Office of the Family and Children's Ombuds

An Independent Voice for Families and Children

2019 Annual Report

Patrick Dowd, *Director*

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Report prepared by Elizabeth Bokan and Sherry Saeteurn

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

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To the Residents of Washington State:

I am pleased to submit the 2019 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, 2018 to August 31, 2019. 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 received 932 complaints and completed 928 investigations regarding 1,398 children. As in past years, the separation and reunification of families is the most frequently identified issue in complaints. Complaints regarding child safety have actually decreased over the past several years, while there has been an increase in complaints about agency conduct and services.

OFCO also identifies systemic issues, and makes recommendations to better serve children and families. This report discusses the ongoing shortage of placement resources for children with complex needs resulting in the use of hotels as emergency placements. Department administrators report this is driven in part by an increase in children entering care with serious mental health concerns, developmental disabilities, or involvement with the juvenile justice system. It is imperative that we provide a sufficient array of placement and treatment services tailored to the needs of these children. OFCO also received several complaints over the past year from professionals who are legally mandated to report suspected child maltreatment and experienced excessive wait times when calling Child Protective Services (CPS). We found that the volume of calls to CPS has increased substantially, and during peak times callers are placed on hold. This can lead to dropped calls which leaves vulnerable children at risk. OFCO recommends that the Department implement an online reporting system for mandated reporters and ensure sufficient staff and resources are dedicated to CPS intake.

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.[1]

This report provides an account of OFCO's complaint investigation activities from September 1, 2018 through August 31, 2019, as well as recommendations to improve the quality of state services for children and families.

CORE DUTIES

The following duties and responsibilities of the Ombuds are set forth in state laws:[2]

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.
[2] 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 ensure children's health and safety;
- Review periodically the facilities and procedures of state institutions serving children and state-licensed facilities or residences;
- Review child fatalities and near fatalities when the injury or death is suspected to be caused by child abuse or neglect and the family was involved with the Department during the previous 12 months;
- Recommend changes in law, policy, and practice to improve state services for families and children; and
- Review notifications from DCYF regarding a third founded report of child abuse or neglect within a twelve-month period involving the same child or family.

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.[3]

WORKING TO MAKE A DIFFERENCE

Systemic issues discussed in this report include:

- **Placement Resources Are Ill Equipped to Meet the Needs of All Children and Youth in State Care**

  While the number of children requiring out-of-home care has increased over the past five years,[4] DCYF administrators also report a change in the population of children served by the Department, specifically an increase in youth with serious mental health concerns, youth involved with the juvenile justice system, and youth who suffer from major developmental disabilities. As a result, children with complex needs are often placed in hotels or Department offices, waiting for the Department to find an appropriate placement. This report describes 1,514 "placement exceptions" involving 282 children. OFCO found that this is primarily a regional concern, occurring most frequently in DCYF Regions 3 and 4. However, other regions may use temporary night-to-night foster placements instead of hotels, but still lack stability for children.

- **Legislation Prohibits Use of Detention for Foster Children Missing from Placement**

  Recognizing that detaining youth for non-criminal behavior is harmful, this year the legislature ended the practice of placing youth who have committed status offenses such as not attending school or running from foster care in detention facilities. In addition to eliminating the use of detention, it is imperative that we provide alternative interventions including secure, semi-secure, and non-secure out-of-home placement options, community-based mentoring,

[3] Child Fatalities and Near Fatalities in Washington State, August 2018. Available at: http://ofco.wa.gov/wp-content/uploads/2018-OFCO-Child-Fatility-and-Near-Fatality-Report.pdf

[4] Partners for Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 9/18/2019]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts

counseling, family reconciliation, behavioral health services, and other services designed to support youth and families and to prevent the need for out-of-home placement.

- **High Volume of Calls to CPS Intake Can Leave Children at Risk**
  CPS intake units are the 24 hour gateway to our child protection system. They receive and process reports of child maltreatment and identify emergent child safety reports requiring an immediate response. The volume of calls CPS intake receives has grown substantially in the past eight years and when CPS intake experiences high call volumes callers are placed on hold for extended periods. This can lead to dropped calls and endanger children as suspected child abuse or neglect may go unreported. The Department should implement an online reporting process for mandated reporters, and ensure sufficient staff and resources are dedicated to CPS intake.

