OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

An Independent Voice for Families and Children

ANNUAL REPORT
2024

Patrick Dowd, Director
ofco.wa.gov

Table of Contents

EXECUTIVE SUMMARY 2

SECTION I: IMPROVING THE SYSTEM 5
- PLACEMENT EXCEPTIONS 6
- OUTREACH 14
- JUVENILE REHABILITATION 15
- 2024 CHILD FATALITIES AND NEAR FATALITIES REPORT 17

SECTION II: LISTENING TO FAMILIES AND CITIZENS 18
- INQUIRIES AND COMPLAINTS 19
- COMPLAINT PROFILES 20
- COMPLAINT ISSUES 23

SECTION III: TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES 26
- INVESTIGATING COMPLAINTS 27
- OFCO'S ADVERSE FINDINGS 30

APPENDICES 33
- APPENDIX A: COMPLAINT INVESTIGATIONS BY REGION AND OFFICE 34
- APPENDIX B: SUMMARIES OF OFCO'S ADVERSE FINDINGS 37
- APPENDIX C: OFCO ORGANIZATIONAL CHART 60

Report prepared by:
Elizabeth Bokan, Deputy Director
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 2024

To the Residents of Washington State:

I am pleased to submit the 2024 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, 2023, to August 31, 2024. 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 728 investigations regarding 1,003 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. While DCYF has made significant progress this year in reducing the number of placement exceptions, more placement resources, such as licensed receiving care and independent living programs for older youth, are still needed to eliminate the practice of housing children in unlicensed placements.

OFCO also receives complaints about the safety of youth and young adults in Juvenile Rehabilitation (JR) facilities. Concerns include improper use of force by JR Staff, conditions of confinement, lack of education and therapeutic services, and safety within the facility. State laws do not clearly define OFCO's authority to investigate these complaints or respond to concerns about young adults ages 18-25 years placed in JR facilities. OFCO is listening to concerns raised by families of incarcerated youth and advocates and is working with policymakers to clarify OFCO's role in providing independent oversight of JR facilities.

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, 2023, through August 31, 2024.

MISSION

The Office of the Family and Children's Ombuds protects children, youth, and families from harmful agency action or conduct, informs agency officials and policy makers of system-wide issues, and makes recommendations to strengthen families and improve outcomes for children and youth.

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.

[1] RCW 43.06A and RCW 26.44.030.

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;
- 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

PLACEMENT EXCEPTIONS

This past year, the number of unlicensed placement exceptions and short-term night-to-night foster care for children fell by 57% and the number of children experiencing a placement exception also decreased from 358 children in 2023 to 216 children in 2024. The Department identified a suitable placement for 63% of children within five days or less of a placement exception. The number of children experiencing lengthy stays in placement exceptions also fell this year. This year 34 children spent 20 or more nights in a placement exception compared to 64 children in 2023.

The drop in placement exceptions has increased safety for both youth and staff. Reports of safety incidents involving youth in placement exceptions fell from 49 reports in 2023 to 15 reports in 2024. By reducing the number of placement exceptions, particularly those in hotels, the unstable circumstances and volatile situations that endanger DCYF staff and other youth have decreased.

OUTREACH

This year, OFCO initiated projects aimed at connecting with communities from whom we have historically received disproportionately low numbers of complaints. This effort is in accord with achieving our agency's Pro-Equity Anti-Racist goals, as well as our statutory duties to provide information to those impacted by child welfare systems. OFCO reached out to the 29 sovereign, federally recognized Indian Tribes in Washington State this year. State and federal laws protect the rights of Native American children, parents, and Tribes involved with state child welfare agencies. OFCO contacted the directors of the tribal child welfare agencies to inform them of our services

[2] Child Fatalities and Near Fatalities in Washington State, September 2024. Available at: https://ofco.wa.gov/reports-and-data.

and goal of ensuring our state child welfare system works in partnership with tribal child welfare agencies to protect the rights of Native American families.

OFCO also partnered with the Office of the Corrections Ombuds (OCO) to connect with incarcerated parents. Incarcerated parents with children involved in the child welfare system often struggle to fully participate in their child's case, access services, or engage in parent-child visits. Additionally, they cannot access OFCO's website for information about the child welfare system or to file a complaint. OFCO visited six Department of Corrections (DOC) facilities with OCO on both the west and east side of the state and met with residents and discussed how our office can assist parents involved in the child welfare system.

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2023, and August 31, 2024, OFCO completed 728 investigations regarding 1,003 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-nine complaints prompted intervention by OFCO in 2024. OFCO provided assistance in an additional 51 complaints to resolve either the complaint issue or a concern identified by OFCO in the course of its investigation.

In 2024, OFCO made 39 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]

DCYF responses to adverse findings this past year often identified staffing challenges that contributed to case activities required by policies not occurring. In addition to increased workforce recruitment and retention efforts, the Department should implement a process to provide case coverage to permit staff to take earned leave or attend training and ensure that required case activities occur during their absence.

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

SECTION I:
IMPROVING THE SYSTEM

Placement Exceptions

Outreach

Juvenile Rehabilitation

2024 Child Fatalities and Near Fatalities Report

PLACEMENT EXCEPTIONS

PLACEMENT EXCEPTIONS FOR FOSTER CHILDREN

Figure 1: **Number of Placement Exceptions, 2015-2024**

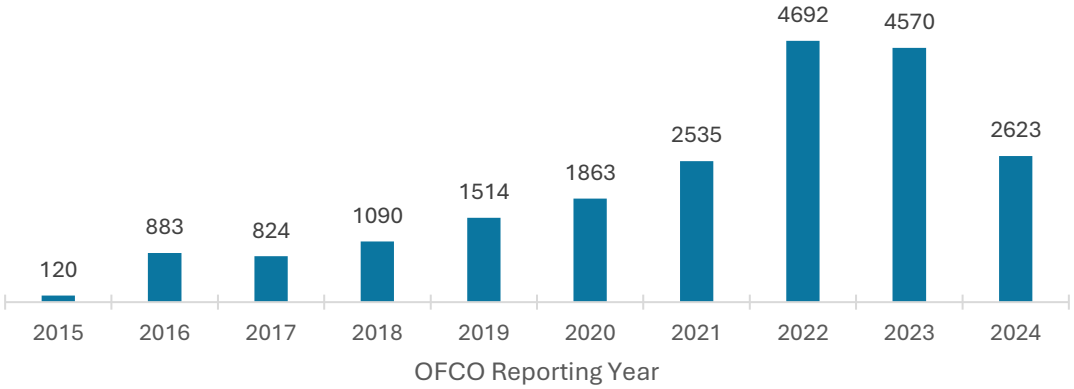
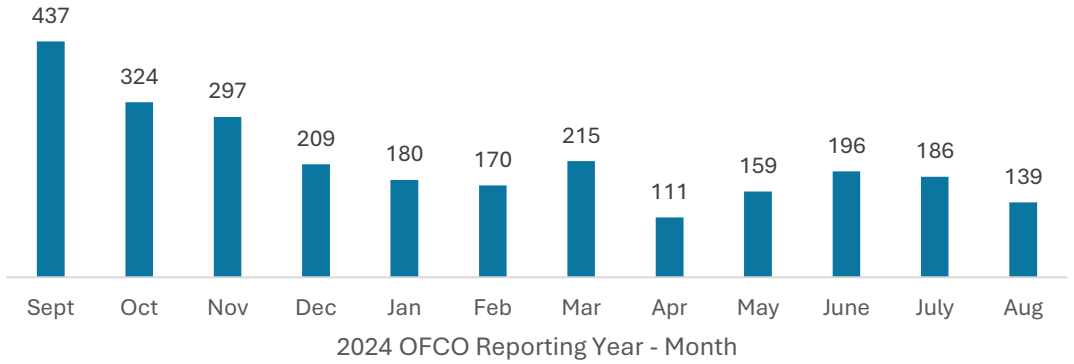


Figure 2: **Number of Placement Exceptions by Month, 2024**



DCYF has for years housed children in unlicensed placements such as hotels, leased facilities operated by the Department, or night-to-night licensed foster homes[4] when there is no ongoing or short-term licensed foster placement or unlicensed kinship placement available that can meet the child's needs. Housing children in hotels and temporary facilities is disruptive for children and often traumatic. These placements also contribute to circumstances that can endanger youth, DCYF staff, and other professionals.

This past year, DCYF significantly reduced reliance on temporary placement exceptions for children in state care. From September 1, 2023, to August 31, 2024, OFCO received notice of 2,623 placement exception events. This is a 57% decrease in the number of placement exceptions from last year. The number of children experiencing a placement exception also decreased from 358 children in 2023 to 216 children this past year. The Department has continued to expand the use of

[4] 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.

leased facilities staffed by DCYF employees to provide temporary placement for children and reduce the number of placements in hotels. This reporting year, just 6.3% of placement exceptions occurred in hotels, dropping over 91% from last year. Over 84% of placement exceptions occurred in leased facilities, and 9.4% occurred in night-to-night licensed foster homes.

DCYF LEASED FACILITIES

DCYF state run facilities are a short-term option for complex youth needing care, support and intensive supervision who do not have placement. Youth must be thirteen years or older to qualify for admission.

Before a youth is accepted for supervision, all other placement options must be exhausted, including family foster care, relative placements, fictive kin, and other residential placements, including out of county options.

Youth entering facilities often present with complex trauma, behaviors, mental health, and developmental concerns that are barriers to licensed placement options.

There are three DCYF facilities: Lake Burien in Burien (Region 4), Aspire House in Centralia (Region 6), and Belonging House in Vancouver (Region 6).

Table 1: **Location of Placement Exceptions and Number of Children Who Experienced Placement Exceptions by DCYF Region, 2024**

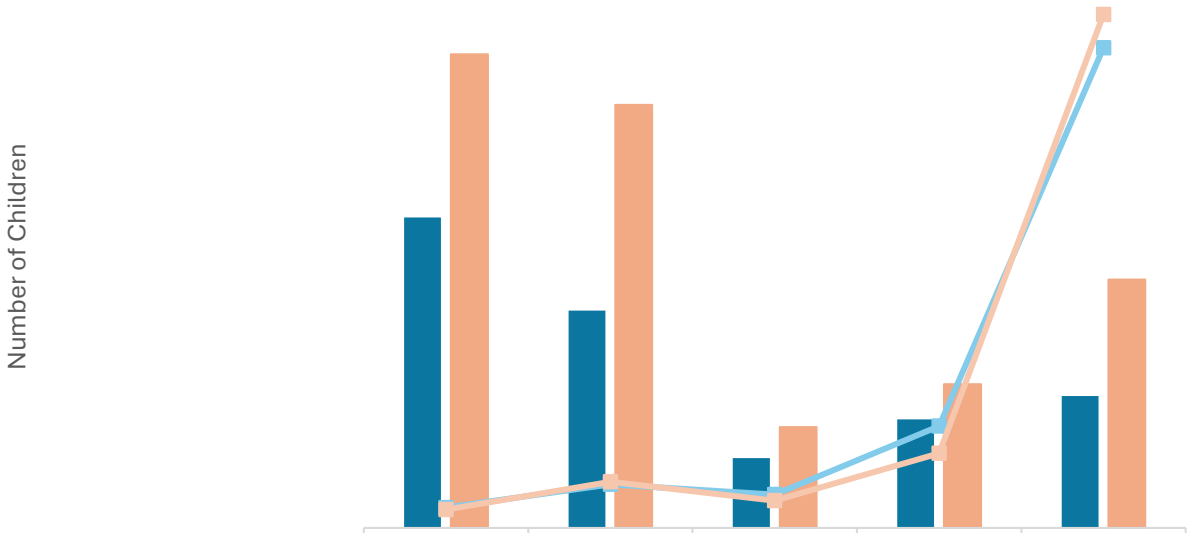
DCYF Region	Hotel	Night-to-Night	Leased Facility	Total Number of Placements (Percent of Placement Exceptions)	Number of Children (Percent of Placement Exception Population)
Region 1	16	2	40	58 (2.2%)	8 (3.7%)
Region 2	--	--	--	--	--
Region 3	24	23	1	48 (1.8%)	20 (9.3%)
Region 4	32	42	933	1007 (38.4%)	65 (30.1%)
Region 5	11	81	253	345 (13.2%)	45 (20.8%)
Region 6	82	98	985	1165 (44.4%)	78 (36.1%)
Total (Percent of Placement Exceptions)	165 (6.3%)	246 (9.4%)	2212 (84.3%)	2623	216

The majority of placement exceptions occurred in DCYF Region 6 (44.4%) and Region 4 (38.4%).[5] The majority of hotel stays (82) also occurred in Region 6.

[5] DCYF Region 4: King County; DCYF Region 6: Clallam, Jefferson, Mason, Grays Harbor, Thurston, Pacific, Lewis, Wahkiakum, Cowlitz, Skamania, and Clark Counties. DCYF Regional Map: https://www.dcyf.wa.gov/sites/default/files/pubs/COMM_0008.pdf.

DCYF typically locates a placement within a few days for most children who experience placement exceptions. This year, DCYF identified a suitable placement for 63% of children within five days or less of a placement exception occurring. However, consistent with the previous years, these children accounted for less than 10% of all reported placement exceptions. The number of children experiencing lengthy stays in placement exceptions also fell this year. Thirty-four children spent twenty or more nights in a placement exception compared to 64 children in 2023. These 34 youths comprised 15.7% of children experiencing a placement exception yet accounted for over 70% of all placement exceptions, with a combined total of 1,854 nights. Fifteen of these 34 youth spent over 50 nights in a placement exception, representing over half of all reported placement exceptions (1,326 nights).

