OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

An Independent Voice for Families and Children

ANNUAL REPORT
2025

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December 2025

I am pleased to submit the 2025 Annual Report of the Office of the Family and Children's Ombuds (OFCO). This report provides an account of OFCO's activities from September 1, 2024, to August 31, 2025. We thank the parents, youth, relatives, foster parents, professionals, and others who brought their concerns to us this year. We take their trust and confidence in our office most seriously.

During this reporting period, OFCO completed 777 investigations involving 1,138 children. As in previous years, the most frequently identified complaint issues related to the conduct of DCYF staff and other agency services. Issues concerning the separation and reunification of families represented the next highest category of issues identified 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 the past decade, we have described the ongoing placement crisis and use of hotels, leased facilities staffed by the Department of Children, Youth, and Families (DCYF) workers, and night-to-night foster care as emergency placements for children. DCYF continues to make progress in reducing the number of placement exceptions; we highlight those improvements as well as the work that remains.

This year also brought changes to OFCO's core duties and mission. In July 2025, new legislation expanded OFCO's responsibilities to include responding to concerns regarding the well-being of residents in juvenile rehabilitation (JR) facilities. In previous years, OFCO received a handful of complaints regarding JR. This year, with our statutory authority and responsibility clear, we have begun the work of establishing this program, including hiring two full-time JR ombuds, conducting outreach with stakeholders, and developing procedures. We have already begun receiving more JR-related complaints and expect a notable increase in the coming year.

In September, we said goodbye to our longtime director, Patrick Dowd, upon his retirement. The impactful and important work discussed in this report reflects his final year as director.

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,

Elizabeth Bokan

Elizabeth Bokan, J.D.
Acting Director / Deputy Director

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, residences, or Juvenile Rehabilitation facilities, 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, 2024, through August 31, 2025.

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.

[1] RCW 43.06A and RCW 26.44.030.

- **CREDIBLE REVIEW PROCESS.** Ombuds staff have a wealth of collective experience and expertise in child welfare law, social work, mediation, and clinical practice, and are qualified to analyze issues and conduct investigations.

SYSTEM OVERSIGHT AND IMPROVEMENT:

- Monitor the procedures as established, implemented, and practiced by DCYF to carry out its responsibilities in delivering family, youth, and children's services and juvenile rehabilitation services, with a view toward appropriate preservation of families and ensuring health and safety. Periodically review the facilities and procedures of state institutions including juvenile rehabilitation facilities, those 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.
- 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 59%, and the number of children experiencing a placement exception also decreased from 216 children in 2024 to 108 children in 2025. DCYF identified a suitable placement for approximately 64% of children within five days or less of a placement exception occurring (compared to 63% in 2024). The number of children experiencing lengthy stays in placement exceptions also decreased, with 16 children spending 20 or more nights in placement exceptions compared to 34 last year. These 16 children accounted for over 63% of placement exceptions, with a combined total of 677 nights. Expanded mental and behavioral health resources are needed to address the needs of those children who continue to experience placement exceptions.

JUVENILE REHABILIATION

In 2025, the legislature expanded the scope and duties of OFCO to include responding to concerns regarding the Juvenile Rehabilitation (JR) system. Specifically, OFCO's duties now include providing information on the rights and responsibilities of individuals receiving JR services, investigating administrative acts by JR alleged to be contrary to law, rule, or policy, monitoring procedures implemented by DCYF to deliver JR services, periodically reviewing JR facilities, and recommending

[2] Child Fatalities and Near Fatalities in Washington State, June 2025. https://ofco.wa.gov/reports-and-data.

changes in procedures for addressing the needs of individuals in JR facilities. OFCO has begun this work by hiring two full-time ombuds, developing operating practices and procedures, communicating with DCYF JR, and engaging stakeholders.

OUTREACH AND COLLABORATION

In addition to the extensive outreach involved in developing the JR ombuds program, OFCO continues to engage in outreach and collaboration across the child welfare and ombuds spectrums. We have continued to partner with the Office of Corrections Ombuds in engaging in outreach with incarcerated parents. We also jointly presented an online training with the Office of the Education Ombuds entitled "Supporting Families—Mandatory Reporting for Child Abuse and Neglect and Education Resources to Support Families."

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2024, and August 31, 2025, OFCO completed 777 investigations involving 1,138 children. The most frequently identified complaint issues related to the conduct of DCYF staff and other agency services. Issues concerning the separation and reunification of families represented 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 mistakes by DCYF. This year, 52 complaints prompted intervention by OFCO. OFCO provided assistance in an additional 40 complaints to resolve either the complaint issue or a concern identified by OFCO in the course of its investigation.

OFCO provides DCYF with written notice of adverse findings resulting from a complaint investigation. DCYF is invited to respond to the findings and may present additional information and request a revision or rescission of the findings. This process provides transparency of OFCO's work as well as accountability for DCYF.[3] This year, OFCO made 25 adverse findings against DCYF.

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

SECTION I:
IMPROVING THE SYSTEM

Placement Exceptions

Juvenile Rehabilitation

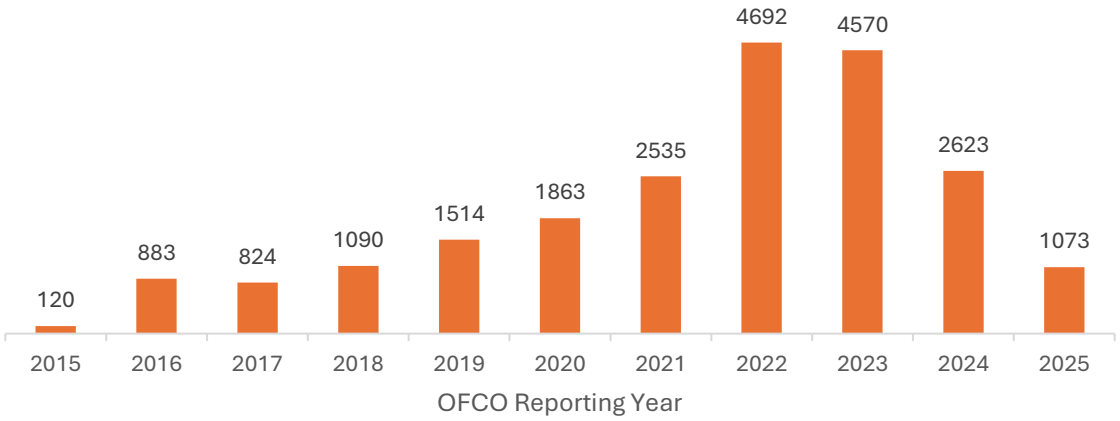
PLACEMENT EXCEPTIONS

PLACEMENT EXCEPTIONS FOR FOSTER CHILDREN

For years, DCYF has housed children in unlicensed placements such as hotels, leased facilities operated by DCYF, and night-to-night licensed foster homes, when appropriate placements capable of meeting the child's needs are unavailable.[4] As described in previous OFCO reports, 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.

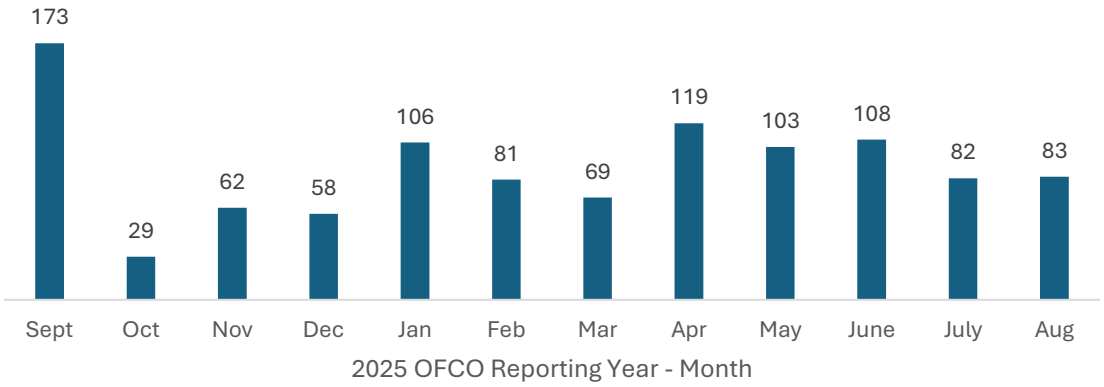
In 2021, Disabilities Rights Washington (DRW) filed a lawsuit (D.S. v. DCYF) on behalf of Washington children in foster care with behavioral health needs and/or developmental disabilities and who experienced significant periods of time in placement exceptions. The D.S. Settlement Agreement requires DCYF to end the use of placement exceptions and develop an array of placement resources including: an Emerging Adulthood Housing Program to support young people ages 16 to 20 who prefer to live independently; a Professional Therapeutic Foster Parenting licensing category to care for children with developmental disabilities or behavioral health needs; and a Statewide Hub Home Model where an experienced licensed foster parent serves as a "Hub Home" and supports up to ten satellite homes.

Figure 1: **Number of Placement Exceptions, 2015-2025**



[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.

Figure 2: **Number of Placement Exceptions by Month, 2025**



Placement exceptions peaked in 2022 with 4,692 placement exception events. Over the past two years, the number of placement exceptions has dropped significantly. Between 2023 and 2024, placement exceptions fell by 57%, declining from 4,570 to 2,623. This reporting year, from September 1, 2024, to August 31, 2025, DCYF's use of placement exceptions fell to 1,073 – the lowest number since 2017 and a 59% decrease from last year. The number of children experiencing a placement exception also fell from 216 in 2024 to 108 this past year. DCYF has continued to primarily utilize leased facilities for temporary placements.[5] This reporting year, over 87% of placement exceptions occurred in leased facilities.

