit. OFCO was informed that the worker had not yet seen the children. The worker eventually visited the home and met with the family, and no concerns were reported by the children.

After the CPS investigation was approved for closure in August 2023, the worker contacted the mother by phone to inform her that the case was closing and later that same day, visited the children at daycare for a health and safety visit.

Violations:

- **DCYF Policies and Procedures Guide, 2332 (1)(a)(i) requires that DCYF make initial contact with the parents or guardians to arrange an initial meeting, inform them that a CPS FAR referral has been received, and to explain the CPS FAR pathway.**
  The intake screened in for CPS FAR in January 2023. There was no documentation of attempts to contact or interview the stepfather, the alleged subject of physical abuse, until after a new intake screened in more than three months later.
- **DCYF Policies and Procedures Guide, 2332 (3)(d) and 4420 (1)(a)(vii) requires that DCYF conduct monthly health and safety visits for all children identified in a CPS FAR case open longer than 60 days.**
  The case was open continuously from January 2023 until August 2023. There was no documentation of health and safety visits occurring with any of the children in April 2023 or with the two older children in June 2023.
- **DCYF Policies and Procedures Guide, 2332 (5)(a)(i) states that a FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or guardian receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030.** The intake screened in for CPS FAR in January 2023. The FAR Family Assessment was submitted and approved for closure in June 2023.
- **DCYF Policies and Procedures Guide, 2331 also mandates that investigators "interview professionals and other individuals who may have knowledge of the children or youth, parents or guardians, or the allegations of CA/N."**
  During the CPS investigation of the May intake, there was no documentation of contact with professionals, such as the mother's medication management provider, the couple's counselor, or the mental health counselor that the stepfather was seeing, to verify the parents' report of engagement in services, their progress and efforts made to address the issues that led to DCYF's involvement, and the children being placed in protective custody.

DCYF Response:

DCYF reported there were vacancies in the office and priority was given to complete IFF visits on new cases to ensure children were immediately assessed for safety. Steps were taken to manage workload and improve timeliness, such as providing time each morning dedicated to helping workers document case activities in order to close cases more efficiently, assigning afterhours staff to assist with case activities, directing supervisors to work with staff to prioritize cases, and providing refresher training through the Safety Boot Camp.

DCYF requested a recission or modification to the fourth finding, reporting that the mother's counselor was contacted and provided details about counseling and goals of the mother and family. DCYF also said the mother was in inpatient mental health treatment at the time the CPS intake was received and she reported she had gone off her medication due to medical complications and was receiving services that were being monitored and could result in changes to any prior medications. OFCO declined to modify or rescind the finding, noting that collateral contacts with service providers engaged with the parents to address mental health issues were particularly crucial in this case considering the circumstances leading to the Department's involvement with the family.

A CPS FAR case remained open beyond the required timeframes and required health and safety visits were not conducted.

In January 2023, CPS FAR received an intake alleging physical abuse of a 13-year-old by their mother. The assigned worker completed the IFF, and the youth denied that the incident occurred. At the conclusion of the interview, the worker documented that there were no identified safety concerns. The worker reached out to the youth's probation officer who did not have any concerns. Except for monthly supervisor reviews, there was no documentation of work for approximately three months after the IFF. In February 2023, the supervisor review documented that the worker still needed to interview the parents. There was no documented supervisor review in March. OFCO contacted DCYF in June 2023 regarding the status of the FAR case, whether there had been any contact with the youth's parents, and if a health and safety visit had been completed. DCYF reported that a health and safety visit had not been completed but completed one shortly after, and the parents were interviewed soon after that.

Violations:

- **Per DCYF Policies and Procedures Guide, 2332 (1)(a)(i)(A) and (B), parents and alleged subjects are to be notified of any allegations of child abuse and/or neglect and to arrange a meeting.**
  The interview of the mother, identified as the alleged subject in the intake, did not occur timely. The mother was not interviewed until June 2023, over four months after the intake screened in.
- **DCYF Policies and Procedures Guide, 2332 (5)(a)(i)(A) mandate that CPS FAR cases must be closed within 45 calendar days from the date that CPS receives the intake, unless the parent is receiving services and consents to the case remaining open.**
  The FAR case was open for over 90 days.
- **DCYF Policies and Procedures Guide, 4420, Health and Safety Visits with Children and Monthly Visits with Caregivers and Parents, and 2332 (3)(d) mandates that monthly health and safety visits be conducted with children identified in a CPS FAR case open longer than 60 days.**
  Required health and safety visits did not occur. The case had been open since January 2023 and there had been no documented face-to-fact contact or attempts to contact the children in the home until June 2023.