Figure 3: **Number of Placement Exceptions per Child, 2023-2024**



	Only 1 night	2 to 5 nights	6 to 9 nights	10 to 19 nights	20 or more nights
2024	80	56	18	28	34
2023	122	109	26	37	64
Percent of Total Placement Exceptions 2024	3.0%	6.4%	4.9%	15.0%	70.7%
Percent of Total Placement Exceptions 2023	2.7%	6.8%	4.0%	11.0%	75.6%

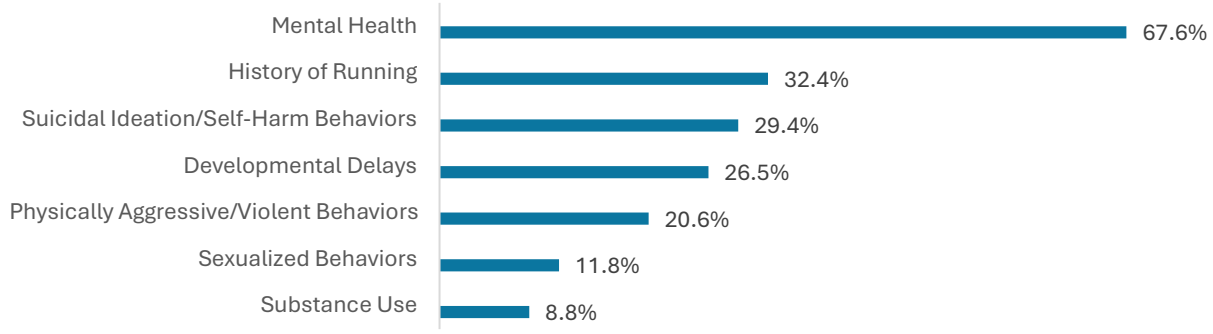
THE 34 YOUTHS WHO SPENT 20 OR MORE NIGHTS IN PLACEMENT EXCEPTIONS

- Five youths stayed over 100 nights in a placement exception. Three of the five youths had significant complex needs, such as mental health issues, developmental delays, physically aggressive and violent behaviors, and/or substance use disorder.
- The highest number of nights in placement exceptions reported for a single child was 198 nights.
- The majority (85.3%) of these youth were 10 years of age or older. More than half (52.9%) were between the ages of 15 and 17.
- As of September 2024, placement has been located for all but four of these youth.[6] Two are currently in a juvenile detention or juvenile rehabilitation facility, one remains in a DCYF leased facility, and one is currently missing from care.

Table 2: **Current Placement for the 34 Youth Experiencing 20 or More Nights in Placement Exceptions**

Current Placement	Number of Youths
BRS Placement	17
Foster Home	3
EFC – Supervised Independent Living	3
Parent	3
Relative/Suitable Other Placement	2
Group Home	2
Juvenile Detention/Rehabilitation	2
DCYF Leased Facility	1
Missing From Care	1

Figure 4: **Characteristics and Behaviors of the 34 Youth Experiencing 20 or More Nights in Placement Exceptions, 2024**



[6] Placement information as of 9/18/2024.

Table 3: **Age, Race, and Gender of the 34 Youth Who Spent 20 or More Nights in Placement Exceptions, 2024**

	Number of Youth	Percent of Youth Who Spent 20 or more Nights in Placement Exceptions
Age		
0-4 years	2	5.9%
5-9 years	3	8.8%
10-14 years	11	32.4%
15-17 years	18	52.9%
Race/Ethnicity[7]		
American Indian/Alaska Native	4	11.8%
Asian/Pacific Islander	0	0.0%
Black/African American	13	38.2%
Hispanic/Latino	2	5.9%
White/Caucasian	15	44.1%
Gender/Sex[8]		
Female	14	41.2%
Male	18	52.9%
Other	2	5.9%

[7] 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; Black/African American, Multiracial has been combined with Black/African American; and Asian/Pacific Islander, Multiracial has been combined with Asian/Pacific Islander.

[8] 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.

DEMOGRAPHICS OF CHILDREN EXPERIENCING PLACEMENT EXCEPTIONS

Of the 216 children who spent at least one night in a placement exception, 124 were male (57.4%), 85 were female (39.4%), and 7 identified as transgender or other gender (3.2%).[9]

Although children ages 10 to 17 years of age make up 29.1% of the total out-of-home care population in Washington State,[10] they comprise over 70% of the children experiencing placement exceptions. As shown in Figure 6, and consistent with previous years, children who experience placement exceptions tend to be older than the total out-of-home care population.[11] Children ages 10 to 14 spent an average of 11 nights in placement exceptions, and children ages 15 to 17 spent an average of 19 nights.

Figure 5: **Gender of Children in Placement Exceptions, 2024**

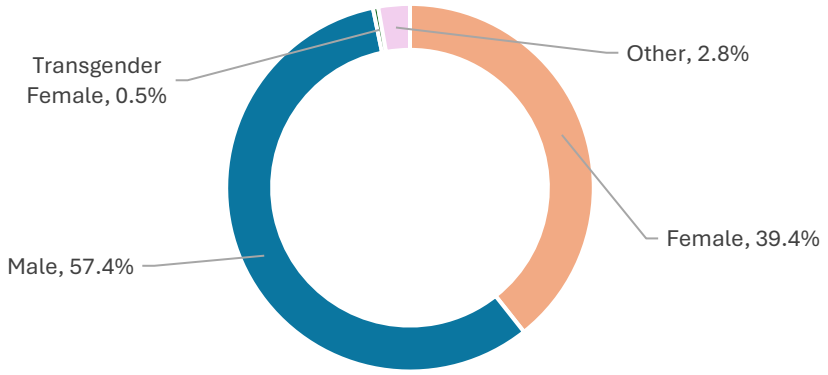
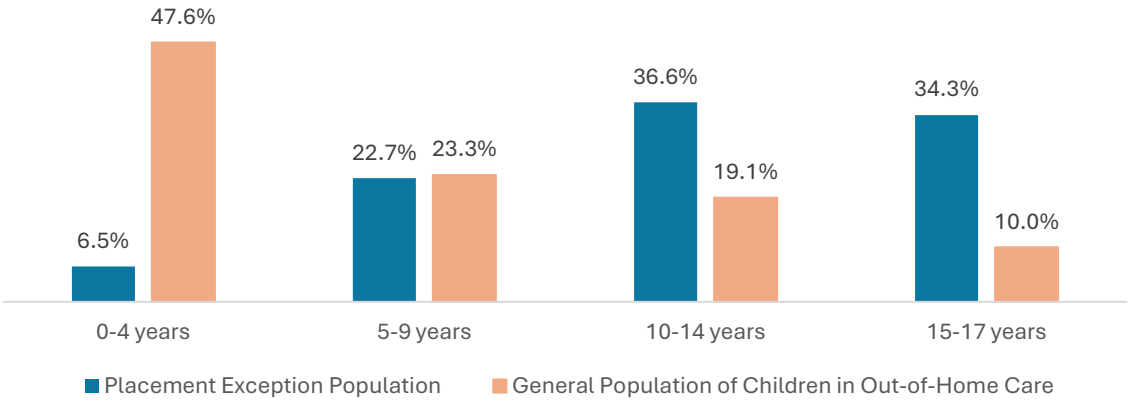


Figure 6: **Age of Children in Placement Exceptions, 2024**

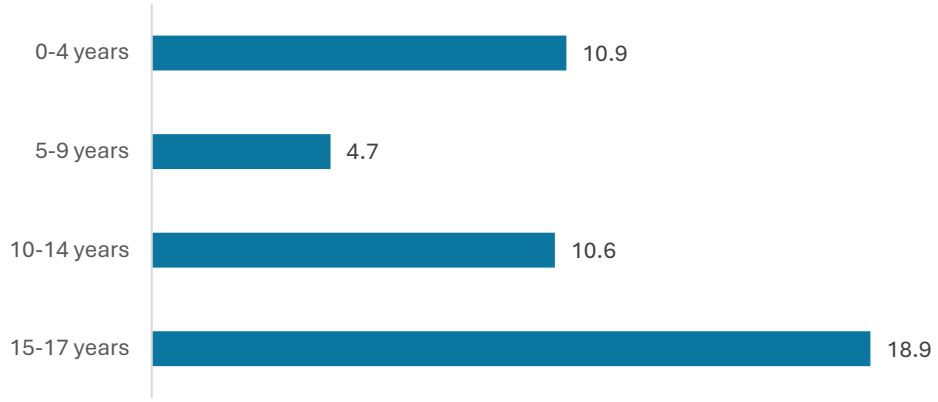


[9] While the DCYF documents the legal and preferred name, and reported pronouns and gender identity of the child, some children may not feel comfortable sharing this information. See, DCYF Policies and Procedures Section 6900.

[10] Department of Children, Youth, and Families. Number and Percent of Children/Youth Who Experienced Out-of-Home Care, by Age, SFY 2023. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

[11] Ibid.

Figure 7: **Average Number of Placement Exceptions by Age, 2024**



The majority of the children four years of age and younger spent just one night in a placement exception. Two children, four years of age with complex needs, were among the 34 children who experienced over 20 nights in a placement exception. One child spent 57 nights, and the other spent 77 nights.

Table 4: **Race/Ethnicity of Children in Placement Exceptions, 2024**

Race/Ethnicity	Placement Exception Population	Washington State Out-of Home Care Population[12]
American Indian/Alaska Native	13.4%	17.0%
Asian/Pacific Islander	5.1%	3.0%
Black/African American	26.4%	15.0%
Hispanic/Latino	12.0%	17.0%
White/Caucasian	41.2%	46.0%
Unknown	1.9%	--

DROP IN PLACEMENT EXCEPTIONS INCREASES SAFETY FOR YOUTH AND STAFF

Last year, OFCO documented 49 reports involving physical assaults or conduct by youth during a placement exception that endangered DCYF staff or other professionals, including medical staff, therapists, and security guards. While most of these incidents did not result in serious injury and DCYF staff successfully deescalated the situation, even these "minor incidents" underscored the vulnerability of the DCYF staff and the potential risk to others.

This year, OFCO reviewed 15 staff safety incidents involving 10 youths who were in a placement exception. By reducing the number of placement exceptions, particularly those in hotels, the unstable circumstances and volatile situations that endanger DCYF staff and other youth have decreased.

[12] Department of Children, Youth, and Families. Children in Care by Race/Ethnicity, Last Day of SFY 2016-2023. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

STRATEGIES TO ELIMINATE PLACEMENT EXCEPTIONS

D.S. SETTLEMENT AGREEMENT

In January 2021, Disabilities Rights Washington (DRW) filed a lawsuit (D.S. v. DCYF) 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. Under the D.S. Settlement Agreement, DCYF is required to end the use of placement exceptions, including hotel and office stays, night-to-night foster care placements, and placements in leased facilities. The Settlement Agreement requires the Department to implement an Emerging Adulthood Housing Program (EAHP) to support young people ages 16 to 20 years who prefer to live independently; develop a Professional Therapeutic Foster Parenting licensing category to care for children with developmental disabilities or behavioral health needs; and implement a Statewide Hub Home Model where an experienced licensed foster parent serves as a "Hub Home" and supports up to ten satellite homes.

RECOMMENDATIONS

- **Emerging Adulthood Housing Program**
  Ensure that DCYF has sufficient resources to fully implement the EAHP to meet the needs of young people in care. DCYF estimates ten additional placements, five in Region 4, and five in Region 6, are needed to meet the demand for this program.

- **Expand Licensed Receiving Care Resources**
  Licensed Receiving Care provides short-term placement and supports for children and youth when there is an emergent need for placement and no ongoing placement is available. Licensed Receiving Care Resources should be expanded, particularly in Region 4 and Region 6, which experience the highest number of placement exceptions.[13]
  Additionally, efforts to expand receiving care should focus on children ages 12 to 17 years with complex needs.

[13] Region 1 and Region 2, by comparison, have the highest number of licensed receiving care beds and the lowest number of children experiencing placement exceptions.

OUTREACH

OFCO has had an exciting year in outreach. We have undertaken two new projects aimed at connecting with communities from whom we have historically received disproportionately low numbers of complaints. This effort is in accord with achieving our agency's Pro-Equity Anti-Racist goals, as well as our statutory duties to provide information to those impacted by child welfare systems.

This year, OFCO partnered with the Office of the Corrections Ombuds (OCO) to connect with incarcerated parents. Incarcerated parents with children involved in the child welfare system often struggle to fully participate in their child's case, access services, or engage in parent-child visits. Additionally, they cannot access OFCO's website for information about the child welfare system or to file a complaint.

Neither DCYF, DOC, nor the court system tracks how many incarcerated parents have children in care or involved with the child welfare system due to allegations of child maltreatment. In 2024, the legislature addressed this issue and directed the Administrative Office of the Courts to submit a report describing in part, how many children in dependency proceedings have incarcerated parents.[14] This information will assist the child welfare system target services and supports for parents in DOC facilities.

This past year, OFCO visited six Department of Corrections (DOC) facilities on both the west and east side of the state with OCO, where we met with DOC residents and discussed how our office can assist parents involved in the child welfare system, provided contact information and paper copies of our complaint form for ease of access, and collected any current complaints residents had. OFCO also partnered with the DOC Parent Navigator Program which assists incarcerated parents, including those with open dependency cases. These efforts have resulted in an increase in complaints from incarcerated parents.

OFCO also reached out to the 29 sovereign, federally recognized Indian Tribes in Washington State this year. State and federal laws protect the rights of Native American children, parents, and Tribes involved with state child welfare agencies. OFCO contacted the directors of the tribal child welfare agencies to inform them of our services and goal of ensuring our state child welfare system works in partnership with tribal child welfare agencies to protect the rights of Native American families. OFCO is in the process of offering to meet with a designated representative of each Tribe at a location of their choosing to describe our services, to receive feedback on the system successes and gaps, and to collect any complaints.

[14] ESSSB 6068, Chapter 326, Laws of 2024. 6068-S2.SL.pdf (wa.gov).

JUVENILE REHABILITATION

OVERSIGHT OF JUVENILE REHABILITATION IS ESSENTIAL TO PROTECT YOUTH AND YOUNG ADULTS

The Office of the Family and Children's Ombuds (OFCO) was established in 1996 to ensure that the state child welfare agency responds appropriately to children in need of protection, children residing in state care, and families receiving agency services due to allegations of child abuse or neglect. OFCO's statutory authority centered on the actions and conduct of the Children's Administration, then a division of the Department of Social and Health Services (DSHS), and did not extend to the Juvenile Rehabilitation Administration which was also within DSHS.

In 2018, the Department of Children, Youth, and Families (DCYF) was created, combining Children's Administration and the Department of Early Learning, and in 2019 Juvenile Rehabilitation (JR) was integrated into DCYF. The statutory changes creating DCYF, however, did not expand OFCO's investigative authority. Also in 2019, the legislature passed "Juvenile Rehabilitation to Age 25"[15] expanding the ages of young adults eligible to be housed in JR facilities, allowing young people sentenced in adult court for crimes committed under age 18 to go to a JR facility until age 25.

Currently, complaints or concerns about the safety or welfare of an individual at a JR facility are handled in a variety of ways, including investigations conducted by the DCYF Licensing Division (DCYF/LD) and incident reviews by the JR Critical Incident Review Team (CIRT) and through an internal complaint resolution process. These avenues do not adequately ensure that JR actions and conduct comply with laws and policies or that agency decisions are made in a fair, consistent, and unbiased manner.