Table 1: **Location of Placement Exceptions and Number of Children Who Experienced Placement Exceptions by DCYF Region, 2025**

DCYF Region[6]	Hotel	Night-to-Night	Leased Facility	Office	Total Placements (Percent of Placement Exceptions)	Number of Children (Percent of Placement Exception Population)
Region 1	1	0	143	0	144 (13.4%)	9 (8.3%)
Region 2	--	--	--	--	--	--
Region 3	18	2	72	0	92 (8.6%)	18 (16.7%)
Region 4	71	4	239	0	314 (29.3%)	37 (34.3%)
Region 5	6	14	423	3	446 (41.6%)	33 (30.6%)
Region 6	13	0	64	0	77 (7.2%)	11 (10.2%)
Total	**109**	**20**	**941**	**3**	**1073**	**108**

[5] 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 two DCYF facilities: Aspire House in Centralia and Belonging House in Vancouver (Region 6). While some placement exceptions occurred at Lake Burien facility (Region 4) this reporting year, that facility is no longer operational.

[6] DCYF Regional Structure: 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 reporting year, DCYF identified a suitable placement for approximately 64% of children within five days or less of a placement exception occurring. These children accounted for less than 14% of placement exceptions.

The number of children experiencing lengthy stays in placement exceptions also decreased, with 16 children spending 20 or more nights compared to 34 last year. These 16 children accounted for over 63% of placement exceptions, with a combined total of 677 nights. Most of these children were between the ages of 15 and 17. The highest number of nights in placement exceptions for a single child was 124 nights. Table 2 displays the current placement for these 16 youths.[7] Placements have been identified for all except two youths who are missing from care.

Figure 3: **Number of Placement Exceptions per Child, 2025**

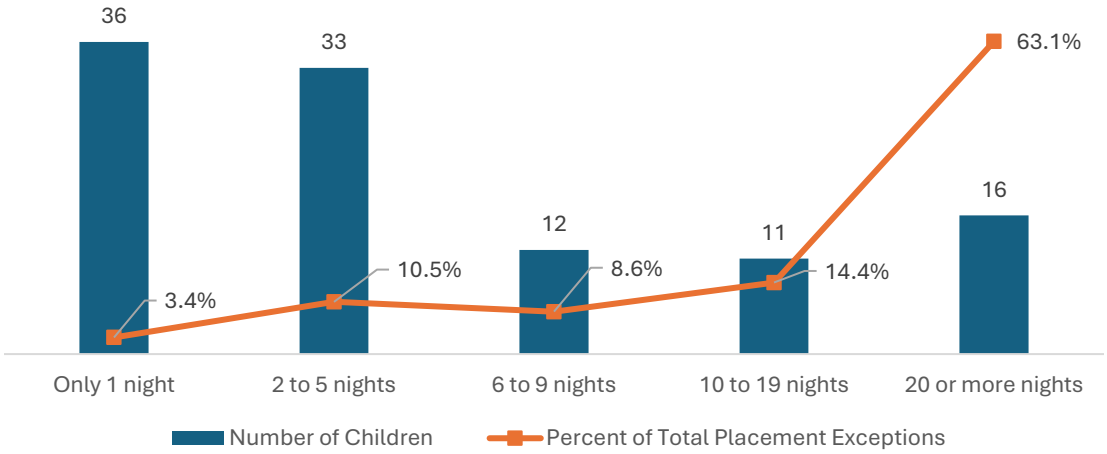


Table 2: **Current Placement for the 16 Youth Experiencing 20 or More Nights in Placement Exceptions**

Current Placement	Number of Youths
BRS Placement	6
EFC - Supervised Independent Living or Adult Transitional Living Program	3
Supported Living Group Home/Residential Center	2
Missing From Care	2
Foster Home	1
In-patient Treatment Facility	1
Parent	1

[7] Placement information as of 10/01/2025.

DEMOGRAPHICS OF CHILDREN EXPERIENCING PLACEMENT EXCEPTIONS

Table 3: **Age, Gender/Sex, and Race/Ethncity of Children in Placement Exceptions, 2025**

Gender/Sex[8]	Number of Children	Percent of Placement Exception Population
Female	37	34.3%
Male	64	59.3%
Transgender Female	1	0.9%
Other	6	5.6%
Child Age		
0-4 years	11	10.2%
5-9 years	20	18.5%
10-14 years	23	21.3%
15-17 years	54	50.0%
Race/Ethnicity[9]		
American Indian/Alaska Native	18	16.7%
Asian/Pacific Islander	5	4.6%
Black/African American	28	25.9%
Hispanic/Latino	10	9.3%
White/Caucasian	47	43.5%

As discussed in the D.S. Settlement Annual Monitoring Report, DCYF has encountered challenges and delays in establishing new placement resources and the drop in the number of placement exceptions is the result of careful placement decisions and not the result of a "new and more robust placement portfolio."[10]

The drop in the number of placement exceptions is also due, in part, to a reduction in the number of children entering state care and particularly older children ages 11–17. One of DCYF's strategic priorities is to safely reduce the number of children and youth in out-of-home care. Additionally, the Keeping Families Together Act aims to safely reduce the number of children and youth removed from their families by increasing the legal standard for removing a child from the parent's care. These efforts have cut in half the number of children entering state care over the past ten years, from 6,092 children in 2015 to 2,837 children in 2024.[11] The majority of children entering state care in 2024 were ages 0–9, and only 23% of the children and youth entering state care in 2024 were 11–

[8] While 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.

[9] OFCO reports race and ethnicity according to DCYF's WSRDAC/M standard: American Indian/Alaska Native, Multiracial combined with American Indian/Alaska Native and Black/African American, Multiracial combined with Black/African American, and Asian/Pacific Islander, Multiracial combined with Asian/Pacific Islander.

[10] D.S. Settlement Annual Monitoring Report (p. 3). Kathleen Noonan, JD, Court Monitor. (May 2025). https://dcyf.wa.gov/sites/default/files/pdf/DS.Settlement-CourtMonitorReport.pdf.

[11] Department of Children, Youth, and Families, Office of Innovation, Alignment, and Accountability. Child Welfare Agency Performance Dashboard. (2024). https://dcyf.wa.gov/practice/oiaa/agency-performance/reduce-out-of-home-care/cw-dashboard.

17 years of age.[12] However, the 11–17 age group made up over 69% of the youth experiencing 20 or more nights in placement exceptions.

Table 4: **Children Entering Care in State Fiscal Year, Ages 10–17, 2019-2024**[13]

Age	2024	2023	2022	2021	2020	2019
10	98	102	105	136	161	205
11	103	109	132	140	162	216
12	104	134	143	161	176	209
13	109	119	128	144	200	220
14	120	156	136	157	168	206
15	109	109	133	161	179	232
16	85	102	103	120	146	176
17	44	67	61	97	122	134
TOTAL	**772**	**898**	**941**	**1,116**	**1,314**	**1,598**

The characteristics of youth who spend 20 or more nights in placement exceptions underscore the need to expand mental health and behavioral health services in Washington State. The majority of youth experiencing lengthy placement exceptions have unmet mental health needs. Half of these youth in 2024 were eventually placed in Behavioral Health Services placements.

There is a growing need for mental health and behavioral health services for all children and youth in Washington State. The percentage of children who have one or more emotional, behavioral, or developmental conditions in our state increased from 19% in 2016 to 26% in 2023.[14] Children and teens with anxiety or depression also increased from 10% in 2016 to 17% in 2023.[15] Suicide and suicide attempts by adolescents ages 10–17 increased by more than 160% between 2016–2022.[16] Current resources are not adequate to meet the needs of these children as two thirds of adolescents ages 11–17 suffering from major depression do not receive effective professional help.[17]

[12] Department of Children, Youth, and Families, Office of Innovation, Alignment, and Accountability. Child Welfare Agency Performance Dashboard. (2024). https://dcyf.wa.gov/practice/oiaa/agency-performance/reduce-out-of-home-care/cw-dashboard.

[13] Ibid.

[14] The Annie E. Casey Foundation. Kids Count Data Center. Children Who Have One or More Emotional, Behavioral, or Developmental Conditions in Washington. (2025). https://datacenter.aecf.org/data/tables/10668-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=1&loct=2#detailed/2/49/true/2490,2105,2043,1769,1603/any/20456.

[15] The Annie E. Casey Foundation. Kids Count Data Center. Children and Teens with Anxiety or Depression in Washington. (2025). https://datacenter.aecf.org/data/tables/11429-children-and-teens-with-anxiety-or-depression?loc=49&loct=2#detailed/2/49/false/2490,2105,2043,1769,1696,1648,1603/any/22085,22084.

[16] Department of Children, Youth, and Families, Office of Innovation, Alignment, and Accountability. Youth Suicide Rates. (2023). https://dcyf.wa.gov/practice/oiaa/agency-performance/youth.

[17] Building the Mental Health System Our Teens Need and Deserve Now, Children's Alliance. Reid Saaris. (2024). https://www.childrensalliance.org/blog/new-report-building-the-mental-health-system-our-teens-need-and-deserve-now.

RECOMMENDATION:

Agency leaders and legislators should identify and implement cost effective recommendations of the Children and Youth Behavioral Health Work Group.[18] The workgroup's recommendations that meet the needs of adolescents at greatest risk of entering state care and experiencing a placement exception include:

- Enhance substance use disorder (SUD) prevention services and quality SUD and co-occurring mental health care for youth.
- Behavioral health funding for school districts.
- Expand the Bridge Residential housing program.
- Support expansion of recovery high schools.
- Increase the psychotherapy reimbursement rate.
- Fund youth-focused curriculum for Behavioral Health Support Specialists.

[18] Children & Youth Behavioral Health Work Group Annual Report, 2025 Recommendations. The CYBHWG was established by the Joint Legislative and Executive Committee on Behavioral Health. (2025). https://www.hca.wa.gov/assets/program/report-cybhwg-recommendations-part1-2025.pdf.

JUVENILE REHABILITATION

OFCO'S DUTIES EXPANDED TO INCLUDE OVERSIGHT OF JUVENILE REHABILITATION

When OFCO was established in 1996, its statutory authority focused on the provision of child welfare services to families and the protection of children from abuse or neglect. In 2025, new legislation expanded OFCO's responsibilities to include responding to concerns regarding the wellbeing of residents in juvenile rehabilitation (JR) facilities.[19]

Under this legislation, OFCO is now responsible for:

- Providing information on the rights and responsibilities of individuals receiving JR services.
- Investigating administrative acts by JR alleged to be contrary to law, rule, or policy.
- Monitoring procedures implemented by DCYF to deliver JR services.
- Conducting periodic reviews of JR facilities.
- Recommending changes in law, policies, or procedures for addressing the needs of individuals in JR facilities.