DCYF Response:

DCYF reported that the local office now inventories all open investigation cases to ensure appropriate case contacts have been completed and is also devoting resources to closing cases. Workers and supervisors identify case closure goals on a weekly basis which will help remedy the problem with failure to complete health and safety visits for overdue cases. The AA has developed a plan that workers temporarily assigned to other programs or offices receive proper clinical supervision.

Poor Casework Practice - Inadequate Investigation and/or Documentation

DCYF improperly investigated a CPS intake related to medical neglect, improperly closed the investigation, and inadequately investigated allegations of physical abuse.

In July 2022, DCYF received an intake alleging medical neglect of a 14-month-old child. The intake screened in for a CPS investigation with a 24-hour response time. The assigned worker attempted to complete the initial IFF meeting with the child the following day but was informed that the family was ill. The IFF was completed 10 days later. Although the intake identified a 3-month-old child in the home, the child was not seen or assessed by the worker. The worker communicated with the mother about the need for the 14-month-old to be seen by a medical provider due to the child's medical diagnoses. The mother reported that she would be changing providers and would attend appointments with the new provider. However, there was no indication that the child ever received care by the new provider.

In August 2022, DCYF received a second intake reporting that the 14-month-old child was taken to the hospital due to cardiac arrest and had passed away. The hospital indicated that they did not consider the death suspicious due to the child's medical complexity. There was no information that any provider at the hospital had seen the child prior. The intake was screened into CPS investigations with a 24-hour response time. However, approximately two weeks later, the Investigative Assessment was closed, noting that CPS was unable to complete the investigation and that the screening decision had been changed to screen out.

The Investigative Assessment for the initial intake made in July 2022 was also closed, noting that CPS was unable to complete the investigation due to the child's death. There was no indication that DCYF requested further information on the circumstances of the child's death from any providers, specifically whether a cardiac arrest was a possible outcome of the child's diagnosis or if the cardiac arrest was attributable to medical neglect. There was also no evidence that any records relating to the event were requested or obtained prior to the closing of the case.

In September 2022, an intake was received alleging that bone fractures in various stages of healing were discovered during the child's autopsy, and a lacerated spleen was likely the cause of the child's death. The intake was screened in as Risk Only, relating to the risk of the other child who remained in the home. Two days after the intake was received, that child was assessed for the first time when they were placed in protective custody and assessed for injuries. The CPS investigation was closed two weeks later, but the case remained open for services.

In October 2022, OFCO contacted the CPS supervisor to discuss the decision to close the medical neglect investigation without further information and investigation. The supervisor reported they were relying on the providers reporting that the child's death did not appear suspicious. The supervisor did not know if the worker attempted to obtain further information relating to the child's death, or the relationship between the stated cause of death and the child's diagnoses, or whether medical neglect was a contributing factor. The supervisor also stated her office did not consider changing the screening decision for the intake from September 2022 from risk only to allow for an investigation that could result in founded findings, nor did they consider adding allegations. The supervisor reported their primary concern was ensuring the safety of the other child as quickly as possible.

In November 2022, OFCO spoke with the AA for DCYF Central Intake regarding the screening decision of the September 2022 intake. The AA believed the unit made an appropriate decision by screening in the intake as risk only but that it also would have been appropriate to screen the decision into CPS Investigation. The AA noted that a local office can and should add additional allegations that arise to an open intake, and that this could have occurred in this case.

The Investigative Assessment for the initial intake received in August 2022 was amended from "unable to complete investigation" to "founded" as the mother had committed neglect by failing to ensure the child had attended necessary medical appointments both prior to DCYF involvement and during its open case.