Allegations of abuse or neglect reported to Child Protective Services (CPS) are investigated by the DCYF/LD. A LD/CPS investigation determines whether the facts support an administrative finding that child abuse or neglect occurred. If the alleged victim is 18 years of age or older, a finding of child abuse or neglect cannot be made. The LD informs JR administration of the LD/CPS investigative findings for further action. JR facilities are not licensed by the LD and therefore LD does not investigate infractions that do not meet the definition of child maltreatment. Alleged infractions are referred to JR administration.

In 2023, JR established the Critical Incident Review Team (CIRT) to review incidents involving the use of force and other critical incidents. The CIRT process does not take the place of a LD/CPS investigation and JR staff are required to report suspected child maltreatment to CPS.[16] Many incidents involving use of force concerns do not rise to a level requiring a CPS report, but still must be reviewed to identify areas for improvement and ensure that practices are followed, and that JR employees and young people are safe. The CIRT also reviews other incidents, such as a suicide attempt, death of a client, drug use, significant injury, escape, assault, illegal contraband, medication error, or significant facility damage.

[15] ESSHB 1646, Chapter 322, Laws of 2019.

[16] RCW 26.44.030.

Youth and young adults in JR facilities are encouraged to informally resolve issues or concerns but may submit a written complaint. Complaint forms and boxes are in living units and complaints are picked up daily. A JR facility program manager or supervisor reviews the complaint with the individual to address the concerns. If the complaint is not resolved, the individual may appeal to the next level. Some youth, parents, and advocates state they have little faith in this complaint process, as it is handled internally at the facility which is the subject of the complaint. DCYF is requesting funding for the 2025-2027 biennium to implement a uniform grievance process for youth to dispute JR decisions or actions, increase transparency, and reduce biased or disparate treatment.[17]

Additionally, JR does not have a formal hearing process for behavioral infractions or placement decisions. DCYF is also requesting funding for the 2025-2027 biennium to establish an impartial hearing process and provide youth with due process protections and the right to seek review of behavioral infractions or placement decisions. DCYF notes that the lack of a hearing process undermines the Department's credibility and can escalate tensions within JR institutions, contributing to unrest and violence.[18]

RECOMMENDATIONS

- **Provide sufficient funding for DCYF to establish both a formal hearing process and a uniform grievance process for youth and young adults in JR Facilities.**
  JR should afford youth with due process and a formal hearing when their liberty interests are impacted by a disciplinary action or placement decision. Additionally, youth should have access to a credible grievance process to resolve complaints, such as living conditions, safety, staff behavior, services, medical care, and access to education.

- **Modify state laws clarifying OFCO's duties and responsibilities regarding youth and young adults in JR facilities.**
  Over the past few years, OFCO has responded to complaints about the safety and well-being of youth in JR facilities. Complaint issues have included the use of room confinement and isolation, assault of a youth by other residents, youth accessing illegal drugs, use of force by JR staff against youth, and inhumane living conditions in a JR facility. DCYF administrators have cooperated with OFCO's investigations, however, the current statutory framework does not clearly define OFCO's authority regarding JR, ability to access JR's case management system, or duties related to young adults serving adult sentences and placed in JR managed facilities. Expanding OFCO's duties and responsibilities to JR would require devoting additional resources to OFCO to investigate these complaints.

[17] DCYF Decision Package 2025-27 Regular Budget Session, H5- Safety and Security Processes.
[18] Id.

2024 CHILD FATALITIES AND NEAR FATALITIES REPORT

In July, OFCO released its 2024 Report on Child Fatalities and Near Fatalities in Washington State, describing critical incident reviews from January 1, 2023, to December 31, 2023.[19] Systemic issues described in this report include sleep-related child fatalities and critical incidents resulting from a child's accidental ingestion of fentanyl.

Despite efforts to educate families about infant safe sleep practices, sleep-related infant fatalities persist and impact Black/African American and American Indian/Alaska Native families at a higher rate compared to White/Caucasian families. Of the 79 child fatalities OFCO reviewed in 2023, nearly one-third (26 fatalities) were sleep-related infant deaths. Ninety-two percent (24 cases) of these sleep-related fatalities occurred while the parent was co-sleeping or surface sharing with the child at the time of the incident. In many of these cases, the parent was surface sharing with the infant due to lack of adequate housing. Efforts to prevent sleep-related infant fatalities should also address housing instability and economic disparities.

The report also describes a significant increase in critical incidents involving a child's accidental ingestion of drugs and drug overdoses. Accidental ingestions and overdoses accounted for 20% of the fatalities (16 fatalities) and nearly 73% of the near fatalities (51 fatalities) OFCO reviewed. Eighty-five percent of critical incidents from accidental ingestion of drugs or drug overdose involved fentanyl. Child fatalities and near fatalities involving fentanyl increased from 38 in 2022 to 57 in 2023. Young children are particularly at risk for accidental ingestion of drugs. Of the 67 incidents involving accidental ingestions, 45 incidents involved accidental ingestion by children 11 years of age or younger.

[19] ofco.wa.gov.

SECTION II:
LISTENING TO FAMILIES AND CITIZENS

Inquiries and Complaints

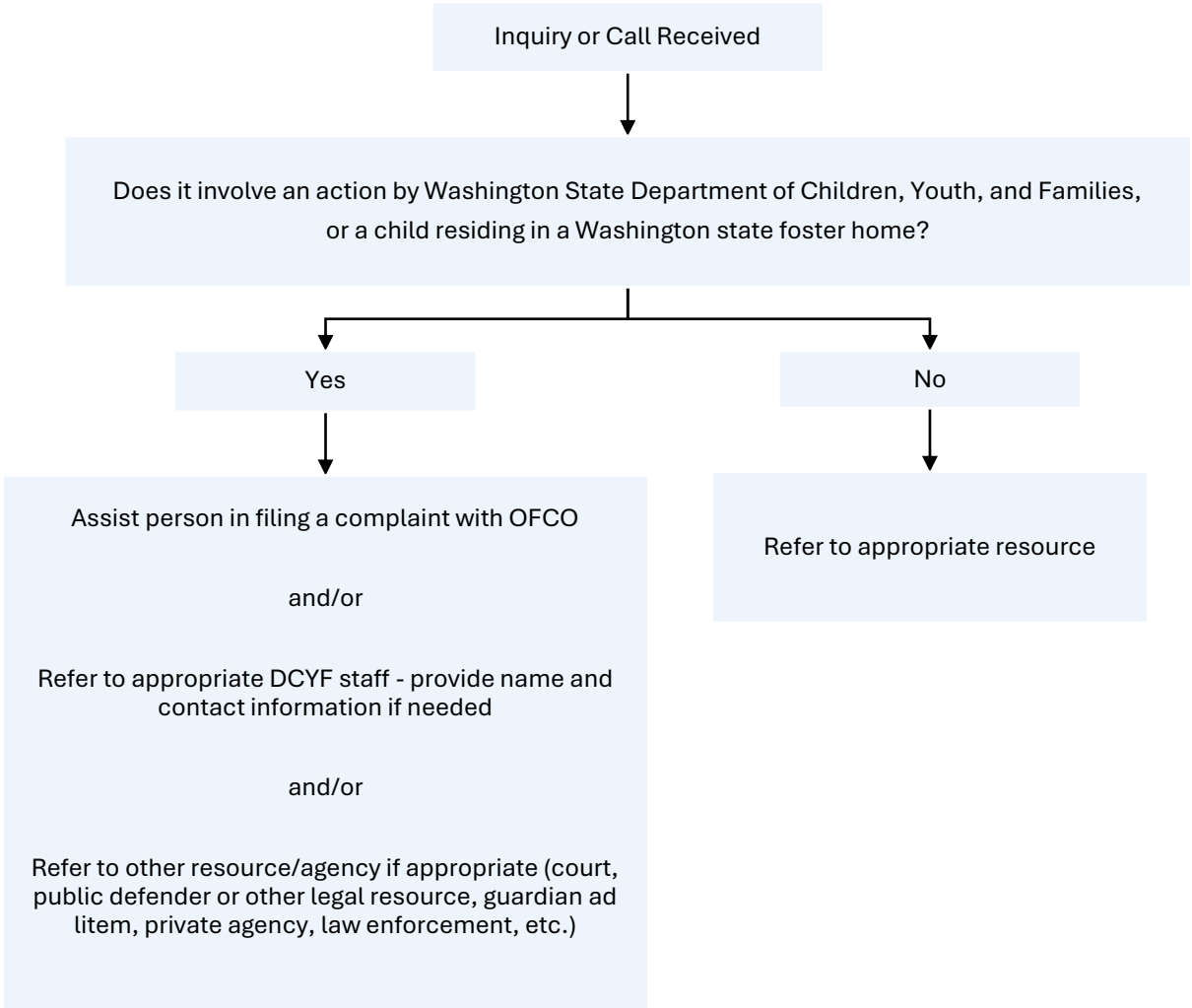
Complaint Profiles

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 8: **What Happens When a Person Contacts OFCO?**



COMPLAINT PROFILES

This section describes complaints filed during OFCO's 2024 reporting year: September 1, 2023, to August 31, 2024. OFCO received 713 complaints during this reporting year. Most complaints received by OFCO were submitted via OFCO's website.

Figure 9: **Number of Complaints Received by Year, 2014-2024**

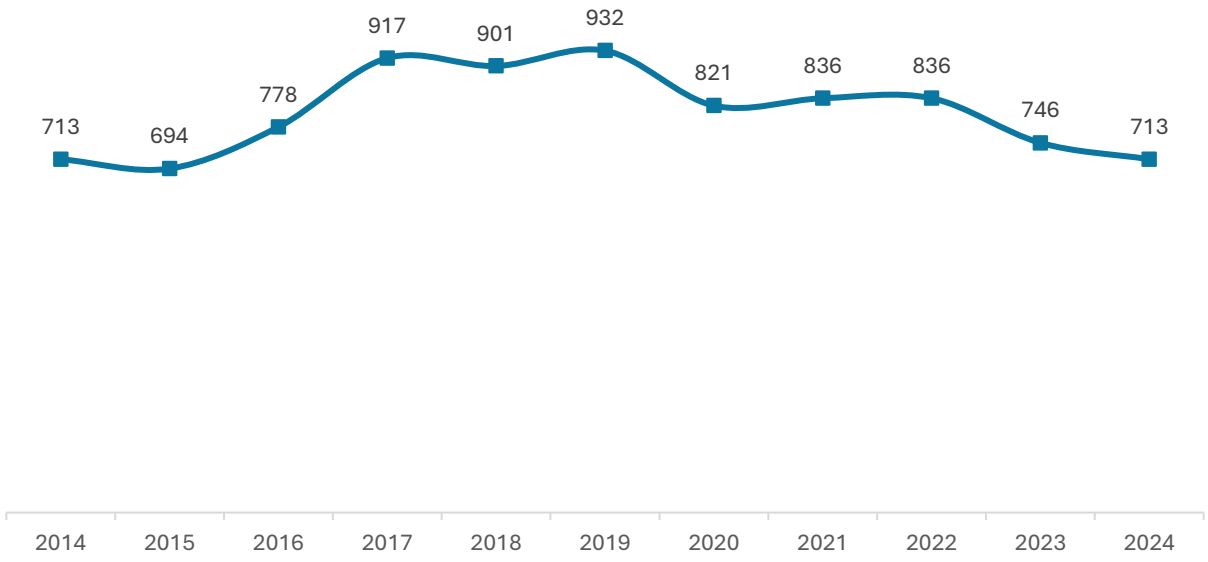
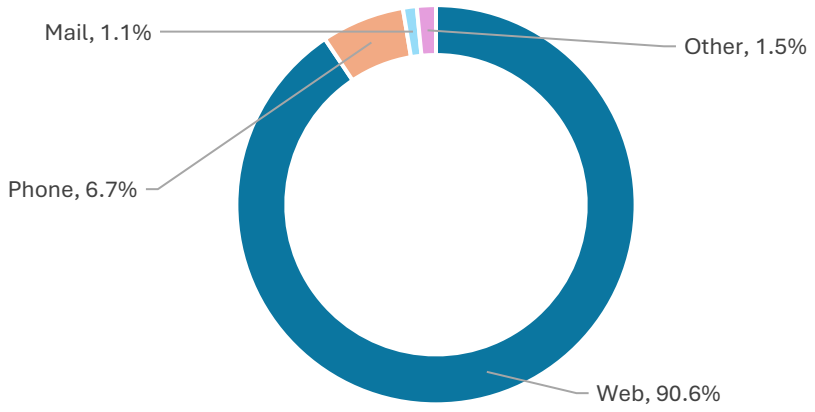


Figure 10: **How Complaints Were Received, 2024**



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 (75.3%).

Table 5 displays the race and ethnicity of this year's complainants.