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2018 and August 31, 2019, OFCO completed 928 complaint investigations regarding 1,398 children. As in previous years, issues involving the separation and reunification of families were by far the most frequently identified complaint issues. The conduct of DCYF staff and other agency services comprised the next highest categories of issues identified in complaints.

OMBUDS IN ACTION

OFCO takes action when necessary to avert or correct a harmful action or oversight, or an avoidable mistake by DCYF. Eighty-six complaints prompted intervention by OFCO in 2019. OFCO provided substantial assistance to resolve either the complaint issue or a concern identified by OFCO in the course of its investigation in an additional 68 complaints.

In 2019, OFCO made 47 formal adverse findings against DCYF. OFCO provides DCYF with written notice of adverse findings resulting from a complaint investigation. DCYF is invited to respond to the finding, and may present additional information and request a revision of the finding. This process provides transparency for OFCO's work as well as accountability for DCYF.[5]

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

IMPROVING THE SYSTEM

- Placement Resources Are Ill Equipped to Meet the Needs of All Children and Youth in State Care
- Legislation Prohibits Use of Detention for Foster Children Missing from Placement
- CPS Intake System Leaves Children at Risk

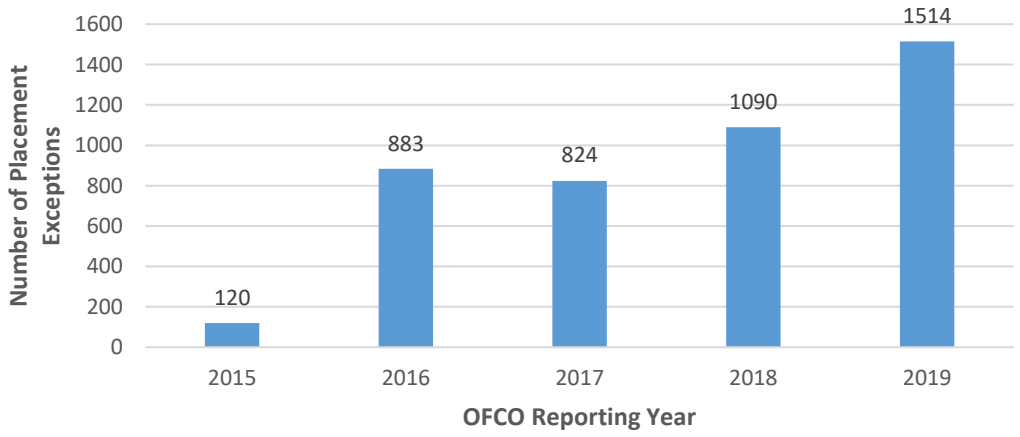
PLACEMENT RESOURCES ARE ILL EQUIPPED TO MEET THE NEEDS OF ALL CHILDREN AND YOUTH IN STATE CARE

HOTELS USED AS EMERGENT PLACEMENTS FOR FOSTER CHILDREN

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

Since 2014, OFCO has tracked the Department's use of hotels and Department offices as emergency placements for children.[6] These are referred to as "placement exceptions".[7] Unfortunately, the placement of children in hotels continues at an alarming rate in Washington. From September 1, 2018 to August 31, 2019, OFCO received notice of **1,514 placement exceptions involving 282 different children,** an increase of 424 stays from 2018 and the most placement exceptions noted since OFCO began keeping track in 2014. The vast majority of these placement exceptions (1,507) involved children spending the night in hotels supervised by caseworkers. There were six instances of children spending the night in DCYF offices and one reported placement exception in which the notification received by OFCO did not indicate the placement location.