To fulfill these duties, OFCO is authorized to:

- Communicate privately with residents in JR facilities.
- Access JR facilities.
- Inspect all relevant information, records, or documents in the Department's possession.
- Access the JR case management system and all relevant database systems without restriction.

To support these expanded responsibilities, the legislature allocated funding for two full-time ombuds staff persons. Kayla Elladae and Ann Chae joined OFCO this fall to handle these duties and responsibilities.

Kayla Elladae joined OFCO in September. Previously, she worked as an Ombuds for the Special Commitment Center, addressing concerns related to individuals in civil commitment. She also has experience as a program evaluator at the Kaiser Permanente Health Research Institute, where she focused on evaluating health programs and services. She holds a Master of Public Health from Columbia University.

Ann Chae joined OFCO in October. Previously, she worked as an investigator with DSHS, where she investigated allegations of abuse, neglect, and exploitation involving vulnerable adults. She also worked as a tribal social worker with the Muckleshoot Indian Tribe and as a social service specialist with DCYF where she supported families involved in Child Protective Services and Child and Family Welfare Services. Ms. Chae began her career in the non-profit sector working with at-risk youth. She holds an LSWAIC and Master of Social Work from the University of Washington.

[19] SB 5032. https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/Senate/5032.SL.pdf.

OFCO'S ACTIVITIES TO ESTABLISH JR DUTIES

JR Ombuds Training

Both Ombuds took part in the JR New Employee Academy at Echo Glen Children's Center. This five-week training program included 23 courses covering a broad range of topics relevant to youth rehabilitation. The Ombuds trained alongside incoming JR staff, gaining insight into both the theoretical foundations of youth support as well as the applied practices of de-escalation and personal safety techniques. The Academy also included training on the juvenile justice system, gang-related topics, the Prison Rape Elimination Act (PREA), and suicide prevention. Going forward, the Ombuds plan to participate in each of the New Employee Academies to introduce themselves and the Ombuds program to incoming staff.

Access to JR Case Management System and Records

In November, OFCO and DCYF/JR finalized a data sharing agreement allowing OFCO access to JR's case management system and records. This access will allow for the JR Ombuds to support timely, minimally invasive, confidential, and thorough investigations.

Meeting with JR Leadership and Community Partners

Beginning in October, the Ombuds and Acting Director/Deputy Director initiated a series of meetings with key stakeholders. This included visiting each JR facility to meet with superintendents, associates, and other staff members. The Ombuds team also held a virtual meeting with the JR Executive Management Team. OFCO has also met with other ombuds offices engaging in similar work both within Washington State as well as those practicing in other jurisdictions, and with TeamChild, a legal aid organization that provides individual legal advocacy for JR residents. These meetings allowed the JR OFCO team to introduce themselves and their developing program, gain a deeper understanding of each party's role in the JR system, and explore opportunities for collaboration.

Establishing Practices and Procedures

As a new program, the JR Ombuds team has focused on developing the foundational practices and procedures needed to address JR-related complaints. Over the past several months, the team has made significant progress in strengthening communication, conducting site visits, and creating standard operating procedures (SOPs). The developing SOP outlines the steps for receiving complaints, investigating allegations, and making determinations. The goal is to ensure that all matters are handled in an objective, independent, and confidential manner.

To improve awareness and accessibility:

- The Ombuds developed a poster outlining all available ways for residents and others to contact the office and submit complaints.
- Ombuds contact information has been added to resident tablets at Harbor Heights.
- The OFCO website has been updated to clearly indicate that complaints can now be submitted regarding JR matters.
- The JR website has been updated to include OFCO information.
- OFCO information has been submitted to be included in upcoming JR newsletters.

- The Ombuds have already begun receiving and responding to complaints from JR residents and third parties.

The team has also established a schedule to visit each of the three main facilities at least once per month to meet with residents in person. These facility visits will begin in December and visits with the eight JR community facilities will begin next year.

Looking Forward

In the coming year, the JR Ombuds team aims to expand its reach and strengthen engagement with the broader community. A key goal for the coming year is to develop an outreach plan to connect with family members, advocates, and other interested stakeholders. These efforts may include in-person or virtual meetings where the JR Ombuds can share emerging trends in JR complaints and gather feedback.

The team also plans to engage Washington's tribes to raise awareness about Ombuds services and invite collaboration.

Finally, the JR Ombuds remain committed to ensuring that residents and their families can easily and consistently contact the Ombuds to share their concerns or file complaints.

SECTION II:
LISTENING TO FAMILIES AND CITIZENS

Inquiries and Complaints

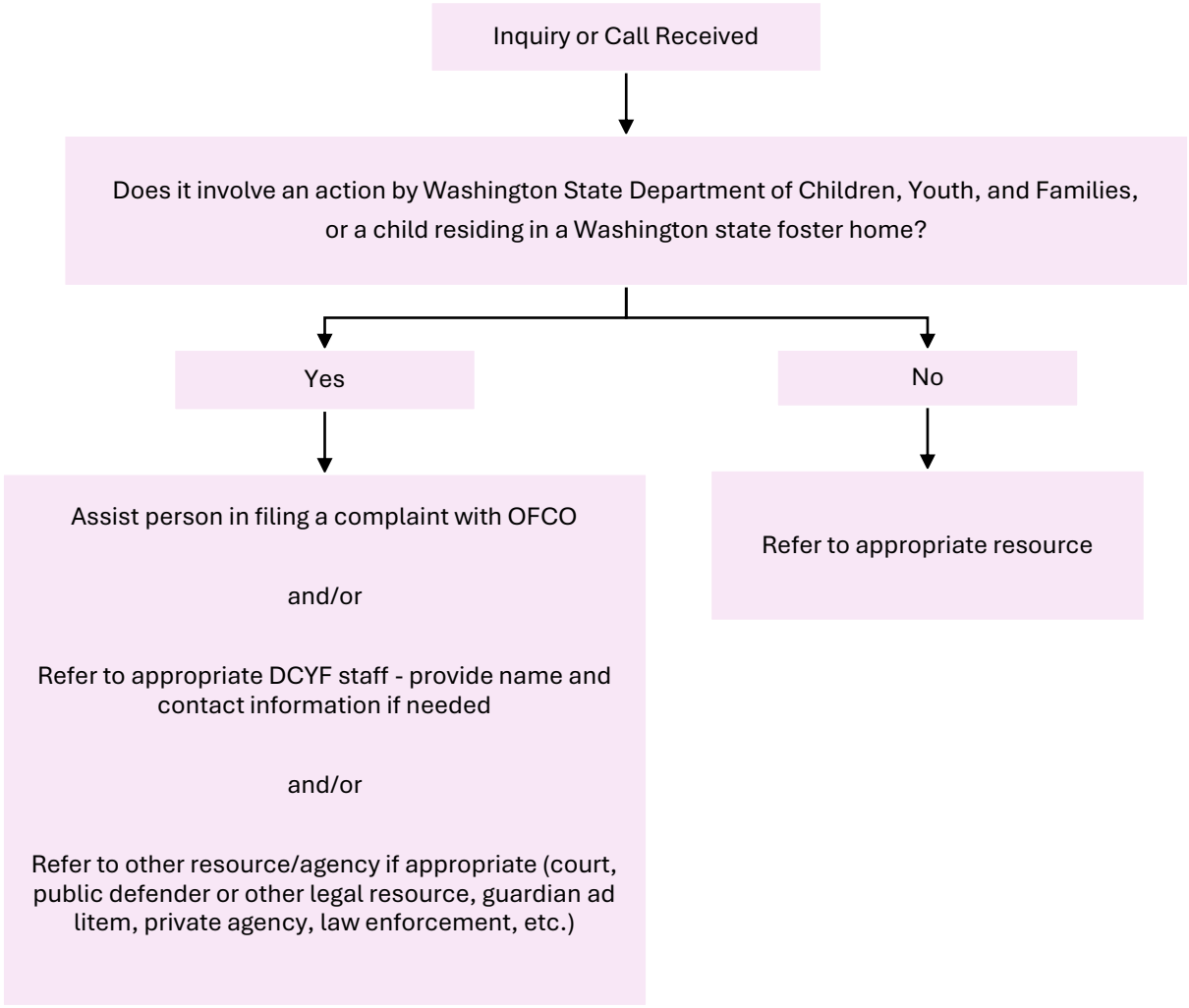
Complaint Profiles

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



COMPLAINT PROFILES

COMPLAINTS RECEIVED

Between September 1, 2024, and August 31, 2025, OFCO received 794 complaints. Most complaints received by OFCO were submitted via OFCO's website.

Figure 5: **Number of Complaints Received by Year, 2015-2025**

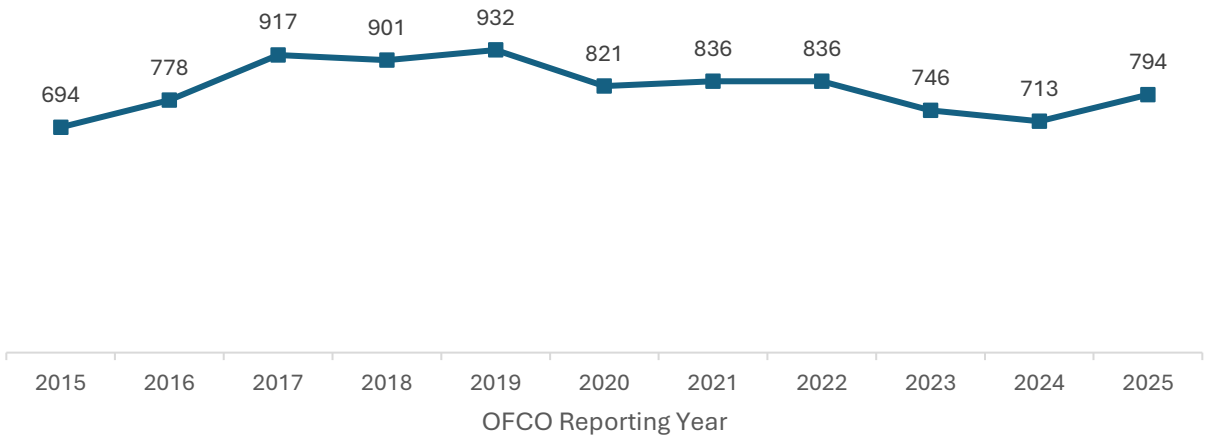
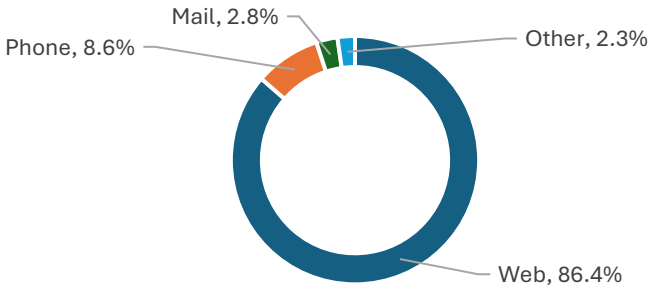


Figure 6: **How Complaints Were Received, 2025**



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 (77.7%). Table 5 displays the race/ethnicity of this year's complainants.