Figure 11: **Complainant Relationship to Children, 2024**

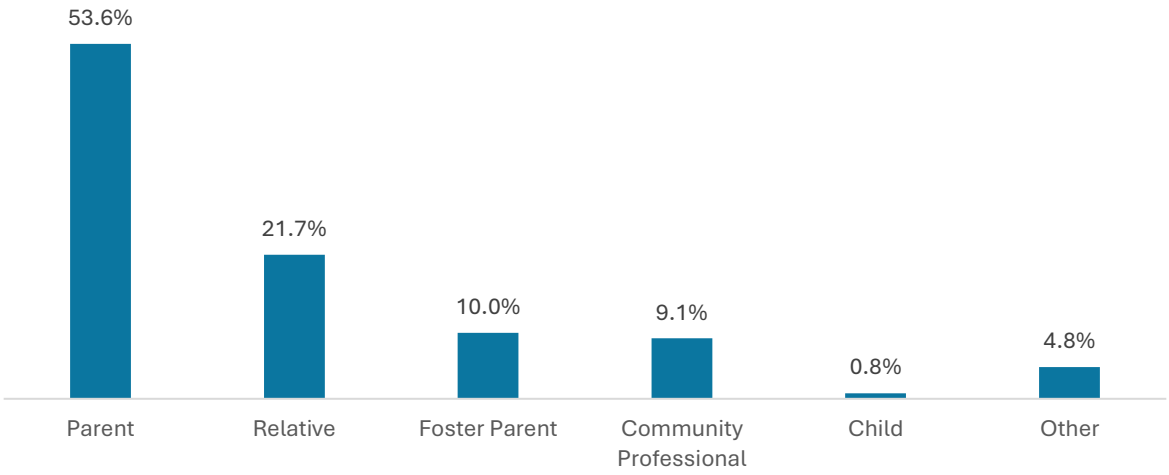


Table 5: **Complainant Race and Ethnicity, 2024**

Complainant Race/Ethnicity	OFCO Complainants	Washington State Population[20]	Washington State Children in Out-of-Home Care[21]
American Indian/Alaska Native	5.9%	2.0%	17.0%
Asian/Pacific Islander	2.8%	10.3%	3.0%
Black/African American	8.3%	4.5%	15.0%
Hispanic/Latino	6.5%	14.5%	17.0%
White/Caucasian	58.3%	71.9%	46.0%
Declined to Answer/Unknown	18.2%	--	--

[20] Office of Financial Management, Population by Race, 2022. https://ofm.wa.gov/washington-data-research/statewide-data/washington-trends/population-changes/population-race.
Office of Financial Management, Population of Hispanic/Latino origin, 2022. https://ofm.wa.gov/washington-data-research/statewide-data/washington-trends/population-changes/population-hispaniclatino-origin.
[21] Department of Children, Youth, and Families. Children in Care by Race/Ethnicity, Last Day of SFY 2016-2023. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

CHILDREN IDENTIFIED IN COMPLAINTS

Of the 1,003 children identified in complaints this year, 67.4% 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 6: **Age of Children in Complaints to OFCO, 2024**

Age of Children in Complaints	Percent of Children in OFCO Complaints	Washington State Out-of-Home Care Population[22]
0-4 years	34.1%	47.6%
5 to 9 years	33.3%	23.3%
10 to 14 years	23.7%	19.1%
15 to 17 years	7.5%	10.0%
18+ years	1.4%	--

Table 7: **Race/Ethnicity of Children in Complaints to OFCO, 2024**

Race/Ethnicity of Children Identified in Complaints	Percent of Children in OFCO Complaints	Washington State Out-of-Home Care Population[23]	Percent of Washington Children[24]
American Indian/Alaska Native	11.3%	17.0%	2.4%
Asian/Pacific Islander	3.5%	3.0%	10.3%
Black/African American	15.2%	15.0%	4.9%
Hispanic/Latino	10.2%	17.0%	24.6%
White/Caucasian	55.0%	46.0%	63.6%
Declined to Answer/Unknown	4.9%	--	--

[22] Department of Children, Youth, and Families. Number and Percent of Children/Youth Who Experienced Out-of-Home Care, by Age, SFY 2023. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

[23] Department of Children, Youth, and Families. Children in Care by Race/Ethnicity, Last Day of SFY 2016-2023. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

[24] Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2023. 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 12 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. Over half of the complainants expressed these concerns. Consistent with last year, the most frequently identified concerns included:

- Unwarranted, unreasonable, or inadequate CPS interventions (177 complaints);
- Unprofessional conduct by agency staff, such as harassment, discrimination, bias, dishonesty, or conflict of interest (103 complaints); and
- Communication failures, such as caseworkers not communicating with parents or relatives (65 complaints).

Although issues involving family separation and reunification continue to be the second most identified concerns, OFCO has seen a significant decrease in these concerns in the last three years. The most frequently identified concerns included:

- Unnecessary removal of child from parental care (50 complaints);
- Failure to provide contact between child and parents or other family members (37 complaints);
- Failure to place child with a relative (31 complaints); and
- Failure to reunite family (27 complaints).

Figure 12: **Categories of Issues Identified by Complainants**

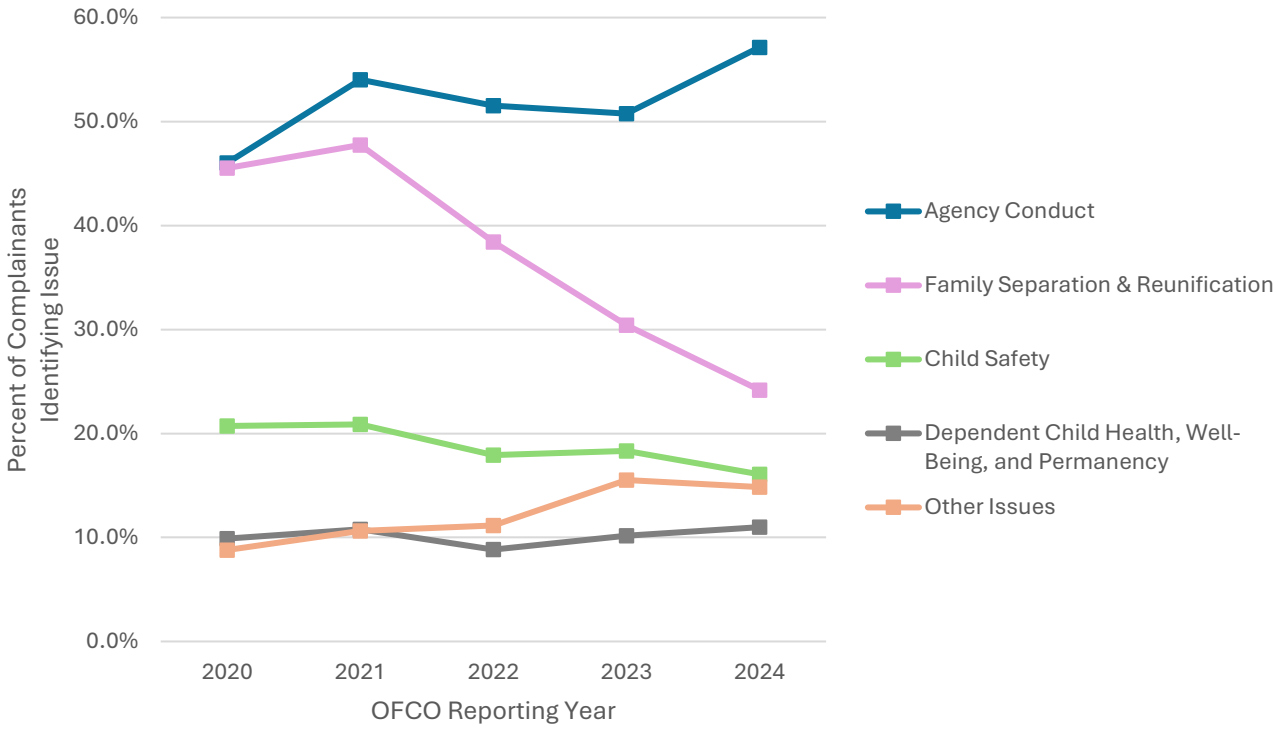


Table 8: **Issues Identified by Complainants**

	2024	2023	2022
COMPLAINTS ABOUT AGENCY CONDUCT	**416**	**399**	**420**
Unwarranted/unreasonable/inadequate CPS intervention	177	166	167
Unprofessional conduct, harassment, conflict of interest or bias/discrimination by agency staff	103	106	110
Communication failures	65	63	72
Unreasonable CPS findings	28	17	17
Breach of confidentiality by agency	17	24	23
Inaccurate agency records	8	8	8
Poor case management, high caseworker turnover, other poor service	8	8	21
Retaliation by agency staff (does not include complaints of retaliation made by licensed foster parents)	4	2	1
Family Assessment Response	3	3	9

	2024	2023	2022
FAMILY SEPARATION AND REUNIFICATION	**176**	**239**	**313**
Unnecessary removal of child from parental care	50	82	104
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	37	45	70
Failure to place child with relative	31	27	32
Failure to reunite family	27	44	55
Other inappropriate placement of child	10	17	26
Unnecessary removal of child from relative placement	7	10	12
Other family separation concerns	5	4	0
Failure to provide sibling visits and contact	4	7	8
Inappropriate termination of parental rights	4	2	2
Failure to place child with siblings	1	3	4

	2024	2023	2022
CHILD SAFETY	**117**	**144**	**146**
Failure to protect children from parental abuse or neglect	37	48	58
Suspected child neglect	*20*	*23*	*27*
Suspected child abuse	*17*	*25*	*31*
Failure to address safety concerns involving children being returned to parental care	26	29	22
Failure to address safety concerns involving children in foster care or other non-institutional care	23	35	37
Child safety during visits with parents	19	11	18
Child with no parent willing/capable of providing care	8	18	7
Failure by agency to conduct 30-day health and safety visits with child	2	1	1
Safety of children residing in institutions/facilities	2	1	0

DEPENDENT CHILD HEALTH, WELL-BEING AND PERMANENCY	2024 80	2023 80	2022 72
Unreasonable delay in achieving permanency	21	30	21
Failure to provide child with adequate medical, mental health, educational or other services	18	16	20
Inappropriate Permanency Plan/Other Permanency Issues	18	8	2
Other Placement Issues	10	10	--
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	9	6	11
Extended foster care/independent living services	1	2	2
ICPC issues (placement of children out of state)	1	1	3
Failure to provide appropriate adoption support services/other adoption issues	0	4	3
Placement instability/multiple moves in foster care	0	2	5
Placement not meeting child's unique needs	0	0	2

OTHER COMPLAINT ISSUES	2024 108	2023 122	2022 91
Failure to provide parent with services/other parent issues	23	27	26
Violation of parents' rights	17	22	22
Lack of support/services to foster parent/other foster parent issues	16	20	13
Lack of support/services and other issues related to unlicensed relative or fictive kin caregiver	13	8	14
Foster care licensing issues	7	4	2
Foster parent retaliation	3	2	3
Violations of ICWA	2	7	11
Unreasonable/Inadequate Investigation of Licensed Foster Home	2	2	1

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 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 728 complaint investigations. The majority (90.8%) of investigations were standard, non-emergent investigations, and 9.2% met OFCO's criteria for initiating an emergent investigation. OFCO intervened or provided timely assistance to resolve concerns in 25.4% 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

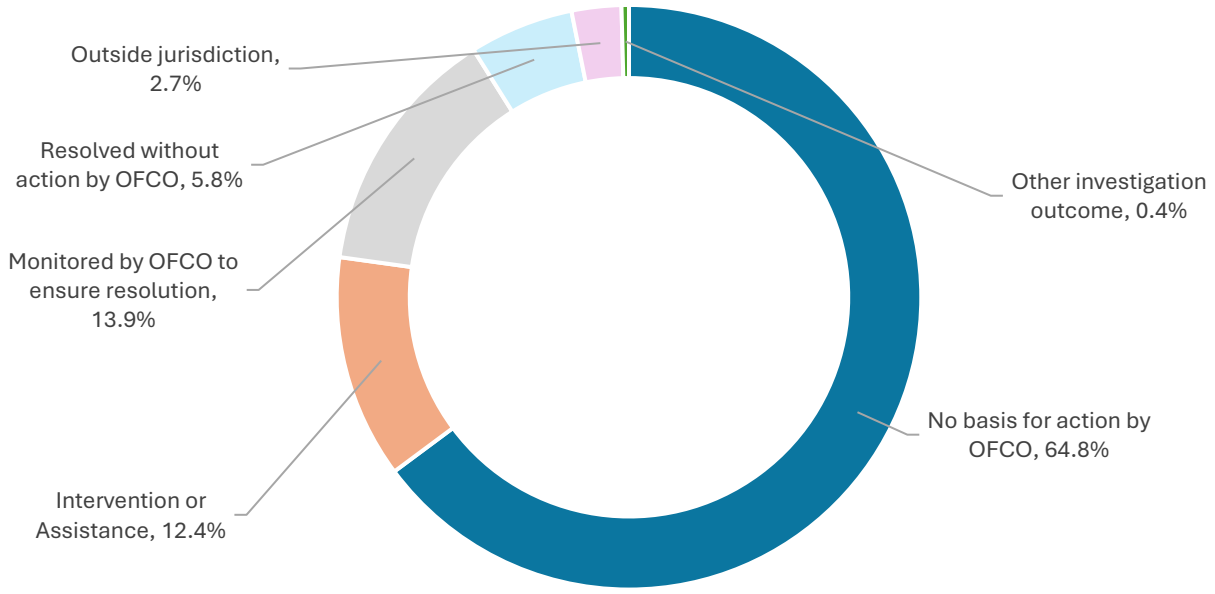
- The complaint involved agencies or actions outside of OFCO's jurisdiction. Where possible, OFCO refers complainants to another resource that may be able to assist them.

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).

Investigation results have continued to remain consistent in recent years. In 2024, OFCO assisted or intervened to try to resolve an identified issue in 90 complaints (12.4%). OFCO monitored 101 complaints (13.9%) 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 most complaints (64.8%).

Figure 13: **Investigation Outcomes, 2024**



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, procedure, or court order; 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 2024, OFCO made 39 adverse findings in a total of 18 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 39 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 9.

Table 9: **Adverse Findings in Complaint investigations by DCYF Region and Office, 2024**

DCYF Region	DCYF Office	Total Number of Findings	Percent of Adverse Findings
Region 1	Moses Lake (3) Newport (1) Spokane Central (3)	7	17.9%
Region 2	Richland (1) Yakima (4)	5	12.8%
Region 3	Region 3 Licensing Division (1)	1	2.6%
Region 4	King South-East (7) King South-West (1) Martin Luther King, Jr. (4)	12	30.8%
Region 5	Bremerton (1) Lakewood (2) Parkland (2)	5	12.8%
Region 6	Aberdeen (1) Tumwater (7)	8	20.5%
DCYF Headquarters	DCYF Headquarters (1)	1	2.6%

Table 10 shows the various categories of issues in which adverse findings were made. Findings most often related to issues concerning child safety and parents' rights.

DCYF responses to adverse findings often identified staffing challenges that contributed to case activities not occurring as required by policies. Staffing issues included vacancies, new staff attending training, workers and supervisors being on planned or unplanned leave, and a worker transferring to a different office. One response noted that staffing issues resulted in only 44% of the workforce available to assign CPS intakes for investigation or family assessment response. OFCO notes that these same staffing issues are often discussed during child fatality and near fatality reviews.

RECOMMENDATION

- In addition to increased workforce recruitment and retention efforts, the Department should implement a process to provide case coverage to permit staff to take earned leave or attend training and ensure that required case activities occur during their absence.