Violations/Unreasonable Findings:

- **DCYF Policies and Procedures Guide, 2310 and 2333 require that the caseworker meet in person with identified children and assess their safety and any risk presented to them.** During the investigation of the initial intake, the 3-month-old child was not seen or assessed before the case was closed.
- **DCYF acted clearly unreasonably by closing the investigation into the initial intake when the 14-month-old child passed without conducting further investigation and did not investigate the second intake which also provided an opportunity to investigate the circumstances of the child's death.**
  The agency reopened the Investigative Assessment into the first intake and changed its outcome to a founded finding of neglect. The case note regarding this decision indicated it was based on the agency obtaining new information, however, the information necessary to conclude the founded finding was available at the time that the initial Investigative Assessment was closed. Central Intake properly screened in the second intake which provided another avenue for the agency to investigate the child's death, but the local staff executed a screening override and closed the investigation without conducting further casework.
- **DCYF acted clearly unreasonably by not investigating the physical abuse allegations resulting in the 14-month-old child's death.**
  The third intake that screened in as Risk Only should have been screened into CPS Investigations to determine whether the mother physically abused the child, instead of a CPS Risk Only that only addressed the other child's safety. When the investigating office received the Risk Only intake that contained new allegations of physical abuse resulting in the child's death, it should have been recognized that these allegations had not yet been investigated. Instead, the Risk Only investigation was completed in less than 20 days and, while the other child was properly assessed and removed from the mother, no steps were taken to investigate the 14-month-old child's death.

DCYF Response:

The Department reported that leadership would be issuing a practice memo reminder to all workers and supervisors in the local office and discuss the requirements of DCYF Policies and Procedures, 2310 and 2333, necessitating that workers assess all children in the household for safety. Although the Department did not agree that the second intake warranted an investigation, the Department did agree that the initial intake required completion. Central Intake placed the expectation on the agenda for a supervisor and unit meeting to screen in for investigation when there is a fatality related to

abuse or neglect. The Department also reported that the local office would review the relevant page of the Intake Training Guide, and the Area Administrator would discuss the screening error with the supervisor individually.

Parents' Rights

DCYF inappropriately disclosed confidential information regarding an ongoing dependency.

DCYF improperly shared information regarding an open dependency case with a parent who was not a party to the case and was in an adversarial position to the parents in that case in a family law matter. While a non-dependent child was in the care of their father and stepmother who had an open dependency regarding her own child, concerns arose regarding the non-dependent child's safety due to the stepmother. The assigned worker of the non-dependent child shared confidential information about the stepmother's dependency with the other parent of the non-dependent child who then used the information in family court proceedings. OFCO contacted the supervisor on this case and the supervisor agreed that the disclosure was improper and reported they discussed the matter with the worker and explained to the worker what would have been appropriate to share instead.

Violation:

- OFCO found that disclosing confidential information regarding the dependency with the other parent who was not a party to the dependency case violated **RCW 13.50.100**. OFCO recognizes that DCYF was authorized to share general information with the other parent regarding the need to protect the child and seek relief in family court, however, the extent of the disclosure to the other parent was not appropriate, as it included information regarding the existence of and reasons for the mother's dependency regarding her own child.

DCYF Response:

The Department reported that the assigned worker, supervisor, and AA staffed the situation. The assigned worker was attempting to ensure safety for the child and did not realize that certain information should not have been shared. Training was held for the local office to address confidentiality.

Family Separation and Reunification

DCYF did not conduct a proper relative search.

In June 2021, DCYF screened an intake in for a CPS Risk Only intervention regarding concerns of a newborn whose parents were struggling with substance abuse and were unable to care for the child. A caseworker met with the mother the following day, and the mother reported that she and the father were engaged and living together. The mother requested that the child be placed with the paternal relatives should out-of-home placement be necessary. A caseworker later spoke with the father and completed a walk-through of the parents' home. Neither parent expressed doubt as to the

child's parentage and both parents participated in the FTDM meeting. The child was placed with the paternal aunt and uncle following an order for removal.

In July 2021, an email was sent and uploaded indicating that a relative search was being conducted on the mother. No search was completed on the father, who had not been named on the birth certificate.

In October 2021, the child was placed with a couple described as family friends of the paternal aunt and a potential permanent placement. There was no indication that a new relative search was conducted at that time. In January 2023, the parents had a second child who was also placed in the same home. The placement was considered a suitable other, as their sibling was still placed there.

A relative search on the paternal side was conducted for the first time in February 2023. The search identified relatives who expressed interest in placement and were already licensed foster parents. The agency considered the relatives for placement but determined that they would not be moving the children.