Figure 7: **Complainant Relationship to Child, 2025**

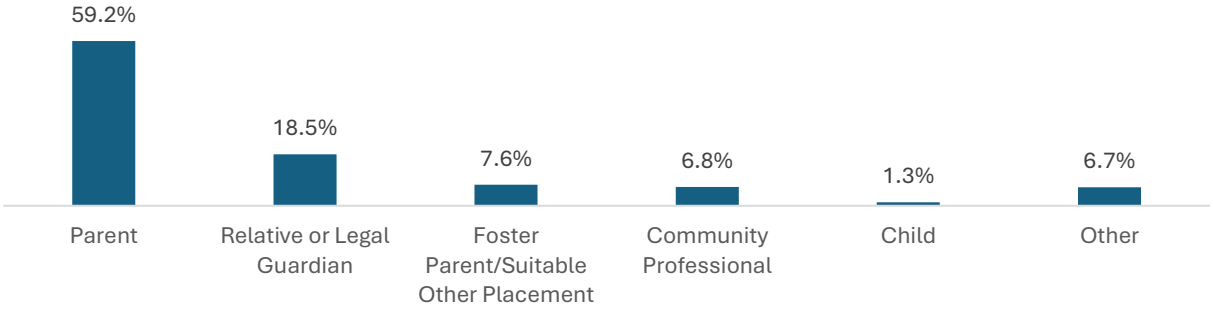


Table 5: **Complainant Race/Ethnicity, 2025**

Complainant Race/Ethnicity	Percent of Complainants
American Indian/Alaska Native	7.3%
Asian/Pacific Islander	2.1%
Black/African American	8.7%
Hispanic/Latino	8.1%
White/Caucasian	50.1%
Declined to Answer/Unknown	23.7%

CHILDREN IDENTIFIED IN COMPLAINTS

This reporting year, OFCO completed 777 complaint investigations involving 1,138 children, of which 64.7% were nine years of age or younger.

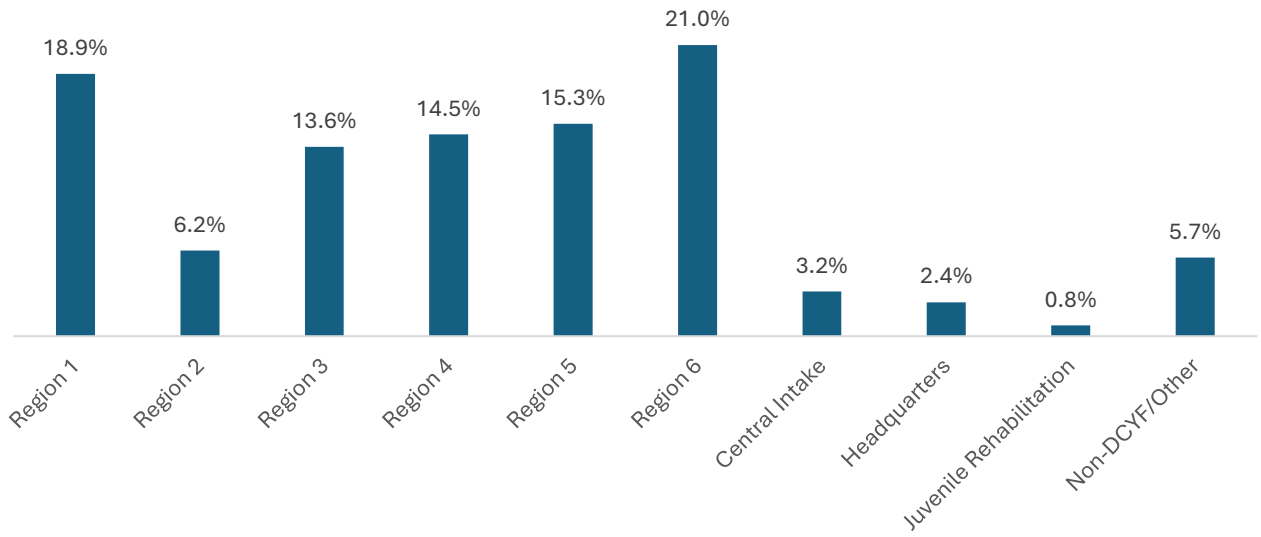
Table 6: **Age and Race/Ethnicity of Children in Complaints to OFCO, 2025**

Age of Children	Number of Children	Percent of Children in Complaints
0-4 years	372	32.7%
5 to 9 years	364	32.0%
10 to 14 years	264	23.2%
15 to 17 years	117	10.3%
18+ years	21	1.8%
Race/Ethnicity of Children		
American Indian/Alaska Native	166	14.6%
Asian/Pacific Islander	43	3.8%
Black/African American	164	14.4%
Hispanic/Latino	150	13.2%
White/Caucasian	542	47.6%
Declined to Answer/Unknown	73	6.4%

COMPLAINTS BY DCYF REGION

Figure 8 displays a breakdown of DCYF regions identified in complaints investigated between September 1, 2024, and August 31, 2025. The distribution of complaints concerning individual offices within each region is provided in Appendix A.

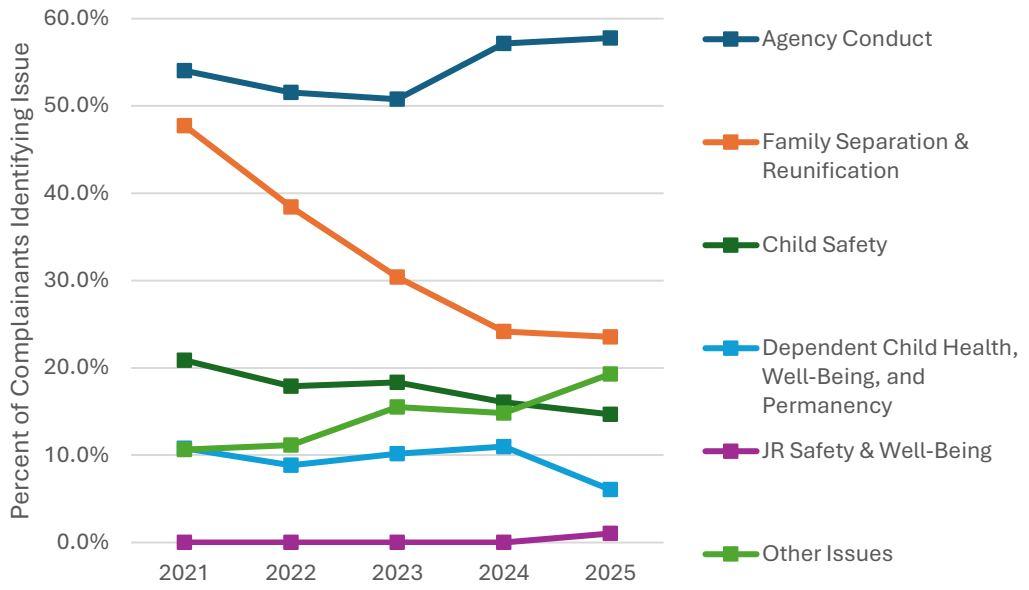
Figure 8: **OFCO Complaint Investigations by DCYF Region/Division, 2025**



COMPLAINT ISSUES

Complaints can often be complex, and complainants may identify multiple issues or concerns they would like investigated. Figure 9 displays the categories of issues identified by complainants.

Figure 9: **Categories of Issues Identified by Complainants**



This year more than half of complainants expressed concerns related to the conduct of DCYF staff and other agency services. Consistent with the previous years, the most frequently identified concerns included:

- Unwarranted, unreasonable, or inadequate Child Protective Services (CPS) interventions (172 complaints);
- Unprofessional conduct by agency staff, such as harassment, discrimination, bias, dishonesty, or conflict of interest (126 complaints); and
- Communication failures, such as caseworkers not communicating with parents or relatives (65 complaints).

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

- Unnecessary removal of child from parental care (62 complaints);
- Failure to reunite family (35 complaints);
- Failure to provide contact between child and parents or other family members (28 complaints); and
- Failure to place child with a relative (16 complaints).

Table 7 on the following pages lists the issues identified by complainants.