Table 10: **Adverse Findings by Issue**

	2024	2023	2022
CHILD SAFETY	**14**	**14**	**6**
Failure by DCYF to ensure/monitor child's safety - Failure to conduct required monthly health and safety visits	8	9	3
Failure to complete safety assessment	5	5	--
Other child safety findings	1	--	--
Inadequate CPS investigation or case management	--	--	2
Inappropriate CPS Finding (Unfounded)	--	--	1
PARENTS' RIGHTS	**14**	**14**	**7**
Delay in completing CPS investigation/CPS FAR or internal review of findings	12	11	5
Failures of notification/consent, public disclosure, or breach of confidentiality	1	3	2
Failure to communicate with or provide services to parent	1	--	--
POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY	**5**	**4**	**5**
Failure to conduct supervisory reviews	3	--	--
Inadequate investigation	1	2	--
Other poor practice	1	1	2
Inadequate documentation of casework	--	1	3
FAMILY SEPARATION AND REUNIFICATION	**3**	**1**	**--**
Failure to provide appropriate contact / visitation between parent and child	2	--	--
Relative search issues	1	--	--
Other family separation and reunification issues	--	1	--
OTHER FINDINGS	**2**	**1**	**1**
Failure to notify subject of founded findings review results	1	--	--
Delay in ICPC	1	--	--
Failure to assess character, competence, and suitability of Unlicensed Relative or Suitable Other Caregiver	--	1	--
ICWA Violation	--	--	1
FOSTER PARENT/RELATIVE CAREGIVER ISSUES	**1**	**--**	**--**
Failure of notification	1	--	--
DEPENDENT CHILD WELL-BEING AND PERMANENCY	**--**	**--**	**1**
Delay in achieving permanency	--	--	1
NUMBER OF FINDINGS	**39**	**34**	**20**
NUMBER OF CLOSED COMPLAINTS WITH ONE OR MORE FINDING	**18**	**13**	**10**

APPENDICES

Appendix A: Complaint Investigations by Region and Office

Appendix B: Summaries of OFCO's Adverse Findings

Appendix C: OFCO Organizational Chart

APPENDIX A: COMPLAINT INVESTIGATIONS BY REGION AND OFFICE

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

Figure 14: **OFCO Complaint Investigations by DCYF Region/Division, 2024**

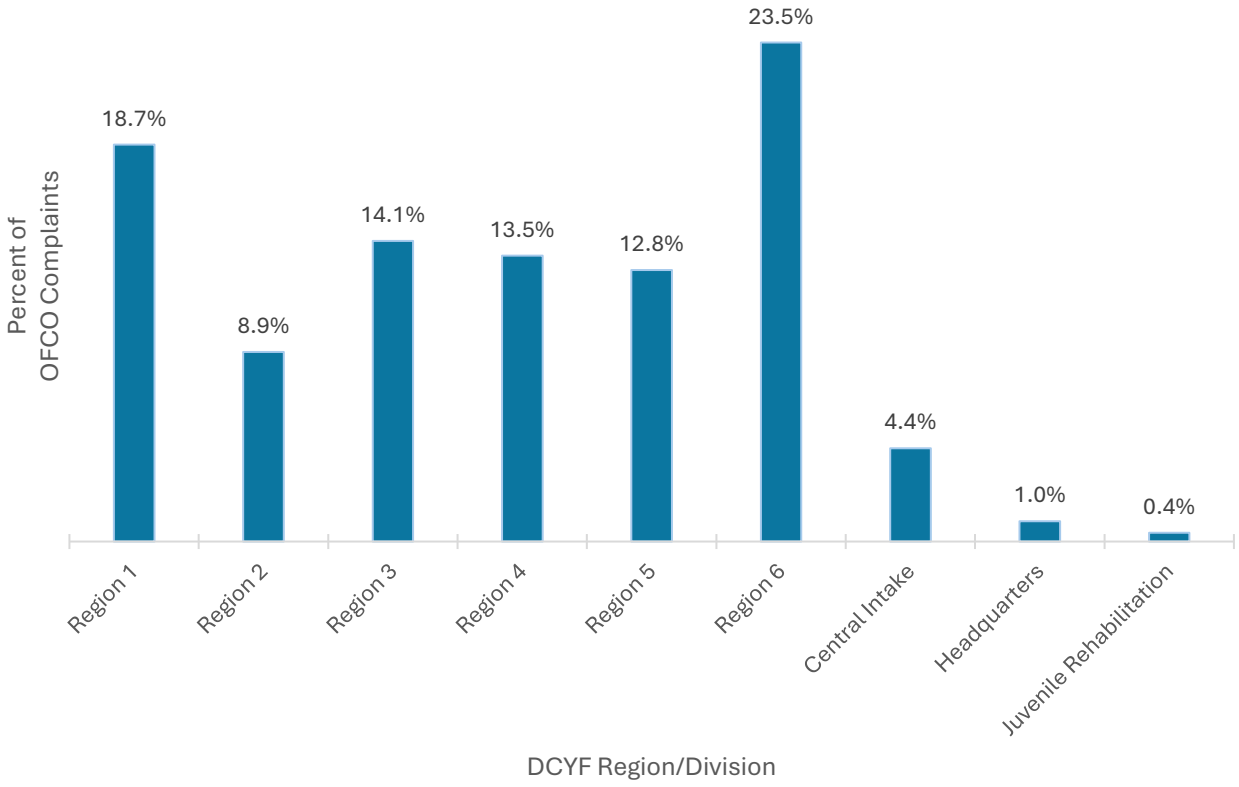


Table 11: **Number of OFCO Complaint Investigations Completed by DCYF Office/Division, 2024**

Region 1			
Clarkston	0	Region 1 - Adoptions	3
Colfax	4	Region 1 - Licensing Division, Safety & Monitoring	3
Colville	3	Region 1 - Regional Intake	1
Lincoln	1		
Moses Lake	15		
Newport	3		
Omak	3		
Republic	0		
Spokane Central	31		
Spokane ICW	12		
Spokane North	24		
Spokane Valley	19		
Wenatchee	14		
Region 2			
Ellensburg	9	Region 2 - Regional Intake	4
Goldendale	5	Region 2 - Licensing Division, Foster Care Licensing	1
Richland (Tri-Cities)	21		
Sunnyside	0		
Toppenish	4		
Walla Walla	5		
White Salmon	0		
Yakima	16		
Region 3			
Bellingham	20	Region 3 - Centralized Services	2
Everett	19	Region 3 - Licensing Division, Child Care Licensing	1
Friday Harbor	0	Region 3 - Licensing Division, Foster Care Licensing	2
Lynnwood	9	Region 3 - Licensing Division, Safety & Monitoring	2
Mount Vernon	15	Region 3 - Regional Intake	4
Oak Harbor	2		
Sky Valley (Monroe)	8		
Smokey Point (Arlington)	19		
Region 4			
King East (Bellevue)	15	Region 4 - Adoptions	5
King South-East (Kent)	10	Region 4 - Licensing Division, Safety & Monitoring	3
King South-West (Kent)	25	Region 4 - Licensing Division, Foster Care Licensing	1
King West (Seattle)	10		
Martin Luther King Jr.	22		
Office of Indian Child Welfare	4		
West Seattle	3		

Region 5			
Bremerton	14	Region 5 - Adoptions	3
Lakewood	23	Region 5 - Licensing Division, Safety & Monitoring	3
Parkland	19	Region 5 - Regional Intake	1
Puyallup	14		
Tacoma	16		
Region 6			
Aberdeen	18	Region 6 - Adoptions	6
Centralia	11	Region 6 - Licensing Division, Child Care Licensing	1
Forks	0	Region 6 - Licensing Division, Safety & Monitoring	2
Kelso	32	Region 6 - Licensing Division, Foster Care Licensing	1
Long Beach	1	Region 6 - Regional Intake	3
Port Angeles	6		
Port Townsend	1		
Shelton	14		
South Bend	2		
Stevenson	4		
Tumwater	37		
Vancouver-Cascade	10		
Vancouver-Clark	12		
Vancouver-Columbia	10		
Other			
Central Intake	32		
Headquarters	7		
Juvenile Rehabilitation	3		
Non-DCYF/Other	24		

APPENDIX B: SUMMARIES OF OFCO'S ADVERSE FINDINGS

FAMILY SEPARATION AND REUNIFICATION AND PARENTS' RIGHTS

DCYF did not maintain adequate contact with the father of a dependent child, submitted false information to court regarding the status of a no-contact order, and did not provide court-ordered parent-child visits.

In July 2020, DCYF filed for dependency of two children following allegations of physical abuse and neglect. During this time, the father was living outside of the home due to a protection order. In December 2020, the father was arrested and detained in county jail.

OFCO received a complaint alleging that from December 2020 until May 2023, the DCYF caseworker had only visited the father on two occasions while he remained in the facility. In reviewing case records, OFCO did not find documentation of monthly visits with the father. Although the court entered an order vacating the protection order in July 2021, the Department continued to inaccurately reference the protection order at subsequent dependency review hearings and took no action to reinitiate contact between the father and child. Zoom visits did not occur until May 2023 when the court denied DCYF's motion to suspend visits and ordered that supervised visits between the father and child begin immediately. The court also found that a relative caregiver and the DCYF caseworker colluded to prevent the child from having contact with their father.

Violations:

- **DCYF did not maintain regular contact and communication with the father as required by DCYF Policies and Procedures, 4420 which mandates that DCYF caseworkers conduct monthly contact in-person, whenever possible, with all known parents.**
  The father had remained accessible in the county jail since December 2020, yet the caseworker only met with him on two occasions before May 2023.

- **DCYF did not encourage maximum parent and child contact as required by state law. RCW 13.34.136 provides that visitation is the right of the family, and early, consistent, and frequent visitation is crucial for maintaining parent-child relationships and making it possible for parents and children to safely reunify. The Department must encourage the maximum parent and child contact possible when it is in the best interest of the child, including regular visitation. Visitation may be limited or denied only if the court determines that such limitation or denial is necessary to protect the child's health, safety, or welfare.**
  After the protection order was vacated in July 2021, the Department failed to establish contact and visitation between the child and father.

- **DCYF did not verify, as required by state law, the status of the protection order issued in 2020 and vacated in July 2021 and continued to falsely assert this order remained in effect, prohibiting parent-child visits. RCW 13.34.400 states that if a DCYF court report contains a recommendation, opinion, or assertion by the**

Department relating to visitation with a child, the Department shall attach the document upon which the recommendation, assertion or opinion is based.
The Department's erroneous assertion that the protection order prohibited visits and the subsequent deprivation of parent-child contact from July 2021 until May 2023 caused actual harm to both the child and the father.

DCYF Response:
The Area Administrator was advised of concerns in August 2023. The Area Administrator and the Deputy Regional Administrator conducted court observations and a qualitative review of the case which resulted in reassignment of the case to a new unit for case management and supervision.

CHILD SAFETY AND PARENTS' RIGHTS

DCYF did not complete investigative activities in a timely manner.

In July 2023, CPS received an intake alleging the father neglected his two children by leaving them in the care of his girlfriend's 13-year-old child during which they were injured. The intake screened into CPS Family Assessment Response (FAR). The worker spoke with the children's mother, who lived out-of-state, and confirmed that the children had returned to her care. The mother added she had additional information to share, including photos and audio records, which the worker documented reviewing in August 2023.

A companion intake also screened in for a CPS Risk Only investigation as to the father's girlfriend with concerns regarding supervision of her 13-year-old and an additional child in the home. Neither child made any disclosures during the initial face-to-face (IFF), but the 13-year-old acknowledged that one of the father's two children got bruised while they were wrestling.

In August 2023, CPS screened for FAR an additional intake alleging that the father had chased and thrown his son on the ground. OFCO reached out to the supervisor inquiring whether the two children and parents had been interviewed. The supervisor reported that the worker would update their case notes, and they would follow up with the mother who resided out-of-state.

As of December 2023, there were no other documented investigative activities other than monthly supervisor reviews in August, September, and November 2023 regarding the CPS FAR cases. The supervisory review entered in November 2023 indicated that the worker needed to interview the father regarding the second FAR intake, call the other state agency to see if they will complete an IFF, and see if a forensic interview was completed regarding the allegations. The worker followed up with the father who reported that he was still visiting with his children out-of-state.

The companion CPS Risk Only case had no documentation of investigative activities for approximately four months since the IFF except for the monthly supervisory reviews dated August, September, and November 2023. The supervisory review entered in November 2023 indicated that the next steps were to interview the parents and complete collateral work.

OFCO contacted DCYF in November 2023 regarding the status of the related CPS cases and whether the father had been interviewed. OFCO was informed that the worker would follow up with the father and find out if the children completed a forensic interview out-of-state.

Violations:

- **DCYF Policies and Procedures, 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 caregiver receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030. Additionally, DCYF Policies and Procedures Guide, Section 2331(2)(e)(i) mandates that CPS cases must be closed within 60 calendar days from the date that CPS receives the intake. CPS cases can be open a maximum of 90 days.**
  The intakes that screened into CPS FAR in July and August 2023 and the intake that screened in for CPS Risk Only in July 2023 remained open as of December 2023.

- **DCYF Policies and Procedures, 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.**
  This case was open July 2023 and, as of December 2023, there had been no documented face-to-face contact or attempts to contact the children residing in Washington since the July IFF.

- **DCYF Policies and Procedures, 1120 (1)(i)(a) requires that a Safety Assessment be completed on all screened in CPS intakes no later than 30 days of the intake.**
  As of December 2023, the Safety Assessments for the three intakes had not been completed.

DCYF Response:

DCYF confirmed that the necessary tasks on this case were not completed timely as priority was given to complete IFF visits on new cases. To manage workload and improve timeliness, the Area Administrator committed to completing the following tasks:

- The supervisor will ensure the Safety Assessment is completed on cases prior to monthly supervision.
- The supervisor will ensure the health and safety visits for cases open over 60 days is documented during monthly supervision and detail expectations for completion if not done.
- The Area Administrator will randomly check supervisory notes to ensure there is clinical direction provided to the caseworker.
- The Area Administrator will monitor the case closure plan for the local office to ensure future cases are closed within timeframes and currently overdue cases are given priority.

A CPS FAR was not conducted within the required timeframes. A comprehensive assessment of the family did not occur in a timely manner, and the agency did not conduct required health and safety visits or clinical supervision case reviews.

In March 2023, CPS screened for FAR reported child neglect related to the mother's drug use. The child's godmother brought the child home with her after viewing conditions of the mother's home. The IFF contact with the child occurred the following day. The caseworker documented that the next steps were to request the mother take the child to the dentist and the doctor for a well-child exam, offering parenting classes, and reviewing the use of force policy.