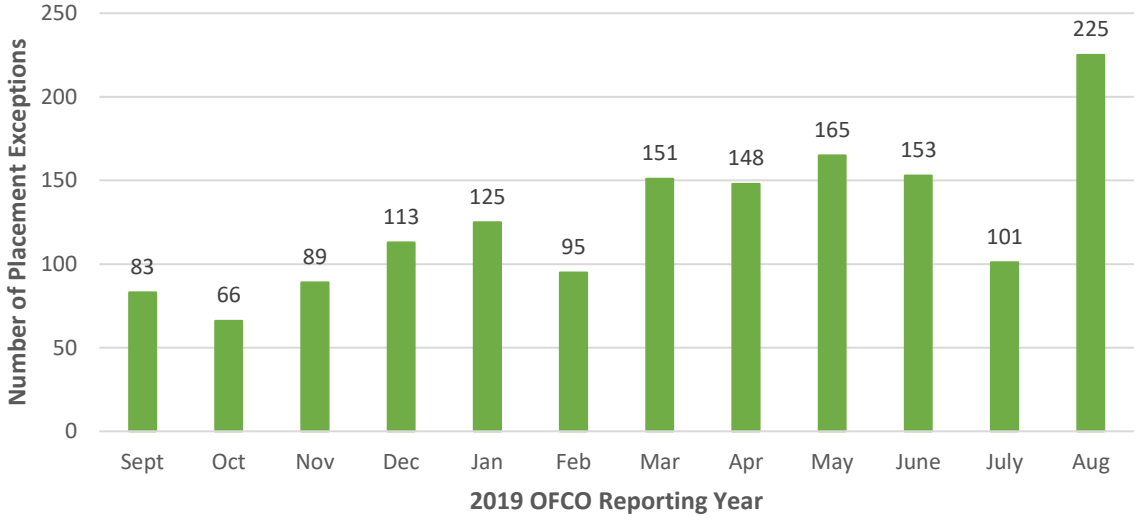
Figure 1: **Number of Placement Exceptions**



[6] See 2015, 2016, 2017, and 2018 Annual Report, at http://ofco.wa.gov/reports/

[7] OFCO receives notification of placement exceptions and other critical incidents through CA's Administrative Incident Reporting System (AIRS).

Figure 2: **Placement Exceptions by Month, 2019**



REGIONAL ADMINISTRATORS STATE PLACEMENT EXCEPTIONS ARE HARMFUL TO DCYF STAFF AS WELL AS CHILDREN

For the past five years, OFCO has been reporting on Washington's placement exception crisis and its impact on youth and their communities. To better understand how this crisis also affects DCYF and the people who comprise the agency, this year OFCO spoke with the regional administrators (R.A.s) managing the six different DCYF regions of Washington State. These conversations focused on the causes for placement exceptions, the impact on staff and youth, and potential solutions.

TRANSIENT PLACEMENTS FOR CHILDREN INCLUDE HOTELS, DCYF OFFICES AND "NIGHT-TO-NIGHT" FOSTER CARE

R.A.s said the most common placement exception is the hotel stay, however, on occasion youth spend the night in a DCYF office. Office stays can occur when an appropriate placement is available, but the youth refuses to go. In other instances, an office stay is in fact the preferred option for a child, for example if the youth has recently been assaultive towards staff while the staff is driving a car, or when a youth threatened self-harm if forced to leave the office.

"Night-to-Night" foster care is not technically a placement exception, as it occurs in a licensed foster home, yet there are many similarities to hotel stays in how they are used and the impact on youth and agency staff. Like with hotel stays, night-to-night foster care is only authorized for one night at a time, and usually with a strictly enforced time limit in the foster home, such as 10 P.M. to 6 A.M. While some R.A.s reported that they prefer these placements to a hotel stay because the youth is in a licensed and vetted family home, others believe these placements are emotionally harmful, as the limited hours and engagement can make children repot feeling unwanted. As these events are not considered true placement exceptions, the regions have not been tracking their occurrence as they do hotel stays.

PLACEMENT EXCEPTIONS ARE USED AS A LAST OPTION

Each region spends considerable time and energy planning for placement exceptions whether or not they eventually occur. As soon as a child comes into care, DCYF staff begins looking for an appropriate placement equipped to meet the child's needs. This includes searching for: relative/kinship care; foster care; and group care placement. Additionally, the Department seeks to maintain children in their community and only looks to other regions when a local placement is not available. Night-to-night foster placements are often used to keep youth connected to their local community, especially if it seems a long term local option might soon be available. After these other options are exhausted, staff look to place a child in a hotel room. R.A.s said this almost always happens at the end of the day, and sometimes as late as 9 P.M.