Table 7: **Issues Identified by Complainants**

	2025	2024	2023
COMPLAINTS ABOUT AGENCY CONDUCT	**449**	**416**	**399**
Unwarranted/unreasonable/inadequate CPS intervention	172	177	166
Unprofessional conduct, harassment, conflict of interest or bias/discrimination by agency staff	126	103	106
Communication failures	65	65	63
Breach of confidentiality by agency	29	17	24
Family Assessment Response	17	3	3
Unreasonable CPS findings	14	28	17
Poor case management, high caseworker turnover, other poor service	12	8	8
Record inaccuracies or delays	10	8	8
Retaliation by agency staff (does not include complaints of retaliation made by licensed foster parents)	4	4	2

	2025	2024	2023
FAMILY SEPARATION AND REUNIFICATION	**183**	**176**	**239**
Unnecessary removal of child from parental care	62	50	82
Failure to reunite family	35	27	44
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	28	37	45
Failure to place child with relative	16	31	27
Unnecessary removal of child from relative placement	11	7	10
Other inappropriate placement of child	10	10	17
Inappropriate termination of parental rights	8	4	2
Other family separation concerns	7	5	4
Failure to provide sibling visits and contact	4	4	7
Failure to place child with siblings	2	1	3

CHILD SAFETY	2025 114	2024 117	2023 144
Failure to protect children from parental abuse or neglect	49	37	48
Suspected child abuse	*25*	*20*	*23*
Suspected child neglect	*24*	*17*	*25*
Failure to address safety concerns involving children in foster care or other non-institutional care	25	23	35
Failure to address safety concerns involving children being returned to parental care	16	26	29
Children with no parent willing/capable of providing care	11	8	18
Child safety during visits with parents	10	19	11
Safety of children residing in institutions/facilities	2	2	1
Safety of children in child care facilities	1	0	0
Failure by agency to conduct 30 day health and safety visits with child	0	2	1

DEPENDENT CHILD HEALTH, WELL-BEING, AND PERMANENCY	2025 47	2024 80	2023 80
Failure to provide child with adequate medical, mental health, educational, or other services	10	18	16
Unreasonable delay in achieving permanency	15	21	30
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	8	9	6
Inappropriate permanency plan/other permanency issues	7	18	8
ICPC issues (placement of children out of state)	3	1	1
Placement not meeting child's unique needs	2	0	0
Placement instability/multiple moves in foster care	1	0	2
Failure to provide appropriate adoption support services/other adoption issues	1	0	4
Extended foster care/independent living services	0	1	2

COMPLAINTS ABOUT JUVENILE REHABILITATION	2025 **8**	2024 **--**	2023 **--**
Safety and security at JR facilities	6	--	--
Education and programming at JR facilities	1	--	--
Staff conduct	1	--	--

OTHER COMPLAINT ISSUES	2025 **150**	2024 **108**	2023 **122**
Failure to provide parent with services/other parent issues	31	23	27
Violation of parents' rights	29	17	22
Lack of support/services to foster parent/other foster parent issues	23	16	20
Lack of support/services and other issues related to unlicensed relative or fictive kin caregiver	10	13	8
Foster care licensing issues	5	7	4
Foster parent retaliation	3	3	2
Children's legal issues	3	0	0
Violations of ICWA	2	2	7

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 a variety of ways, including:

- 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 the complainant 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 777 complaint investigations involving 1,138 children. The majority of investigations (91.4%) were standard, non-emergent investigations, while 8.6% met OFCO's criteria for initiating an emergent investigation. OFCO intervened or provided timely assistance to resolve concerns in 16.4% of emergent complaints and 11.4% 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

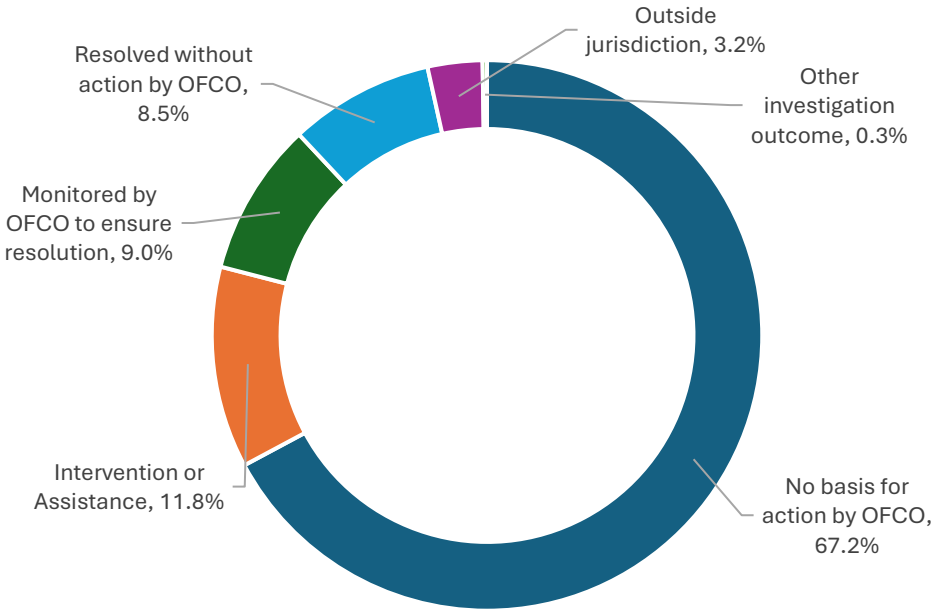
- The complaint involved agencies or actions outside of OFCO's jurisdiction. Where possible, OFCO refers complainants to another resource that may be able to assist them.

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 2025, OFCO assisted or intervened to try to resolve an identified issue in 92 complaints (11.8%). OFCO monitored 70 complaints (9%) for a period until either the identified concerns were resolved or OFCO determined there was no basis for further action. OFCO found no basis for further action in the majority of complaints (67.2%).

Figure 10: **Investigation Outcomes, 2025**



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 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 2025, OFCO made 25 adverse findings in a total of 14 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. The number of adverse findings by region and office are broken down in Table 8.

Table 9 shows the various categories of issues in which adverse findings were made. This year, findings most often related to issues concerning child safety and parents' rights.

Table 8: **Adverse Findings in Complaint investigations by DCYF Region and Office, 2025**

DCYF Region	Office (Number of Adverse Findings)	Total Number of Adverse Findings	Percent of Adverse Findings
Region 1	Wenatchee (3)	3	12.0%
Region 2	Goldendale (1)	1	4.0%
Region 3	--	--	--
Region 4	King East (2) King South-East (1) King West (7) Region 4 Licensing Division (1)	11	44.0%
Region 5	Parkland (2)	2	8.0%
Region 6	Aberdeen (2) Shelton (1) Tumwater (4) Vancouver-Columbia (1)	8	32.0%

Table 9: **Adverse Findings by Issue, 2025**

	2025	2024	2023
CHILD SAFETY	**10**	**14**	**14**
Failure by DCYF to ensure/monitor child's safety - Failure to complete health and safety visits	3	8	9
Failure to complete safety assessment	2	5	5
Inadequate investigation	4	--	--
Inappropriate CPS finding	1	--	--
PARENTS' RIGHTS	**8**	**14**	**14**
Delay in completing CPS investigation/CPS FAR or internal review of findings	4	12	11
Failures of notification/consent, public disclosure, or breach of confidentiality	4	1	3
DEPENDENT CHILD WELL-BEING AND PERMANENCY	**3**	**--**	**--**
Delay in ICPC/ICPC Issues	2	--	--
Other finding	1	--	--
POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD/FAMILY	**3**	**5**	**4**
Failure to conduct supervisory reviews	1	3	--
Inadequate documentation of casework	2	--	1
FAMILY SEPARATION AND REUNIFICATION	**1**	**3**	**1**
Relative search issues	1	1	--
NUMBER OF FINDINGS	**25**	**39**	**34**
NUMBER OF CLOSED COMPLAINTS WITH ONE OR MORE FINDING	**14**	**18**	**13**

APPENDICES

Appendix A: Complaint Investigations by DCYF Region and Office

Appendix B: Summaries of OFCO's Adverse Findings

Appendix C: OFCO Organizational Chart

APPENDIX A: COMPLAINT INVESTIGATIONS BY DCYF REGION AND OFFICE

Table 10: **Number of OFCO Complaint Investigations Completed, by DCYF Region and Office/Division, 2025**

Region 1			
Clarkston	6	Region 1 - Adoptions	2
Colfax	4	Region 1 - Child Care Licensing	1
Colville	6	Region 1 - Licensing Division, Safety & Monitoring	5
Lincoln	1	Region 1 - Regional Intake	1
Moses Lake	27		
Newport	1		
Omak	2		
Republic	0		
Spokane Central	24		
Spokane ICW	6		
Spokane North	25		
Spokane Valley	21		
Wenatchee	15		
Region 2			
Ellensburg	4		
Goldendale	6		
Richland (Tri-Cities)	24		
Sunnyside	1		
Toppenish	1		
Walla Walla	6		
White Salmon	0		
Yakima	6		
Region 3			
Bellingham	13	Region 3 - Adoptions	3
Everett	18	Region 3 - Centralized Services	2
Friday Harbor	2	Region 3 - Licensing Division, Safety & Monitoring	2
Lynnwood	10	Region 3 - Regional Intake	7
Mount Vernon	19		
Oak Harbor	3		
Sky Valley (Monroe)	12		
Smokey Point (Arlington)	15		

Region 4			
King East (Bellevue)	21	Region 4 - Adoptions	3
King Southeast (Kent)	15	Region 4 - Family Treatment Court	2
King Southwest (Kent)	17	Region 4 - Licensing Division, Kinship Care Licensing	2
King West (Seattle)	20	Region 4 – Leased Facility	1
Martin Luther King Jr.	24		
Office of Indian Child Welfare	3		
West Seattle	5		
Region 5			
Bremerton	29	Region 5 - Adoptions	4
Lakewood	16	Region 5 - Centralized Services	1
Parkland	20	Region 5 - Kinship Care Licensing	4
Puyallup	22	Region 5 - Licensing Division, Safety & Monitoring	1
Tacoma	19	Region 5 - Regional Intake	3
Region 6			
Aberdeen	14	Region 6 - Adoptions	7
Centralia	14	Region 6 - Licensing Division, Foster Care Licensing	1
Forks	0	Region 6 - Licensing Division, Safety & Monitoring	3
Kelso	23	Region 6 - Regional Intake	3
Long Beach	1		
Port Angeles	6		
Port Townsend	2		
Shelton	9		
South Bend	2		
Stevenson	0		
Tumwater	34		
Vancouver-Cascade	15		
Vancouver-Clark	12		
Vancouver-Columbia	17		
Other			
Central Intake	25	Non-DCYF/Other	44
Headquarters	19		
Juvenile Rehabilitation	6		

APPENDIX B: SUMMARIES OF OFCO'S ADVERSE FINDINGS

PARENTS' RIGHTS

DCYF failed to notify the subjects of CPS investigations.