In April 2023, the caseworker met with the mother for the initial interview. The mother acknowledged recent drug use and said she would allow the child to remain with her godmother and would work with the godmother on completing guardianship paperwork that week.

From mid-April 2023 through the end of July 2023, there was no documentation of any case activities beyond supervisory review case notes identifying next steps as to complete health and safety visits and assessments.

In August 2023, CPS received a report that the mother had passed away. The child was still in her godmother's care, but law enforcement indicated that the paperwork regarding custody of the child was not legally binding. The CPS intake also stated that the mother had only met the godmother online a few months prior to leaving the child in her care, and alleged drug use by the godmother. The CPS intake screened out. The caseworker spoke to law enforcement and confirmed that the mother had passed away. Law enforcement conducted a welfare check on the child at the godmother's home and reported no concerns.

A caseworker visited the child at the godmother's home. The child reported that she felt safe there. The godmother reported that once she obtained guardianship, she would schedule the medical and dental appointments for the child. A guardianship order was granted a few days later. The FAR Family Assessment was submitted, and the case was closed.

Violations:

- **DCYF Policies and Procedures, 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 CPS FAR intake screened in early March 2023. There was no documentation of attempts to contact or interview the mother until mid-April 2023. Comprehensive information was not gathered complete the FARFA DCYF 10-474 in a timely manner. The Safety Assessment and Structured Decision-Making Risk Assessment (SDMRA) were completed in August 2023.

- **DCYF Policies and Procedures, 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 opened in March 2023 and closed in August 2023. There was no documentation of health and safety visits occurring with the child in May, June, or July 2023.

- **DCYF Policies and Procedures, Section 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 into CPS FAR in March 2023 and the FAR Family Assessment was submitted and approved for closure in August 2023.

- **DCYF Policies and Procedures, 46100 (1) requires that DCYF supervisors "conduct monthly clinical supervision case review and verify policy is followed for the appropriate program with each caseworker under their supervision for all cases open 30 calendar days or more."**
  The case opened in March 2023 and closed in August 2023. There were two supervisory case reviews documented: one in July and another in August 2023.

DCYF Response:
DCYF reported that there were multiple vacancies in the office including one of the three CPS supervisors. The worker assigned to the case also went on unexpected, extended leave. Priority was given to complete IFF visits on new cases. The Area Administrator acknowledged that case tasks were not conducted timely. To manage workload and improve timeliness, the local Area Administrator and the region completed the following steps:

- Providing time each morning (up to two hours) dedicated to helping workers document case activities to close cases more efficiently.
- Assigning afterhours and/or other office staff to assist with intake assignments and case activities in support of assigned workers during workload peaks.
- Establishing a fourth supervisor to reduce the span of control in order to conduct quality clinical supervision throughout the life of the case.
- Providing refresher training through unit meetings, quality practice specialist support, and available Alliance trainings based on unit and worker identified needs.

DCYF did not complete investigative activities in a timely manner.

In March 2023, an intake concerning two children, ages 8 and 13, screened in for a CPS Risk Only investigation. The intake alleged that the caregiver was not being protective after learning the 8-year-old engaged in sexual activity with a neighbor child. The assigned worker completed the IFF the following day, during which neither child made disclosures.

There was no documentation for approximately five months after the IFF except for monthly supervisor reviews in April, July, and August 2023. The supervisory review in April indicated that the next steps would be to complete interviews with both children, the caregiver and her partner, and collateral contacts. The supervisor reviews in July and August indicated that the next step would be to interview the caregiver and her partner, collaterals, and complete a health and safety visit.

In September 2023, OFCO contacted the supervisor regarding whether additional collaterals had been contacted and if a health and safety visit had been completed. The supervisor reported that

a health and safety had not been completed but quickly rectified that. The caregiver and additional collateral contacts were interviewed shortly after.

Violations:

- **DCYF Policies and Procedures, 2331 (2)(e)(I) mandates that CPS cases must be closed within 60 calendar days from the date that CPS receives the intake.**
  At the time the finding was made, the case had been open for 198 days.

- **DCYF Policies and Procedures, 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.**
  This case had been open since March 2023 and other than the IFF, there had been no documented face-to-face contact or attempts to contact the children until September 2023.

- **DCYF Policies and Procedures, 46100 (1) requires that DCYF supervisors "conduct monthly clinical supervision case review and verify policy is followed for the appropriate program with each caseworker under their supervision for all cases open 30 calendar days or more."**
  The case was open in March 2023 and as of September 2023, there had only been three supervisor case reviews documented: April, July, and August 2023.

DCYF Response:

DCYF reported that the local office was down 40% of available investigative staff due to vacancies, extended leave, and new workers in training. Those staff were being supervised by two of four supervisors due to a vacancy and extended leave. The office experienced an increase in intake volume during these months, resulting in high monthly intake assignments per investigator. Priority was given to complete IFF visits on new cases. To manage workload and improve timeliness, the local Area Administrator completed the following steps:

- The local supervisory team will receive data reports twice a month indicating incomplete monthly supervisor reviews to track completion.
- Assigning the Roving Unit and other available staff to assist with case activities in support of timely case closure during workload peaks.
- Establishing a fifth supervisor to reduce the span of control to conduct quality clinical supervision throughout the life of the case.
- Establishing a protocol of rotating staff with the highest open intakes out of the intake assignment to focus on case closure. Supervisors of these staff will identify specific cases to be focused on each week for completion.

A CPS FAR case was not completed within required timeframes.

In July 2023, an intake reporting that a 5-year-old ingested their mother's medication screened into CPS FAR. The FAR social worker contacted the mother the following day, informed her of the FAR intake, and scheduled the mother to bring both her children to the DCYF office. When the

FAR social worker met with the family, the mother stated that both children had gotten into her medication.

Over the next two months, there was no documentation of any case work other than a supervisory case note in August 2023 identifying the next steps as conducting a home walkthrough, contacting collaterals, completing interviews with the parents, and conducting a health and safety visit.

When the FAR social worker contacted the mother in September 2023 to schedule a home visit, the mother expressed frustration with the case still being open. The mother indicated she did not want the agency contacting her or her children and asked to discuss this with the supervisor. The FAR supervisor spoke to the mother about her concerns and explained the allegations and the FAR program and that they would still need to make attempts to see the children.

The children were seen for a health and safety visit at school and no concerns were noted. A monthly supervisory review indicated that the mother was not willing to have her family be interviewed and did not agree to further follow up from her family. The supervisor outlined the next steps as to complete all investigative tasks and the FAR Family Assessment.

In November 2023, the FAR social worker met both children and the father in-person, and no concerns were noted. The FAR case subsequently closed the following day.

Violations:

- **DCYF Policies and Procedures, 1120 (1)(a) requires that a Safety Assessment be completed on all screened in CPS intakes no later than 30 days from the date of the intake.**
  The Safety Assessment for the July intakes were completed in November 2023.

- **DCYF Policies and Procedures, 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 caregiver receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030.**
  Intakes screened in for CPS FAR in July 2023 remained open until November 2023.

DCYF Response:
DCYF acknowledged that necessary tasks on this case were not completed timely. To manage workload and improve timeliness, the local Area Administrator completed the following steps:

- Adding a CPS unit to the local office to manage increased workload.
- Instituting protective time for staff to allow for documentation and case closure.

DCYF did not complete a Safety Assessment in time, did not conduct the required health and safety visits, and missed monthly clinical supervision case reviews.

In January 2023, an intake alleging sexual abuse of a 10-year-old screened in for an emergent CPS investigation. The assigned worker completed the IFF the following day at the parents' home during which the child made no disclosures.

There was no documentation of investigative activities for approximately five months after the IFF other than monthly supervisory reviews in February, March, May, and June 2023.

In July 2023, the worker interviewed the father at his home and completed a health and safety visit with the 10-year-old. The father reported that the child's mother moved back to Texas and was not in the home. The other children were not interviewed.

In September 2023, the worker documented completing a health and safety visit with the father and the other children at their home. The supervisory review indicated that the mother still needed to be interviewed.

In October 2023, OFCO contacted DCYF regarding the status of the CPS case and whether the older children in the home and the mother had been interviewed. DCYF reported that the worker initially assigned to the case transitioned to another office in April 2023 and that another worker recently completed a health and safety visit with all the children. The father refused to allow the Department in his home to speak with his children, and the mother was no longer in the home.

Violations:

- **DCYF Policies and Procedures, 2331(2)(e)(I) mandates that CPS cases must be closed within 60 calendar days, from the date that CPS receives the intake. CPS cases can be open a maximum of 90 days.**
  This case had been open for 266 days.

- **DCYF Policies and Procedures, 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.**
  This case had been open since January 2023 and other than the IFF, there was no documented face-to-face contact or attempts to contact the family until July 2023. The next documented health and safety visit was in September 2023.

- **DCYF Policies and Procedures, 46100 (1) requires that DCYF supervisors "conduct monthly clinical supervision case review and verify policy is followed for the appropriate program with each caseworker under their supervision for all cases open 30 calendar days or more."**
  This case was open in January 2023 and as of October 2023, there were six supervisory case reviews documented: February, March, May, June, July, and September 2023.

- **The Safety assessment 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 received in January 2023 was completed in October 2023, nine months after DCYF's initial contact with the family.

DCYF Response:
DCYF reported that the worker assigned to this case transferred to a different office, the new supervisor went out on leave shortly after the transfer, and the caseworker was out on

unexpected leave. Priority was given to complete IFF visits on new cases. The Area Administrator completed the following steps to manage workload and improve timeliness:

- The Area Administrator will randomly check supervisory notes to ensure there is clinical direction provided to the caseworker.
- The supervisor will go over the health and safety data report with staff bi-weekly to determine if assistance is needed to complete the health and safety visit.
- The unit will have the assistance of the social service specialist 4 and quality practice specialist for identified coaching and field observation of caseworkers.
- The Area Administrator will begin conducting random review of one case per month prior to case closure to ensure the caseworker and supervisor addressed the ongoing assessment of safety of all children.

DCYF did not complete investigative activities in a timely manner.

In August 2023, CPS received an intake alleging sexual abuse of a 9-year-old by the mother's partner. The intake screened in for an emergent CPS investigation. A DCYF worker and law enforcement officer conducted an IFF with the child, during which the child made disclosures and reported concerns for her sister who lived with their mother.

The assigned worker spoke with the mother and informed her that due to the disclosure, the mother's partner could not visit the home or be near the 9-year-old. The worker contacted the mother's partner on the same day regarding the restrictions and he agreed.

CPS received another intake in August reporting that the 9-year-old was fearful she would be punished by her mother for disclosing sexual abuse and that in the past, she had been punished by being locked in her room with food restricted. The assigned worker completed an IFF with the child regarding the new allegations. There were no additional notes through the end of 2023 other than the monthly supervisory review notes.

In January 2024, OFCO contacted DCYF to report that there had been no contact with the family or other case work conducted on this matter since August 2023. DCYF reported that the previously assigned caseworker was no longer with the agency and that the case would be reassigned. On that same day, a caseworker attempted to contact the assigned detective and attempted to see the family. The worker also spoke with the mother that day by phone and text. The following day, the worker completed a health and safety visit with the 9-year-old who declined to speak with the worker. The worker then spoke with the sibling who denied the allegations and did not express concerns for the 9-year-old's safety in the home. The Investigative Assessment for both intakes were completed in mid-January, as was the Safety Assessment, and the case was submitted for closure.

<u>Violations/Unreasonable Finding:</u>

- **DCYF Policies and Procedures, 2331, Procedures (2)(c) and 4420, Policy (1)(a)(vii) requires that DCYF conduct monthly health and safety visits with children when cases are open longer than 60 days.**
  DCYF saw the identified child twice in August 2023 and did not see the child again until January 2024.

- **DCYF Policies and Procedures, 2331 and RCW 26.44.030 state that DCYF child welfare workers will complete investigations on screened in intakes within 60 days from the date the allegations were reported, and no longer than 90 days, unless law enforcement has determined additional time is needed.**
  DCYF received both intakes in August 2023. The Investigative Assessment was completed, and the case was closed in January 2024.

- **DCYF Policies and Procedures ,1120, Safety Assessment requires that the caseworker complete a Safety Assessment on all screened in CPS intakes no later than 30 days from the date the intake was received.**
  DCYF received the intakes in August 2023 and the Safety Assessment was completed in January 2024.

- **DCYF Policies and Procedures Guide 2333, Interviewing a Victim or Identified Child, Policy (3)(b) states that the caseworker must complete a face-to-face present danger assessment of children who are not a victim or identified child in the intake although are related to the household. DCYF Policies and Procedures Guide 1120, Safety Assessment requires that the caseworker complete the Safety Assessment on all screened in CPS intakes no later than 30 days from the date the intake was received.**
  The sibling was identified in the narratives of both intakes in August 2023. DCYF did not contact the sibling until January 2024. OFCO found this delay to be clearly unreasonable.

DCYF Response:
DCYF reported that there were staff vacancies and new staff in training during this period which resulted in only 44% of the workforce available to assign accepted intakes resulting in necessary tasks on this case not being completed timely. To manage workload and improve timeliness, the local Area Administrator completed the following steps:

- The supervisor will ensure the health and safety for cases open over 60 days is documented during monthly supervision and detail expectations for completion if not done.
- The supervisor will ensure the Safety Assessment is completed on cases prior to monthly supervision to support provision of clinical supervision.
- The supervisor will ensure an in-service is provided to the unit on the requirements of the present danger assessment.
- The Area Administrator will be initiating a process that within a week of staff leaving their position, a review of the caseload for immediate safety issues will be conducted by QPS with tasks and/or cases assigned for required next steps.

A CPS Investigation remained open beyond the required timeframes.

In July 2023, an intake alleging physical abuse of a 13-year-old child by their mother screened in for a CPS investigation. The child was placed into protective custody the following day and the afterhours social worker who picked up the child noted that the child had bruising.

A Family Team Decision Making (FTDM) meeting was held, and the mother agreed to a plan for the child to live out-of-state with their father. The father stated he would seek a protection order modifying the parenting plan.

Supervisory reviews occurred in July, August, September, November, and December 2023. Each of the reviews identified the next steps to include following up with law enforcement, submitting a med-con, and interviewing the mother. No further investigative activities were documented until January 2024 when the social worker reviewed law enforcement records.