Unreasonable Finding:

- It was clearly unreasonable under the circumstances for DCYF not to conduct a search for paternal relatives between the time the elder child came into care in 2021 and the time the search on the paternal relatives was conducted in 2023. The parents were residing together and were engaged at the time of the child's birth and neither parent questioned the child's parentage. The Department treated the father as a parent, including him in the FTDM meeting and as a party in the dependency proceeding. Additionally, the Department agreed to placement with the father's sister and husband, recognizing this as a relative placement with the paternal aunt and uncle.

DCYF Response:

The Department requested a withdrawal, reporting that the Relative Search Unit did receive a request for a relative search on both the mother and father from the local office; however, the Relative Search Unit Program Manager confirmed that until paternity was established, a relative search for paternal relatives would not be conducted. DCYF further explained that the father did not meet the statutory definition of presumed father in RCW 26.26A.115, as the father was not married to the mother, was not in a state registered domestic partnership, was not on the birth certificate, and had not resided with the child the first four years of the child's life. The dependency petition identified the father as alleged and not presumed. No relative of the father met the definition of a relative in RCW 74.15.020, as the father did not establish himself as a parent under RCW 26.26A.100. However, the father's name was on the second child's birth certificate, and it was at that time that a relative search was conducted on the paternal side of the family. OFCO maintained its finding on the basis that the agency failed to establish paternity and/or take necessary steps to assess paternal relatives throughout the nearly two years between the older child coming into care and the younger child being born.

Caregiver Issues

DCYF failed to appropriately assess caregivers in a timely manner.

In September 2022, DCYF received an intake alleging neglect and lack of supervision of three children ages 9, 13, and 14 in their parents' care. The intake screened in for an emergent CPS investigation. At the FTDM meeting, the parents agreed to place the three children in relative care through a Voluntary Placement Agreement (VPA). However, by the end of September, the two older children were no longer staying at their relative placements and were both staying with the mother's neighbor. A DCYF Family Voluntary Services (FVS) worker conducted a health and safety visit during which both children reported things were going well with the neighbor and her husband. The worker documented that the previous worker had not found anything of concern relating to the caregiver or her husband. DCYF did not officially change the children's placements until after it filed for dependency in October 2022.

After the court ordered the two older children to be placed with the neighbor as a suitable adult placement, the social worker attempted to request a NCIC Purpose Code X background check. The worker was informed that this type of background check did not apply to this situation because the court ordered placement, however, a regular background check was approved. The worker subsequently emailed the suitable adult caregivers the Placement Agreement and background check information. A supervisory review case note in early November 2022 indicated that the background checks were provided and that the fingerprints were pending.

In December 2022, OFCO contacted DCYF to confirm that the background checks on the caregivers were in process. The agency reported that the background checks were requested in October 2022 but had not been completed as neither applicant had fingerprinted. In January 2023, a supervisory case note indicated that the background checks were resubmitted due to an error. OFCO contacted DCYF in February 2023 and March 2023 to inquire about the status of the background checks. Both times DCYF reported that there had not been any fingerprint activity.

Violation:

- **DCYF did not assess the character, competence, and suitability of the unlicensed caregivers per DCYF Policies and Procedures, 45274 and 6800.**
  The two children, ages 13 and 14, were informally living with the unlicensed caregivers since September 2022. The court ordered the children to officially be placed with the unlicensed caregivers in October 2022. As of March 2023, DCYF had not completed the background checks on the caregivers.

DCYF Response:

DCYF reported that the fingerprints had not been processed, which relies on the caregiver's cooperation. The supervisor will be conducting an internal audit to review needed background checks on cases.

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.

Deputy Director 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.

Senior 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

Deborah Lurie is a licensed attorney with experience representing parents and youth with the King County Department of Public Defense. In that position, she represented clients in Dependencies, Terminations, Involuntary Commitments, At Risk Youth, Child in Need of Services, Truancy and Juvenile Offender cases, as well as adult misdemeanor and felony proceedings. Ms. Lurie graduated from Franklin and Marshall College and earned her J.D. at American University Washington College of Law.

Special Projects/Database Coordinator

Sherry Saeteurn joined OFCO in July 2019. Prior to joining OFCO, Ms. Saeteurn was a private investigator and compliance manager for a legal service technology corporation. Ms. Saeteurn's experience also includes assisting inmates with GED preparation at King County Correctional Facility and coordinating activities for women experiencing homelessness at the YWCA emergency housing shelter. Ms. Saeteurn is a graduate of the University of Washington.