In March 2023, an intake regarding physical abuse of an 11-year-old child by her father was screened in for an emergent CPS investigation. During the initial face-to-face (IFF), the child disclosed ongoing physical abuse by her father. The investigation continued until its conclusion in May 2023, resulting in founded findings of physical abuse by the father. However, the Investigative Assessment (IA) did not mention the father's response to the allegations. In June 2023, DCYF issued the Child Abuse Prevention and Treatment Act (CAPTA) letter informing the father that the allegation of child maltreatment was founded.

Between August 2023 and January 2024, CPS screened in seven additional intakes involving this family, most of which concerned allegations of physical abuse by both parents and neglect. Upon completion of these investigations, CPS determined that all reports were unfounded.

After receiving a complaint involving this case, OFCO reviewed DCYF's records and was unable to confirm that written notice of investigative findings for each unfounded investigation had been sent to the parents. OFCO contacted DCYF and was advised that the findings letters for three of the seven intakes had been sent, but there was no documentation confirming that findings letters were sent for the remaining four intakes. DCYF subsequently sent the findings letters for the remaining four intakes.

Violations:

- **DCYF Policies and Procedures 2331 2(d) requires that caseworkers notify parents of any child abuse or neglect allegations made against them and conduct in-person interviews with subjects.**
  There was no documentation that DCYF informed the father of the specific allegations or that efforts were made to interview him during the investigation.
- **DCYF Policies and Procedures 2559B requires the Department to notify subjects of all approved CPS investigative findings in writing and orally, whenever possible, whether founded or unfounded. For unfounded findings, the agency is to "document the date the letter was provided and how it was provided to the subject in the Delivery Tracking page in FamLink." The findings letter can be sent by United States mail or encrypted mail.**
  There was no documentation under the Document Delivery icon in FamLink of findings letters sent for the seven intakes received between August 2023 and January 2024. The CAPTA letters were launched from the Investigative Assessment in March 2024 for three intakes, but there was no information indicating how the letters were provided to the subjects. There was no documentation that the subjects were notified of CPS investigative findings for the remaining four intakes.

DCYF Response:
DCYF acknowledged that they did not adhere to the required policies. To avoid this type of error in the future, the following steps were addressed:

- The Area Administrator incorporated this as a Lessons Learned during the section's supervisor monthly meeting.
- The Area Administrator worked with the office manager to ensure the clerical team was adhering to the requirements of documenting all CAPTA letters into the Delivery Tracking page in FamLink.

DCYF Licensing Division (LD) CPS investigation was not conducted in a manner consistent with Department policies.

In March 2025, an incident between two youths – one non-verbal – occurred at the Department of Social and Health Services' Lake Burien Transitional Care Facility, leading to a LD CPS Risk Only investigation. The LD CPS investigator conducted the IFF with both youths but was unable to interview the non-verbal youth.

Following receipt of a complaint, OFCO contacted the LD CPS supervisor to confirm if the non-verbal youth's parent had been contacted. The parent had learned of the incident and expressed concern for her child's safety. LD CPS confirmed that contact is to be made with non-dependent children's parents as part of the investigation and that permission to complete an IFF and interview must be obtained. LD CPS indicated that efforts were being made to speak with the parents and to ensure that case notes were entered. The LD CPS investigator spoke with the youth's parent in May 2025, and the investigation was closed in June 2025.

Violation:

- **DCYF Procedures 2310 (1)(b)(ii)(B) requires that if the alleged victim or identified child is not in out-of-home care and in the care and authority of DCYF and the child's parent is not the subject of the allegation, LD CPS investigators must obtain parent or guardian permission prior to interviewing the victim, unless the victim or identified children or youth are determined to be at imminent risk of harm.**
  DCYF Policies and Procedures 2333 (4)(b)(ii) states "the LD CPS investigator must obtain the parent's or guardian's permission prior to the IFF and interview if the child or youth is not in the placement and care authority of DCYF.
  The Investigative Abuse and Neglect in State-Regulated Care (p. 17) further states that this permission should be documented in a case note." This contact would "constitute the initial contact with the parent" but "subsequent contact may be necessary to cover information" such as informing the parent that LD CPS is conducting an investigation regarding their child.
  While the youth is non-verbal and LD CPS did not complete an interview with this youth, it is clearly unreasonable under the circumstances not to inform the youth's parent of the LD CPS investigation in a timely manner. There was no documentation of any attempts to

contact the youth's parent until approximately seven weeks after the intake screened in. This adversely impacted the parent's concern for their child's safety during that time. Had the parent been informed of the investigation, it would have alleviated some of her concerns.

DCYF Response:
This practice of obtaining permission prior to a victim interview when the state does not have legal custody of an alleged victim has already been adopted. Moving forward, DCYF will use the same practice in their facilities in which parents are the legal custodians. DCYF followed up with staff statewide.

POOR CASEWORK PRACTICE

DCYF did not document case-related activities in a timely manner.

In November 2024, OFCO received a complaint concerning an open CPS Family Assessment Response (FAR) case. OFCO reviewed the case and found that, in many instances, case activities – such as communication with parents and IFF contact with a child – were not documented in FamLink until months after the event occurred.

Violation:

- **DCYF Policies and Procedures 6600 requires that case activities be entered in FamLink within specific time frames.**
  Case activities were not entered within the required time frames.

DCYF Response:
The office leadership acknowledged that not all case activities were entered within the required time frames. In order to address this, the regional leadership will conduct a check of documentation during monthly clinical supervision so that guidance can be provided on the timeliness of case note entries.

CHILD SAFETY & POOR CASEWORK PRACTICE

CPS FAR case activities were not completed in a timely manner.

In December 2024, OFCO initiated an investigation following an AIRS notification of a near fatality involving a 6-year-old child. OFCO's concern stemmed from a lack of documentation of case activity in the six months leading up to the incident. OFCO found that CPS FAR case activities were not completed in a timely manner and DCYF did not conduct required health and safety visits. The details are as follows:

In May 2024, DCYF received a report alleging possible mistreatment of a 6-year-old child by their guardian. The report included concerns about the guardian withholding food from the child and possible malnutrition. The intake also identified the guardian's 12-year-old child and the guardian's boyfriend as household members. The intake screened in for CPS FAR.

The FAR social worker conducted the IFF with the 6-year-old child at school the following day. The worker did not document an attempt to interview the child but noted that there were no marks or bruises observed, the child did not appear to be malnourished, and a photo of the child was taken and uploaded into FamLink. Upon review, OFCO was unable to locate the photo in FamLink. The FAR social worker also met with the guardian's 12-year-old child at school; however, only completion of the face-to-face contact was documented, with no further details regarding observation or an interview.

The following week, the worker spoke with the guardian by phone, during which time the guardian denied the allegations. A home visit was scheduled for the next day, but there was no documentation confirming that the visit occurred.

No case notes were entered for the FAR case in June 2024.

In July 2024, another intake involving the 6-year-old child screened in for CPS FAR due to concerns of malnourishment, isolation, and the child reporting that they were required to sleep in the bathroom because of accidents. The FAR social worker completed an IFF with the 6-year-old and entered a brief case note indicating that additional notes would follow.

In August 2024, the worker made a referral for concrete goods for the family. No other case notes beyond supervisory reviews were documented from September to October 2024.

In November 2024, the worker contacted the guardian to arrange a health and safety visit. No further case notes were entered that month.

In December 2024, a newly assigned FAR social worker attempted to contact the child's mother after learning that the child was back in her custody. Attempts were also made to contact the guardian via phone and at her last known address but were unsuccessful. Upon speaking with collaterals, the worker discovered that the child was no longer engaged in support services and had been withdrawn from school. The case was reassigned to another FAR social worker who went to the guardian's apartment and found the 6-year-old's mother and 14-month-old sibling visiting. The guardian's boyfriend's children were also in the home. The worker met with the 6-year-old and found the child to be clearly emaciated. The child was placed into protective custody and transported to the hospital for medical evaluation.

Violations:

- **DCYF Policies and Procedures 2310 requires that social workers address all allegations of CA/N during IFFs as well as for the victim's physical condition and behaviors to be observed and documented. DCYF Policies and Procedures 2333**

requires that a comprehensive interview occur with every victim who is developmentally able to be interviewed, and that during the interview, relevant and sufficient information is gathered, including observations of the child's appearance and non-verbal communication in order to complete safety and risk assessments.
Although the IFF for the May intake was completed within required time frames, the social worker did not document attempts to interview the child.
Although the IFF for the July intake was completed within required time frames, the case notes did not include documentation of attempts to interview the child or observation of the child and his home environment. The case note did not contain details regarding this IFF.

- **An assessment of the family did not occur as required by DCYF Policies and Procedures 2332.**
  Specifically, the referents of the screened in intakes from May and July 2024 were not contacted until December 2024. The other children in the home were not seen and interviewed until December 2024, except for the 12-year-old who was interviewed in May 2024. Relevant collaterals were not contacted timely. There was no documentation that interviews with both subjects occurred in a timely manner, other than the guardian denying the allegations during the social worker's initial call with her in May 2024. The social worker documented plans to go to the home on two other dates, but there was no documentation that those visits occurred.
- **Required health and safety visits did not occur. DCYF Policies and Procedures 4420 and 2331 mandate that monthly health and safety visits occur with children in a CPS case open longer than 60 days.**
  The case opened for CPS FAR in May 2024. Another intake screened in for CPS FAR in July 2024. However, no health and safety visits were documented from August to November 2024. The other children in the home were not seen for health and safety visits.
- **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 for 30 calendar days or more."**
  The case was opened in May 2024. Supervisory case reviews were documented in August, September, October, and December 2024. The case notes for the August, September, and October reviews did not note that health and safety visits were needed.
- **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 May and July 2024 and remained open until early January 2025 after the near fatality incident.

DCYF Response:
DCYF acknowledged that they did not adhere to the required policies. In order to avoid these errors in the future, the region is developing a training plan for all supervisors addressing clinical supervision requirements and engaging staff for difficult conversations. The plan includes

working with their Regional Advisory Group (Alliance and University partners) to determine additional opportunities for continued learning in specific offices.

Investigative activities were not completed in a timely manner.