Violation:

- **RCW 26.44.030(13)(a) states that CPS must conduct investigations within timeframes established by the Department and in no case shall the investigation extend longer than 90 days from the date the report is received, unless a law enforcement agency or prosecuting attorney has determined that a longer investigation period is necessary.**
  DCYF Policy and Procedures, 2331(1) states that DCYF will complete investigations within 60 days from the date the allegation is reported unless law enforcement has determined additional time is needed.
  In this case, there was no documentation that law enforcement directed DCYF to refrain from completing the investigation. As of January 2024, the investigation remained open for over five months since the intake was received and a subject interview, as well as other identified next steps, had not occurred.

DCYF Response:

DCYF reported that there were several staff vacancies and new staff which resulted in necessary tasks not being completed timely. Priority was given to complete IFFs on new cases. To manage workload and improve timeliness, the local Area Administrator committed to completing the following tasks:

- The Area Administrator will randomly check supervisory notes to ensure there is clinical direction provided to the caseworker.
- The Area Administrator will monitor the case closure plan for the local office to ensure future cases are closed within timeframes and currently overdue cases are given priority.

DCYF did not close a FAR intervention timely and delayed contact with the parent identified in the intervention.

In June 2023, DCYF received an intake alleging that the parent was drinking alcohol and driving with their two children. The intake screened into CPS FAR, and the assigned worker completed the IFF meeting with both children and interviewed the non-subject parent.

From July through October 2023, the supervisor entered case notes describing tasks that needed to be completed which included contacting the subject parent and completing a walk-through of the parent's home. The supervisor noted in September 2023 that the health and safety visits would have begun in August 2023. Case notes indicate the first health and safety visit was completed in September 2023 but was not documented until November 2023.

In November 2023, the worker documented contacting the subject parent and completed the FAR Family Assessment. The FAR intervention was closed in December 2023.

Violations/Unreasonable Finding:

- **DCYF Policies and Procedures, 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 the services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030.**
  DCYF received the intake in June 2023. The FAR Family Assessment was completed in November 2023, and the intervention was closed in December 2023.

- **DCYF Policies and Procedures, 2334, Interviewing Subjects of Family Assessment Response Participants requires DCYF to conduct individual and face-to-face interviews of each FAR participant. The worker is further obligated to continue efforts to locate the participant, if they cannot be located, or until they are either interviewed or reasonable efforts to locate have been exhausted.**
  DCYF did not attempt to contact the FAR subject parent until November 2023 when the worker conducted a phone interview with this parent. This was nearly five months after the intake was received and nearly two months after law and policy required that the FAR intervention be completed. OFCO found this delay clearly unreasonable under the guidance of Policies and Procedures Section 2334.

DCYF Response:

DCYF reported that there were staff vacancies and new staff in training during this period which resulted in only half of the workforce available to assign accepted intakes. Priority was given to complete IFF visits on new cases to ensure children were immediately assessed for safety. To manage workload and improve timeliness, the local Area Administrator committed to completing the following tasks:

- The Area Administrator and supervisor will be meeting twice per month to review cases that are not actively engaged in a service. Identification of needed engagement or case closure actions and timeframes will be followed.
- The Area Administrator altered the intake assignment process to achieve a more equitable and balanced workload distribution to support timely case activity completion.

CPS investigations were not completed within the required timeframes, and CPS did not conduct health and safety visits.

In October 2023, a mother contacted CPS, stated she is a domestic violence victim and had moved into a safe house with her three children, ages 3, 7, and 15. The mother reported that her 7-year-old disclosed an incident that occurred in July 2023 at the father's house. While the children were playing inside a box, the father picked up and tilted the box until they fell out, causing injury to the 3-year-old. The intake screened in for an emergent CPS investigation. An interview with the mother and the IFF interviews with all three children were completed two days after the intake was received. Later that week, the mother reported concerns for the 3-year-old's safety, as the court had given primary custody to the father.

In November 2023, the mother contacted CPS intake to report that the father uses marijuana and has an unsecured gun in the home accessible to the 3-year-old. The intake screened in for an emergent CPS investigation. The following day, the CPS worker completed the IFF interview with the 3-year-old in the father's home. No concerns were noted.

In December 2023, the mother again contacted CPS intake to report that during a visit she noticed a scratch on the 3-year-old child's face and the child disclosed that his father slapped him. The intake screened in for an emergent CPS investigation. The following day, the CPS worker conducted an IFF interview with the 3-year-old child at the father's home. The child was not observed to have any marks on his face, and the father denied slapping the child.

Between late December 2023 and early March 2024, there was no documentation of investigative activities beyond two supervisory reviews identifying the next steps for the investigation. During OFCO's investigation, DCYF administration stated these investigations had been impacted by workload issues and vacancies in the office and the assigned worker's caseload. The three investigations were reassigned to another CPS worker and supervisor in February 2024. In March 2024, the mother was awarded custody of the 3-year-old, and the investigations were approved for closure.

Violations:

- **Required Health and Safety Visits did not occur. DCYF Policies and Procedures, 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 must be conducted with children identified in a CPS case investigation open longer than 60 days.**
  This case was open since October 2023. There was no documentation of face-to-face contact with the 3-year-old child victim and his older two siblings in January or February 2024. The Department made multiple attempts to conduct a health and safety visit of the 3-year-old's father's home with no response. This was documented in a case note entered in March 2024, dated for January 2024.

- **DCYF Policies and Procedures, 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.**
  Intakes screened in for CPS investigation in October and November 2023 and were included in one Investigative Assessment and approved for closure in March 2024. Services were provided to the family via concrete goods and those were processed through the payment system. The family had been provided gas vouchers, visa cards, and a voucher to Kroger Fred Meyer in the month of March 2023.

DCYF Response:

The Department requested partial modification of the findings. The Department reported that multiple attempts, documented in a case note dated for January 2024, were made to conduct a health and safety visit of the 3-year-old in the father's home with no response to knocking, phone call and voicemail, and business card left in the door. The Department acknowledged that no attempts were made to contact the children in the month of February 2024. OFCO added additional information to this finding, noting that a health and safety visit in January 2024 was not entered into DCYF's tracking database until the end of March 2024.

The Department acknowledged they did not close the case within 90 days, but services were provided to the family via concrete goods and those were processed through the payment system. The family had been provided gas vouchers, visa cards, and a voucher to Kroger Fred Meyer in the month of March 2023. OFCO added this additional information to the finding.

To manage workload and improve timeless, the Area Administrator committed to the following:

- The supervisor will ensure the health and safety visits for cases open over 60 days are documented during monthly supervision and detail expectations for completion if not done.
- The Area Administrator and supervisors meet weekly to review cases that are overdue or almost overdue. Identified next steps and closure actions and timeframes will be followed.
- The Area Administrator has altered the intake assignment to process to achieve a more equitable and balanced workload distribution to support timely case activity completion.
- The supervisor is providing weekly structured clinical direction on cases for workers struggling with timely case work.
- The Area Administrator has instituted a protected time rotation for staff to focus on documentation and timely and safe case closures.

DCYF did not complete investigative activities in a timely manner.

In September 2023, a report alleging medical abuse of a 22-month-old child screened in for a CPS investigation. The IFF with the child was completed at his daycare a couple days later. A supervisor review entered in October 2023 noted that the parents were interviewed and denied the allegations. However, the parents' interviews were not documented in DCYF's tracking database. There were no investigative activities beyond supervisory reviews until January 2024 when a newly assigned worker contacted collaterals and documented completing a health and safety visit at the child's daycare.

In February 2024, an intake alleging unsanitary living conditions screened into CPS FAR. A different worker was assigned to the FAR case and documented interviewing the parents the same day. Collateral sources were contacted, and the case was transferred to Family Voluntary Services (FVS).

In March 2024, the CPS investigation was closed as "founded" for child maltreatment for seeking excessive and inappropriate medical interventions for conditions that were not diagnosed for the child.

In July 2024, OFCO contacted DCYF regarding the investigation. DCYF reported that the original CPS investigator resigned in October 2023.

Violations:

- **DCYF Policies and Procedures, 2331 (2)(e)(i)(c) II states that a CPS case must be closed within 60 calendar days from the date the intake was received unless an extension has been approved. CPS cases can be open a maximum of 90 days.**

The CPS investigation was open for 184 days. The intake screened in for CPS investigation in September 2023 and closed in March 2024.

- **Required Health and Safety Visits did not occur. DCYF Policies and Procedures, 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.**
  The case opened in September 2023 and the IFF was completed shortly after. However, there were no health and safety visits in November and December 2023. The next documented health and safety visit was completed in January 2024.

- **DCYF Policy and Procedures, 1120 (1)(i)(a) requires that a Safety Assessment be completed on all screened in CPS intakes no later than 30 days after the intake.**
  The Safety Assessment for the September 2023 intake did not occur until March 2024.

DCYF Response:
The Department implemented new procedures in the office to ensure cases are reviewed and addressed quickly when a caseworker resigns unexpectedly. The Area Administrator will be initiating a process that within a week of a staff leaving their position, a review of the caseload for immediate safety issues will be conducted by quality practice specialists or other quality assurance staff with tasks and/or cases assigned for required next steps.

FOSTER PARENT/RELATIVE CAREGIVER ISSUES

DCYF did not provide timely notice to the subject of a CPS finding of child maltreatment and the right to seek administrative review.

In February 2019, DCYF received an intake alleging that the relative caregiver of two dependent children violated the court order and terms of placement by allowing unsupervised contact between the mother and children. The intake screened in for a CPS Investigation. DCYF interviewed the older child who disclosed that his mother was staying at the relative caregiver's home and watching him and his younger sibling unsupervised. Although there were no further documented investigative activities, the case remained open until the Investigative Assessment was approved for closure in November 2019 with a founded finding of neglect by the relative caregiver.

There was no documentation that DCYF attempted to notify the caregiver, and she did not learn of the CPS finding until 2023 when she applied for a position that required a background check. The subject reached out to DCYF and in response, received the Child Abuse Prevention and Treatment Act (CAPTA) letter in September 2023. The subject requested a review, and the finding was upheld.

Unreasonable Finding:

- **DCYF Policies and Procedures, 2559B, Investigative Findings Notification states that the agency must notify subjects of all approved CPS investigative findings in writing and orally, whenever possible, whether founded or unfounded and provide the**

required information regarding the steps necessary to request a founded finding review. While 2559B does not define a timeline for informing a subject of the founded finding, RCW 26.44.100 generally discusses the subject's right to due process, and RCW 26.44.100(2) states "whenever the department completes an investigation of a child abuse or neglect report under this chapter, the department shall notify the subject of the report of the department's investigative findings."
The substantive investigative work was complete by March 2019 and the investigation was closed in November 2019. The subject did not receive notice of the founded finding until four and half years after the incident occurred and the investigative interviews were completed. OFCO found this delay violated the intent of DCYF policy and state law and was clearly unreasonable under the circumstances. Additionally, a nearly four-year delay in notice deprived the subject of her ability to contest this finding in a timely manner and negatively impacted her right to due process.

DCYF Response:
DCYF requested a withdrawal of the finding. DCYF acknowledged that notice of the founded finding to the subject did not occur timely, but service occurred promptly once the oversight was known and the notification contained all required elements within RCW 26.44.100. OFCO maintained the finding that the delay in notice was clearly unreasonable under the circumstances, as the CPS investigation was completed in 2019, yet the subject did not receive written notice of the finding until 2023.

POOR CASEWORK PRACTICE

DCYF did not review available evidence and failed to update its case management system to reflect overturned findings.

In July 2019, a five-month-old child was brought to the emergency department by his parents due to bruising on his leg and abdomen. The parents stated that the child had the bruises when he was picked up at daycare. The child's injuries were reported to CPS, and the intake screened in for an emergent CPS investigation.

The CPS worker went to the daycare facility the following day and met with the director. The CPS worker learned that the facility had video footage and that the daycare staff noticed the bruising the day prior. The worker was also informed that the primary worker in the classroom from the day prior was no longer employed there. A forensic medical examination was completed on the child, and it was determined that the bruise on the child's leg was indicative of a high force grab mark. The worker, accompanied by law enforcement, met with the family later that day at the family home. After meeting with the family, the worker discussed the department's concerns with law enforcement who then decided to place the child in protective custody. The Department filed a dependency petition, and the case was transferred from the CPS worker to the CFWS worker. The transfer note did not address any attempts to review the video footage from the daycare.

A Licensing Division/Child Protective Services (LD/CPS) investigation of the daycare also opened in July 2019 in response to the allegations. Case notes indicate law enforcement reported to the

LD/CPS worker in August 2019 that the daycare director reviewed the video and found no concerns, and they were hoping to review the footage in the next couple of weeks.

At a shared planning meeting in August 2019, the parents once again stated that they believed the bruising occurred at the daycare and was possibly caused by the worker whose employment was terminated. They expressed a desire to speak with the LD/CPS worker and stated that they wanted the investigation to continue as they believed it would reveal the daycare worker had injured their son. The parents were repeatedly told by agency staff that the CPS, LD/CPS, and law enforcement investigations were all separate.

In October 2019, the LD/CPS worker entered a note stating that the detective reviewed the footage. The detective reported that there were no concerning events that would have resulted in the child obtaining the bruises. The court entered a dependency order and placed the child with the parents over the Department's objection. The Investigative Assessment was closed at the end of November 2019 with a founded finding for both parents for neglect and physical abuse.

In December 2019, the mother contacted DCYF Constituent Relations expressing a desire to appeal. The mother reported that she felt the findings were false and she had photographs from the morning of the incident showing the child without the bruises. The mother also noted that she was recently disqualified from a job due to the founded findings.

In March 2020, during a visit at the parents' home, the mother informed the CFWS worker that she watched the video footage from the daycare and saw some concerns. The CFWS worker reviewed the video footage and observed the daycare worker holding the child's leg in the location of the injury. After reviewing the video footage, the CFWS worker contacted the forensic examiner and the assigned detective and communicated concerns regarding the daycare worker's behavior in the video, noting that the worker appeared to be frustrated and handled the child in a rough manner. All parties agreed that the video could explain the injuries to the child's leg.

In April 2020, the CFWS worker entered a closing note stating that law enforcement and CPS reviewed the tape from the day of the incident. However, there was no documentation that a CPS worker reviewed the video. The CFWS worker also noted that her findings were forwarded to the Assistant Attorney General handling the parents' CAPTA appeal and that he was communicating with CPS to determine if the investigation should be reopened. There was no further documentation regarding this communication. After a successful six-month trial return home, the court entered an agreed order dismissing the dependency.

There was no documentation of any DCYF employee reviewing the video footage, despite it being available, until the CFWS worker did so in March 2020 after both the CPS and LD/CPS investigations had been closed.