Some youth stay in hotels for multiple nights, in extreme cases, they can be in these placements for months, and the placement process described above is followed every day. At times there are multiple children experiencing repeated placement exceptions in one office, and the DCYF staff must conduct placement searches every day for each child at risk of being placed in a hotel or office.

Regardless of the type of placement exception used, during the day youth experiencing them frequently spend their time in DCYF offices. This creates a huge staffing and supervision burden on all the staff in that office.

The court ordered that an 11-year-old dependent child be removed from an in-home dependency. The child's former foster parents were willing to have the child placed with them, however, they were unable to take the child into care until the next day. Because of the lack of placement options, the child was placed in a hotel for the night.

A LACK OF FOSTER HOMES IS NOT THE PROBLEM

The R.A.s uniformly agreed the problem of placement exceptions is getting worse and is not necessarily due to a lack of licensed foster homes. In fact, R.A.s noted many foster homes are empty while children languish in a series of hotel stays. They assert that placement exceptions continue because of major changes in the population that DCYF serves, -specifically an increase in youth with serious mental health concerns, youth involved with the juvenile justice system, and youth who suffer from major developmental disabilities. While these new populations of children have grown, the recruiting and training of foster homes remains tied to a traditional view of a foster child that does not address the placement needs for these types of youth. Additionally, decreased use of congregate care, and particularly out-of-state facilities, place greater demands on existing placement resources.

R.A.s said youth with serious mental health needs were previously served by a much more robust community mental health system. However, starting with the financial recession in 2008, funding for these services began to disappear, and slowly so did the services themselves. For example, R.A.s described a six month wait period to simply have a child's mental health assessed through the community mental health system, and a dire lack of adequate inpatient beds for youth in extreme crisis. The loss of supports to youth in their homes and communities contribute to crisis situations endangering

youth and their families, and parents reach a point where they can no longer meet the child's needs in the home. It is at this point that DCYF becomes involved.

RA.s commented that while the dependency process was created to address children who have been abused or neglected, it is now used as a means to provide mental health services that are otherwise unavailable to children and families. For example, in an effort to obtain placement and therapeutic care, a parent may refuse to pick up a child who is otherwise ready for discharge from a psychiatric hospital. The hospital then calls Child Protective Services. DCYF tries to locate services and return the child to a parent or relatives, but if efforts are unsuccessful the Department must address the immediate placement needs of the child, which often results in a placement exception.

Youth involved with the juvenile justice system are for the most part young people from complex circumstances with diverse needs. R.A.s were clear that they support recent reforms moving away from incarcerating youth, but expressed frustration that no systems or supports for families have been created, and as a result these youth often end up receiving services through the dependency system. For example, CPS receives a report from a detention facility that a youth has been released but the parent refuses to pick him up because the youth committed an offense against a younger sibling and cannot safely return home. Often these are older teens who may have violent criminal history and foster homes do not feel equipped to care for them. While in hotel stays, some youth commit new crimes, including assaults and property destruction. Allowing these children to continue to accrue criminal charges in settings in which they are unable to stabilize is not serving their best interests.

R.A.s also identified an increase in serving youth with developmental delays and in particular, children with extreme forms of autism. The R.A.s once again described dwindling resources and community supports resulting in families finding themselves unable to care for their developmentally disabled child. They also noted that there were previously far more placements through the developmental disability administration that served this community. Now, these children are finding themselves in DCYF care, even though there are no allegations of child maltreatment and the only parental deficiency is that the parent is unable to provide the level of extraordinary care the child requires. These children often need specialized care that exceeds the ability of most foster homes -as well as the ability of after-hours workers who provide care during a hotel stay. The goal of a traditional dependency is to address parental deficiencies so that a child can safely return to his or her parents' care. However, these children are in DCYF care because of their special needs, and our current dependency process is not equipped to serve these families.