In July 2025, OFCO initiated an investigation following an AIRS notification regarding a child fatality. While reviewing case records, OFCO found that investigative activities were not completed in a timely manner. The details are as follows:

In April 2025, a report of physical abuse of a five-year-old child by their father screened in for a CPS investigation. After a caseworker called the child's father and left a detailed message, the paternal grandparent returned the call and reported that the child was residing with the mother. The assigned CPS worker completed the IFF with the child the following day at the mother's home and observed unexplained marks on the child. The child informed the worker that they visited their father at the grandparents' home. The worker also met with the child's younger 15-month-old sibling, and no concerns were noted.

Despite supervisory review notes mentioning collateral contacts and parent interviews being completed, there was no further documentation about the investigation until July 2025.
In July 2025, another intake was screened into CPS investigation after the younger sibling was found deceased in the mother's vehicle.

Violations:

- **Required parent and subject interviews did not occur. DCYF Policies and Procedures 2331 2(d)(i)(A) requires that the case worker notify and conduct in-person interview with subjects.**
  The identified subject of the April 2025 intake was the five-year-old's father. There was no documentation that the father was interviewed about the allegation against him as required by department policy. Additionally, there was no documentation that the children's mother was interviewed.
- **Required collateral contacts did not occur. DCYF Policies and Procedures 2331 (2)(i)(iv) requires that the case workers interview professionals and other individuals who may have knowledge of the children and parents including non-custodial parents and other relatives.**
  There was no documentation that the worker contacted the five-year-old's paternal grandparents or the younger sibling's father.
- **DCYF Policy and Procedures 1120 (1)(a)(i) and 2331 2(e)(i)(A) requires that Safety Assessment be completed within 30 days of the intake.**
  The Safety Assessment for the April 2025 intake was not completed.

DCYF Response:
DCYF acknowledged that case activities were not conducted. The case was immediately assigned to a lead worker as soon as the issue was identified.

DCYF did not complete investigative tasks and improperly closed an investigation.

In February 2025, a report alleging physical abuse of a four-year-old child by his father screened in for a CPS investigation. After initial contact with the child and their sibling, the grandmother informed the CPS social worker that she would seek emergency guardianship. In mid-March 2025, the worker closed the case due to the grandmother obtaining guardianship, and the physical abuse allegations were referred to law enforcement. However, the guardianship order expired in late March 2025.

Following receipt of a complaint related to this case, OFCO reviewed the case and found that DCYF had not completed investigative tasks, including notifying and interviewing the subject, interviewing the parents, and gathering sufficient information to determine whether the allegation of child maltreatment was founded. Instead, the investigation was closed as "unable to complete investigation." OFCO contacted DCYF regarding these concerns. DCYF acknowledged that the investigation was improperly closed and stated it would be reopened.

Violation:

- DCYF CPS closed this investigation as "unable to complete" because the grandmother obtained a temporary guardianship order expiring in 30 days and did not complete all components of a CPS investigation as described in **DCYF Policies and Procedures 2331.**

DCYF Response:

DCYF acknowledged that they did not adhere to required policy. To avoid this type of error in the future, the following steps were addressed:

- The Area Administrator arranged for mandatory training to occur for the office supervisors covering complete and comprehensive investigations and supervisor reviews for approval/closure.
  The Area Administrator arranged for mandatory training for all staff covering minimum requirements of a CPS investigation.

DCYF improperly closed a CPS investigation.

In March 2024, DCYF received an intake regarding multiple marks observed on a two-year-old, and the mother admitted to having bitten the child. Additional concerns were raised alleging that the mother struggled with anger and mental health issues and had been isolating herself and the child. The intake screened in for a 24-hour response CPS investigation.

During the investigation, the worker obtained photographs of bite marks and bruises on the child. Collateral contacts also reported concerns about the mother's mental health and treatment of her child. The worker made several attempts to assess the family, but the mother refused to cooperate. DCYF closed the case as "unable to complete investigation - no finding" on the basis that the mother had not engaged with the agency.

Within days of closing the case, another intake alleging further physical abuse by the mother screened in for CPS intervention. Eventually, the child was removed from the mother and the other parent obtained custody.

Unreasonable Finding:

- **DCYF's decision to close this investigation of alleged child abuse as "unable to complete – no finding" was clearly unreasonable under the circumstances as there was sufficient evidence to conclude the abuse did occur and a founded finding was warranted. DCYF Policies and Procedures 2331 Child Protective Services Investigation, RCW 26.44, and WAC 110-30 describe DCYF's duties when completing a CPS investigation. A founded allegation of child abuse means that following an investigation by CPS based on available information, it is more likely than not that child abuse or neglect did occur.**
  In this instance, the agency relied on the fact that it did not successfully contact the mother or child when closing the investigation as unable to complete. Successful contact and interviews with the subject and child are not required to conclude the threshold for a founded finding of child abuse is met. Such a requirement would counterproductively encourage subjects to not speak to CPS and avoid founded findings. There are also situations where, on the advice of an attorney, a subject refuses to speak with a CPS case worker or law enforcement. However, this does not prevent the Department from making a finding that child maltreatment occurred. The requirement for a founded finding is that based on available information, it is more likely than not that the abuse occurred. In this instance, the agency received reports that the mother admitted to biting the child, multiple photos of bite marks and bruises, collateral contacts with community members who reported concerns, and multiple accounts of the mother having anger and mental health issues. The mother was given ample opportunities to provide a different explanation for the bruises or other exculpatory information. Her refusal to provide a plausible explanation for the child's injuries should also be taken into consideration. The standard of more likely than not was met in this investigation, and the investigation should have resulted in a founded finding of physical abuse by the mother.

DCYF Response:

The Deputy Regional Administrator reviewed the case and agreed that DCYF gathered enough information to make a determination as to whether child abuse or neglect had occurred. In order to avoid this type of error in the future, the following steps were addressed:

- The office Area Administrator established the practice expectation that cases being closed as "unable to complete investigation" will be staffed with the Area Administrator or Quality Practice Specialist (QPS) prior to closure.
- The office will be provided with specific training on considerations for safely closing cases when parents are not willing to engage.

CHILD SAFETY & PARENTS' RIGHTS

A CPS FAR case was not completed within the required time frames.

In March 2024, CPS received an intake regarding a 13-year-old feeling unsafe in the home. The child, who lived in the home with five siblings, disclosed that their mother's boyfriend hit their 8-year-old sibling, causing a bruise. The intake screened in for CPS FAR.

The CPS FAR social worker completed the IFF with the 8-year-old the following day. However, there was no documentation of any other case activity, aside from a supervisory case note, until the social worker conducted a health and safety visit with all six children in May 2024.

In late July 2024, the FAR Family Assessment was closed, and the case transferred to CPS investigations due to the mother declining FAR intervention and concerns regarding the treatment of the children.

Violations:

- **DCYF Policies and Procedures 2332 (1)(c)(x) requires that all children in the home that are not identified as victims be seen face-to-face prior to the completion of the Safety Assessment.**
  The Safety Assessment was completed prior to the five siblings of the alleged victim being interviewed.
- **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.**
  The intake screened in for CPS FAR in March 2024 and the mother declined FAR services the following day during her first contact with CPS. There was no documentation of consultation with the supervisor to determine if the case needed to be transferred to CPS investigation until late July 2024. The CPS investigation closed in August 2024, approximately 129 days after the original intake screened in.

DCYF Response:

During this period, there were staff vacancies and new staff that were unable to be assigned cases due to being in their training period. There was also an unanticipated vacancy in the CPS Supervisor position. To ensure cases are reviewed and addressed quickly when a caseworker leaves unexpectedly, 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 or other quality assurance staff with tasks and/or cases assigned for required next steps.

Investigative activities were not completed in a timely manner.

In February 2024, an intake alleging neglect of four siblings while in their father's care screened in for a CPS investigation. One of the children, age 9, suffered a seizure at school, and the report indicated that the hospital was unable to reach the father to obtain consent for a medical procedure. The intake also raised concerns about unsanitary living conditions within the home. The CPS worker completed the IFF the following day at the hospital with the child and their mother.

In March 2024, CPS received additional reports involving the family. One intake, alleging medical neglect of the 9-year-old, screened in for a non-emergent CPS investigation. The worker interviewed the child at school and found no concerns. Subsequently, two additional intakes screened in regarding neglect. During the child's medical appointment, the father overdosed in the hospital bathroom. Law enforcement conducted a welfare check at the family home and placed the children in protective custody after discovering the home in disarray, with drug paraphernalia and evidence of fentanyl use. An FTDM was held and the father agreed for the children to be placed in their mother's care.

Between April and September 2024, there was limited documentation of case activities except for supervisory case review notes.

In September 2024, the case was reassigned, and health and safety visits were conducted with the children.

Violations:

- **Required health and safety visits did not occur. DCYF Policies and Procedures 4420, Health and Safety Visits with Children and Youth and Monthly Visits with Parents and Caregivers, 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.**
  An investigation was opened in February 2024, and three intakes screened in for a CPS investigation in March 2024. The worker documented going to the home and seeing the children within the required time frames for the IFFs; however, no health and safety visits were completed from April through August 2024.
- **DCYF Policies and Procedures 2331 (2)(e)(i)(c) and RCW 26.44(12)(a) mandates that CPS investigations must be closed within 60 calendar days and 90 days respectively from the date that CPS receives the intake.**
  Intakes screened into CPS investigation in February and March 2024. The investigations were closed in September 2024 and were not completed within the required time frames.

DCYF Response:

As a result of the high workload in the office due to vacancies and supporting another office through transition, the Area Administrator identified the need for additional steps to be taken for the local office to move through the impacts. Beginning in May 2024, the region put in place a

plan to provide task-specific support to the office in their efforts to safely close cases open beyond time frames:

- Staff were assigned to a closing team to complete identified tasks necessary to close cases open over timelines.
- Two zip codes shifted back to their original office catchment area, lessening the number of intakes per worker.
- The Area Administrator implemented a tracking tool for monitoring cases across the timeline continuum.
- Weekly reminders sent to staff on casework activities needed to achieve timely case closure/transfer.
- Supervisors following up with the caseworkers on a weekly basis to troubleshoot barriers to achieving timely casework activities.

A CPS FAR case was not completed in a timely manner.