In June 2020, a stipulated agreement and order of dismissal was entered into the Washington State Office of Administrative Hearings for DCYF. The order stated that the Department agreed to reverse the founded findings as to both parents.

In December 2023, OFCO received a complaint that DCYF had not changed the founded findings to unfounded as to both parents and that they were being disqualified from employment due to the founded findings.

Unreasonable Findings:

- **DCYF acted clearly unreasonably when the two separate DCYF CPS branches that were investigating allegations of abuse of a child failed to independently watch an available daycare videotape of the day of the child's injury.**
  The video was eventually watched by the CFWS worker who identified potentially exculpatory information. When the worker brought it to the attention of law enforcement and medical professionals, they agreed it could explain the bruise that had been identified as a high force grab. The parents consistently asserted throughout their involvement with DCYF that the daycare was responsible for the child's injuries. The videotape was available for several months. Throughout that time, DCYF staff repeatedly told the parents that the CPS, LD/CPS, and law enforcement investigations were all separate. Despite that, the CPS worker did not review the video, and the LD/CPS worker did not review the video, stating that law enforcement and the director of the daycare, whose facility was under investigation, had done so. Although DCYF does reasonably rely on the work of law enforcement and other experts in its investigations, in this instance it was not reasonable for two separate DCYF entities to fail to independently review key information relating to allegations of abuse or neglect. Reviewing the video did not require specific expertise, did not subject witnesses to undue hardship or trauma, and did not incur any additional expense on the department. When a worker eventually reviewed the video, DCYF's attorney entered an order in administrative court reversing the founded findings against the parents. Finally, the family was seriously impacted by these events. The child was placed out of home for months, and the mother lost her job and was unable to obtain employment in her field. It was clearly unreasonable that none of the investigators assigned to investigate these events independently reviewed the video.

- **DCYF acted clearly unreasonably by failing to enter an order reversing founded findings against the parent for three and a half years.**
  The order reversing the founded findings was entered in the administrative court in June 2020. The order stated that the findings against the parents were reversed and that the order would be sent to the DCYF records department. There was no timeline attached to that order. In December 2023, the mother attempted to obtain employment and was denied based on the CPS founded findings, as the order had not yet been entered into DCYF records. DCYF entered the order in December 2023, however, it was not reflected in the background check applications until January 2024. It was clearly unreasonable for the agency not to enter the order for three and a half years, and only after the family had already been adversely impacted by the delay.

DCYF Response:

The Department acknowledged that it did not act reasonably by failing to enter the order into their case management system. However, the Department requested a withdrawal of the finding that the Department did not act reasonably by failing to view available evidence in a CPS and LD/CPS Investigation case.

The Department reported that they received the intake in July 2019 which, by statute, provided them until October 2019 to complete the investigation. LD/CPS was not given permission by law enforcement to proceed with interviews at the childcare until October 2019. Law enforcement was involved with both investigations and reported that there were no concerning events found on the video footage. The Department argued that there was no reason to doubt law enforcement's assessment and no policy or statute at that time required LD/CPS to review the video from the childcare independently of law enforcement. The Department also reported that the CPS investigators documented in a case note that they reviewed the video footage at the daycare in July 2019 and indicated there were no incidents noted in the footage.

OFCO maintained the adverse finding that DCYF acted clearly unreasonably by not sufficiently reviewing the available video throughout the investigations. Case notes indicated that the CPS investigators reviewed the cameras, seemingly with the daycare director who was one of the subjects of the investigation, and in fast forward mode. Additionally, neither worker observed the concerning portions of the video. OFCO concluded that whatever review may have occurred was not sufficient.

CHILD SAFETY

DCYF did not conduct required health and safety visits.

In May 2022, DCYF filed dependency petitions seeking removal of an 11-year-old and their 7-year-old half-sibling from their grandfather based on concerns about the grandfather's inability to manage the 11-year-old's medical care and the 7-year-old's behavioral issues, and conditions of the home.

The mother of the 11-year-old was also residing in the grandfather's home and helping care for the children. DCYF indicated that further assessment was needed of the mother due to admitted drug use. At the shelter care hearing, the court found that out-of-home placement was not needed to prevent imminent physical harm to the 11-year-old but that if the grandfather was unable or unwilling to engage in certain services or conditions, out-of-home placement may be warranted. The grandfather did not abide by the conditions set by the court, and the home conditions did not improve.

In June 2022, the court granted DCYF's request for the 11-year-old to be placed in their mother's care with conditions including the mother's cooperation with all reasonable requests by DCYF, including the implementation of necessary services to assist with the care of the child. The mother moved out of the grandfather's home, and the court gave DCYF authority to conduct random and/or monthly health and safety visits.

<u>Violation</u>:

- **DCYF Policies and Procedures, 2332 (3)(d) and 4420 (1)(a)(ii) requires that DCYF conduct monthly health and safety visits for all dependent children or youth who return home on a trial return home or remain home under jurisdiction of the court and until dismissal of the dependency.**

The child was returned to the mother's care through an in-home dependency in June 2022. There was no documentation of regular monthly health and safety visits occurring with the child since they were returned to the mother, and there had been months long stretches with no documented in-person contact. OFCO noted that since the child returned home, the mother had a baby, and the family relocated to a different county sometime over the summer of 2023.

DCYF Response:
The Department reported there was a data entry error which resulted in the missed health and safety visits. The error was corrected. To manage workload and improve timeliness, the local Area Administrator committed to completing the following tasks:

- The supervisor will ensure the health and safety visits for cases open over 60 days is documented during monthly supervision and detail expectations for completion if not done.
- The Area Administrator will be initiating a process that within a week of a staff leaving their position, a review of the caseload for immediate safety issues will be conducted by QPS with tasks and/or cases assigned for required next steps.

PARENTS'S RIGHTS

DCYF did not notify and conduct in-person interviews with an alleged subject.

In September 2023, an intake alleging sexual abuse of a 4-year-old by their father was screened in for a CPS investigation. The investigator contacted law enforcement who reported that the 4-year-old already had two forensic interviews and did not make any disclosures. Additionally, law enforcement stated they would not pursue another interview unless the DNA results indicated abuse. During the investigation, the father denied the allegations and concerns shifted to the mother due to the child experiencing multiple interviews and medical exams with no disclosures or evidence of abuse.

In February 2024, the Department reached out to the sexual assault nurse examiner about the mother taking the child in for repeated medical exams and asking for an opinion on whether this would be considered neglect or medical neglect. The Department received a response noting that the Medical Consult found that the mother medically abused the 4-year-old. The investigation closed with a CPS finding that the mother medically abused the child.

Violation:

- **DCYF Policies and Procedures, 2331 2(d)(i)(A) requires that caseworkers notify and conduct in-person interviews with alleged subjects.**
  The identified subject of the September 2023 intake was the 4-year-old's father. However, during the investigation, concerns shifted to the mother after the Department received a report outlining medical abuse. OFCO contacted the supervisor regarding the new allegation made against the mother. The supervisor reported that because the allegation arose from the same circumstances, it was added to the Investigative Assessment which resulted in the mother receiving a CAPTA finding. There is no documentation that the

Department notified the mother of this new allegation against her or that she was interviewed specifically about this allegation again as required by Department policy.

DCYF Response:
The Department acknowledged that the notification and in-person interview of the subject of an allegation was not conducted.

FAMILY SEPARATION AND REUNIFICATION

DCYF did not conduct ongoing relative searches.

In October 2019, two siblings were placed into protective custody by law enforcement and temporarily placed with relatives. In January 2020, the children were moved to a foster home where they lived for the duration of the case and eventually became legally free.

In January 2023, the children's mother gave birth to a third child in California. The parents moved back to Washington in May 2023 and a risk only intake screened in after the parents were arrested. The infant stayed with the paternal aunt while the parents were incarcerated. A FTDM was held, and it was decided that the infant would be returned to the father after his release.

In July 2023, law enforcement notified DCYF that both the infant and the mother were found with the father. The infant was placed into protective custody due to the infant's condition and the mother's mental health. The infant was placed with the older siblings that same day. A relative search unit worker reached out to relatives and in November 2023, a relative responded requesting placement.

Violation:

- **Violation of DCYF Policies and Procedures, 4251 2(a)(i)A(I)i: Failure to conduct a relative search after children were removed from relative caregivers and throughout the life of the case. DCYF 4251 states that efforts to search for relatives must occur when a child is placed in out-of-home care. *New language was implemented July 1, 2024, that does not mandate workers to complete yearly relative searches; however, the old policy governs up until July 1st. Relative search activities are only discontinued when a permanent plan for a child has been completed*.**
  DCYF did not conduct an ongoing relative search after the children were placed with a relative briefly in 2019. There is no documentation that a relative search was done after the siblings were placed in foster care in January 2020 as required by policy. In addition, from January 2020 until July 2023, there is no documentation that any relative searches occurred. As a result, the timely consideration of potential relative placements did not occur, which has adversely impacted permanency for these children.

DCYF Response:
DCYF reported that the statewide shutdown during the COVID-19 pandemic occurred shortly after the children were placed into foster care. In order to ensure continued awareness of and efforts toward relative placement, the local Area Administrator completed the following steps:

- The supervisor included a discussion about relative search during monthly clinical supervision.
- The area administrator added this policy as a discussion item to the local office all-staff meeting agenda.

OTHER FINDINGS

CPS failed to notify the alleged subject of the results of their founded finding appeal in a timely manner.

In April 2023, an intake screened into CPS for physical abuse after it was reported that a 14-year-old was in a physical altercation with her relative-caregiver. The Investigative Assessment was completed in June 2023 with a finding of physical abuse by the relative caregiver.

DCYF's records indicated that the CAPTA findings letter was mailed to the relative in July 2023 through certified mail, and the Department received her appeal request a few days later. The relative caregiver was not notified that the finding was upheld until February 2024.

In April 2024, OFCO contacted DCYF regarding the CAPTA letter. DCYF reported that the delay in notifying the subject was due to an oversight.

Violation:

- **DCYF Policies and Procedures, 2559 (C)(3) states that "CA staff must notify the subject of the CA founded findings review results within 30 calendar days from the date the department received the request."**
  The subject was not notified of the upheld finding until February 2024, seven months after the appeal request was made. The delay had an adverse impact on the subject's ability to appeal this decision in a timely manner.

DCYF Response:

To manage workload and improve timeliness, the local Area Administrator completed the following steps:

- The Area Administrator changed the process for logging and tracking the CAPTA founded findings review requests.
- The Area Administrator implemented a tickler process to ensure responsive communications are completed.

DCYF did not complete the home study placement decision within required timeframes.

In January 2024, New Mexico requested an Interstate Compact on the Placement of Children (ICPC) adoptive home study for the relatives of an 8-year-old legally free child in New Mexico state care. Documentation indicated that the relatives met with the home study worker and submitted paperwork, but the social worker had been working on a draft home study for several months. Supervisory review notes from June and July 2024 indicated that deadlines were set for

the draft to be completed. At the time OFCO reviewed the case in late July, the home study was still pending.

OFCO contacted DCYF in August 2024 to inquire about the status of the ICPC home study and the reasons for the delay. Within a day, the worker completed a draft of the home study and sent it to the supervisor for review. The ICPC home study was approved the following week.

Violation:

- **DCYF Policies and Procedures, 5602 requires an ICPC home study or closure letter to be completed no later than 180 days after assignment.**
  The ICPC request was received by Washington DCYF in January 2024 and sent to the regional licensing division that same day for assignment. The ICPC home study was completed in August 2024. This delay had an adverse impact on the child who was legally free and awaiting permanent adoptive placement.

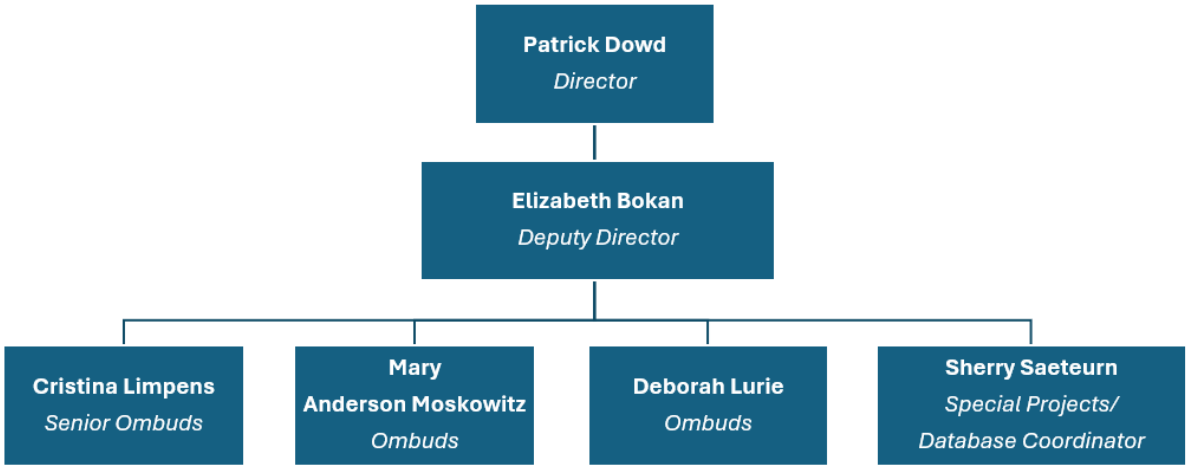
DCYF Response:

The Area Administrator has since implemented the following improvements to ensure there are no future unreasonable delays in providing services to children and families:

- A full review of workload is in place and communications have been made with supervisors and assigned workers regarding overdue assignments. Follow ups are being documented in provider notes by supervisors and area administrators and will be occurring monthly.
- Cross checking workload assignments between multiple systems to ensure work is not missed and for data integrity.
- Follow up in writing after monthly 1:1 on items to be completed and ensuring accountability for timeframes for assigned workers and supervisors.

In addition to the regional response, statewide expectations have been developed for Kinship and Foster Licensing area administrators to review applications with barriers 15 days prior to the due date and overall applications monthly until the application is resolved.

APPENDIX C: OFCO ORGANIZATIONAL CHART



The director ombuds is appointed by the Governor and confirmed by the Senate for a term of three years. The director ombuds continues to hold office until reappointed or until his or her successor is appointed. The governor may remove the director ombuds only for neglect of duty, misconduct, or inability to perform duties.

Patrick Dowd has served as director ombuds since his appointment on January 16, 2015.