In April 2025, an intake alleging child neglect screened in for CPS FAR. The worker went to the family home the same day, met with the mother, and completed the IFF with her two children, ages 7 and 10. The supervisor documented speaking with the mother in April and May 2025. From May through July 2025, there were no other documented CPS FAR activities except for monthly supervisory reviews. Additionally, there was no documentation of DCYF establishing a case plan or obtaining the parent's permission to extend the FAR case beyond 45 days.

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**
  The intake screened in for CPS FAR in April 2025 and remained open at the time this adverse finding was made in early August 2025. There was no documentation that the mother agreed to her case remaining open or that the family was receiving services. **Furthermore, DCYF Policies and Procedures 2332 3(b) (ii) requires the Department to develop a case plan within 15 days of the parent's agreement and (iii) obtain the parent's permission to leave the case open up to 120 days for case planning and services.**
  There was no documentation of DCYF establishing a case plan or obtaining the parent's permission to extend the FAR beyond 45 days.
- **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 2332 (3)(d) mandates that monthly health and safety visits be conducted with children identified in a CPS case open longer than 60 days.**
  Since the initial face-to-face meeting in April 2025, there had been no documented face-to-face contact or attempts to contact the children.

- **DCYF Policy and Procedures 1120 (1)(a)(i) and 2332 1(c)(viii)(A) requires that a Safety Assessment be completed within 30 days of the intake.**
  The Safety Assessment for the April 2025 intake had not been completed as of August 2025.

DCYF Response:
DCYF acknowledged that not all health and safety visits occurred and although the safety assessment determination was concluded in April 2025, it was not entered into the safety assessment tool and approved by the supervisor within time frames. In order to address this, the regional leadership will conduct a check of documentation during monthly clinical supervision so that guidance can be provided on the timeliness of all activities.

DCYF requested a withdrawal of the finding related to FAR case closure requirements. DCYF explained that there was a need to monitor the case due to changes in parental custody. Additionally, the mother requested support and services in April and August 2025, which extends the closure requirement to 120 days.

OFCO maintained the finding on the basis that:

- RCW 26.44.030 states that the Department must complete the family assessment response within 45 days and provides that the FAR may be extended up to 120 days upon parental agreement.
- DCYF Policies and Procedures 2332 3(b) (ii) requires the Department to develop a case plan within 15 days of the parent's agreement and (iii) obtain the parent's permission to leave the case open up to 120 days for case planning and services.

While the Department provided assistance with concrete goods in April 2025, this was not an ongoing service that would necessitate extending the FAR beyond 45 days. There was no documentation of the Department establishing a case plan or obtaining the parent's permission to extend the FAR beyond 45 days. The mother's request for services and concrete goods was not made until four months after the FAR opened.

DEPENDENT CHILD WELL-BEING AND PERMANENCY

DCYF did not adequately inform licensed foster parents of a dependent child's known medical diagnosis.

A four-year-old dependent child with an asthma diagnosis was placed with licensed foster parents. A Child Information and Placement Referral (CHIPR) was generated and provided to the foster parents at the time of placement. Although DCYF had documented the asthma diagnosis in a previous CHIPR, the information was not included on the CHIPR provided to these foster parents. The foster parents were not verbally informed of the child's diagnosis, nor were they

provided with an inhaler. The child later suffered a serious asthma attack, leaving the foster parent, who was unaware of the condition, distressed by the incident.

Violations:

- **DCYF Policies and Procedures 4250 Out of Home Placements requires that when making a placement decision or change, DCYF must provide the child's caregiver with the child's healthcare information. Further, 4313 Notification of Court Hearings, Providing Reports to Court, and Information Sharing with Out-Of-Home Caregivers Procedure states that a caseworker must share a child's healthcare information and provide the placement with a completed Child Information and Placement Referral. Additionally, 4517, Health Care Services for Children Placed in Out of Home Care Procedures states that caseworkers must collaborate with health care providers, parents or guardians, and caregivers to verify health care needs are followed up on and met, obtain medical records, and share them with parents and caregivers, and assist parents and caregivers with obtaining services. It also states the caseworker must document in FamLink and the court report the child's diagnoses and results of appointments and upload all received related reports.**
  The CHIPR provided to the foster parents did not identify the child's asthma diagnosis. The information was also not verbally shared with them. The child did not come to the placement with her inhaler, nor had one provided to her in the two months she was placed there. The child had an asthma attack, and the foster parents did not know what was happening to her or how to treat it.

DCYF Response:
DCYF acknowledged that the CHIPR provided to the foster parents did not include the asthma diagnosis. In order to address the error, the local Area Administrator took the following steps:

- The child's health record was updated to ensure all information was documented in the child's health record of FamLink. This will ensure any future staff who create a CHIPR will have this information available.
- A new CHIPR was created in July 2025 with the corrected health information.
- The caseworker is helping the caregivers to create and maintain a medical binder for the child that includes the Action Plan created by the attending physician in May 2025.

DCYF did not begin the ICPC process timely.

In February 2024, a child was placed in foster care after the mother confirmed her intention to give up her parental rights. DCYF obtained information that the adoptive parent of the child's sibling was interested in placement and adopting this child. After speaking with the adoptive relative who lived out of state, DCYF planned to submit an ICPC request if dependency was established. The supervisor later noted that the adoptive relative was relocating to another state. In June 2024, the supervisor noted the dependency had been established and the referral for ICPC would be made once the relative relocated.

The adoptive relative moved in August 2024. DCYF submitted the ICPC in January 2025.

Unreasonable Finding:

- **DCYF Policies and Procedures 5601 (1)(a)(i)(A)(II, III, IV) states that an ICPC request and approval is required prior to sending a dependent child or youth out of state for placement with relatives, foster home, or adoptive home.**
  DCYF received the intake in February 2024. Dependency was established in June 2024. The initial request for ICPC was submitted in January 2025. While the policy does not dictate a timeline for submission of an ICPC, the delay from August 2024, when the relative established a new residency, to January 2025 was clearly unreasonable.

DCYF Response:
DCYF acknowledged that although the policy was followed and there is no time frame for submitting an ICPC request, the delay can be considered unreasonable. As soon as it was identified by the newly assigned caseworker, the ICPC packet was submitted. Additionally, the region provided training on timely relative search efforts and timely completion of ICPC requests.

DCYF did not send Quarterly Supervision Reports (QSR) as required by policy to another state regarding a dependent child from that state.

In October 2022, another state submitted a request to DCYF for an ICPC foster home study for a relative of two dependent children there, ages 9 and 6. DCYF approved the foster home study in December 2022, and both children were placed with the relative in January 2023. The 9-year-old returned to the other state for a new placement in July 2024, while the 6-year-old remained until removal in January 2025 following concerns of inadequate care.

Following receipt of a complaint involving this case, OFCO found that DCYF completed five QSRs over the 23 months that the child was placed in Washington, sending them to the other state in June 2023, December 2023, April 2024, September 2024, and February 2025.

Violation:

- **DCYF did not complete required ICPC QSRs in a timely manner. DCYF Policies and Procedures 5602 (1)(b)(iii)(D) states for in-state ICPC cases, caseworkers must "submit quarterly supervision reports for biological parent, relative, foster, or adoptive homes to the HQ ICPC office." HQ ICPC is responsible for sending the QSRs to the sending state's ICPC office. DCYF Policies and Procedures 5602(1)(b)(v) specifies that "caseworkers must complete a quarterly supervision report and send to HQ ICPC within 10 business days after the last home visit of the quarter."**
  OFCO found that DCYF completed five QSRs over the 23 months that the child was placed in Washington. The QSRs covered four- to six-month periods. The child was ultimately removed from this placement due to concerns of inadequate care. Timely QSRs are essential for the sending state agency to make informed placement decisions.

DCYF Response:
DCYF acknowledged that they did not adhere to the required policy, although there was regular contact with the other state. To avoid this type of error in the future, the following steps were initiated:

- ICPC refresher training will be provided to support caseworker knowledge and skill development.
- The Area Administrator will provide a focused training and discussion with the office supervisors on clinical supervision requirements and following up with case managers on identified next steps.

FAMILY SEPARATION AND REUNIFICATION

DCYF did not conduct ongoing relative search activities as required.

In March 2021, DCYF received an intake regarding a newborn who had been prenatally exposed to fentanyl. Given concerns about the child's medical needs and the mother's ongoing substance use, the child was placed into protective custody upon discharge from the hospital. DCYF filed a dependency petition the following month, and an agreed shelter care order was entered, authorizing the child's placement in licensed foster care. The order directed DCYF to continue making reasonable efforts to identify and assess an appropriate relative or other suitable person available and willing to care for the child.

In May 2021, the Relative Search Unit (RSU) initiated a relative search and mailed letters to the child's relatives. Although some relatives responded and expressed interest, those who did either did not follow through or were not approved during the home study process. By March 2024, both parents' rights had been terminated and the case transferred to the adoption unit. Case notes at that time indicated that the most recent relative search had been conducted in May 2021.

In April 2024, the RSU began another relative search inquiry and identified a relative who expressed interest in placement. At this point, the child had remained in the same foster placement since 2021, and the foster parents had already entered into an open adoption agreement with the child's father.

Violation:

- **DCYF Policies and Procedures 4251 requires the Department to conduct relative searches throughout the life of the case or until the child is returned to the parent, placed with a relative caregiver, or the conditions for voluntary adoption plan are met. Subsequent relative searches are to occur when the child remains in foster care and it has been more than 12 months since a previous search was completed or when the child is legally free and not placed with a relative.**
  DCYF did not conduct an ongoing relative search after the initial search in May 2021. As a result, the timely consideration of the child's relative did not occur.

DCYF Response:
The Department acknowledged that relative search efforts did not occur every 12 months as required by policy. In order to improve the early and ongoing identification of relatives, the regional leadership took the following steps:

- Every month, the QA teams send notifications to the region about the need to conduct relative searches and shares the relative placement data.
- Key staff have access to TransUnion to run relative searches at initial placement and at shared planning staffings to ensure updated relative searches are conducted.
- Relative searches are reviewed and/or conducted at complex youth staffings.

APPENDIX C: OFCO ORGANIZATIONAL CHART