The R.A.s repeatedly noted that the children and families who should be served by the mental health, developmental disabilities or juvenile justice systems are often funneled to DCYF, which becomes the service provider of last resort. The R.A.s stated that these are families that clearly need help, but that the placement exception crisis is a stark indication that the DCYF system is not equipped to serve them. Because of this, both DCYF staff and the youth they serve are adversely impacted by their use.

An autistic 16-year-old youth was removed from his placement after he began playing with fire and his caregiver was no longer able to meet his supervision needs. The youth, a registered sex offender, was not allowed to be around children younger than himself. Due to his supervision needs, the Department could not locate a placement and he was placed in hotels for three nights until being placed in a group home.

On the most basic level, DCYF staff are not properly trained to care for children during placement exceptions and as a result, they feel ill equipped and unsupported. R.A.s said the 24 hour care for children during hotel stays should be provided by professionals with the training and supervision similar to line staff in a therapeutic group home- such as training on de-escalation, milieu therapy, and motivational interviewing. The R.A.s also noted that the staff who most often work with children during placement exceptions are the after-hours workers, who are almost always the least experienced of the DCYF team. After hours staff are often students and young people looking to gain experience and R.A.s worry that, given how frequently these staff burn out, future hiring may also be impacted as traditionally some of these staff later become full-time employees.

The lack of experience and staff training is concerning given identified concerns with physical safety, emotional safety and morale, and the impact on assigned tasks. Unfortunately, assaults on staff by youth experiencing placements exceptions are not uncommon. These can run from mild shoving or grabbing to occasionally more serious physical assaults, including attempts to assault staff while they are driving. Some youth have been previously adjudicated for committing violent assaults, or in some cases, sexually motivated crimes, and have later been physically or sexually intimidating towards staff. Youth have also destroyed workers' personal property, hotel property and office property. In some instances youth have tried to, or have actually set fires in DCYF offices. Staff are also sometimes tasked with the care of a seriously developmentally disabled youth, who may have physical outbursts or be otherwise unable to control their behavior. Some of these youth need significant personal hygiene care but are prone to injuring those who attempt to help.

An 11-year-old dependent child was brought to the United States when he was three years old as part of an international disaster relief program for orphans. The child had been living with his sponsor since coming to the United States in May 2010, however, due to severe behavioral and mental health issues, the child was no longer able to reside in this home and was placed in the Department's care. Following treatment in a psychiatric hospital, the child moved to a residential treatment program but was later removed due to increased, chronic behavioral issues including physical and verbal abuse of staff, breaking car windows, and running from campus and into oncoming traffic. Over the past year, the child has spent 77 nights in a hotel. During a hotel stay, the child slammed the door on a hotel staff member's finger causing injury to the hotel staff member. The child is currently placed in an out-of-state group care facility.

PLACEMENT EXCEPTIONS ENDANGER CHILDREN

The R.A.s also described their concerns about the harmful impact of placement exceptions on children. One issue that came up frequently was physical safety. R.A.s noted that in placement exceptions and in offices youth commit assaultive crimes towards staff and one another. There have also been allegations of youth sexually assaulting one another while in placement exceptions. Another recurring theme was youth engaging in self-harm. Youth have made suicidal statements and gestures, as well as suicide

attempts while in placement exceptions. Placement exceptions seem to have a dysregulating effect on all youth, and youth presenting with major mental health issues are particularly at risk. The nature of placement exceptions can contribute to an environment that results in criminal behavior by youth. Some youth incur multiple criminal charges and convictions while in placement exceptions, which may impact them for the rest of their lives.

Youth often run from hotel stays and sometimes return inebriated. Staff have responded by calling emergency medical providers to assess the youth and occasionally the youth are taken to the hospital; sometimes they are assessed as safe and left in the hotel. Youth in placement exceptions also on occasion recruit one another into engaging in dangerous behaviors.

The R.A.s felt it was clear that spending their evenings in hotels and their daytimes in offices harms young people. They receive an unhealthy diet, usually consisting of a large amount of fast food. R.A.s described DCYF staff trying to address this harm by cooking at home to bring healthy food into the office for these children, but noted that the youth can go months without access to a kitchen or homemade food. Placement exceptions also disrupt regular school attendance. Occasionally, DCYF is able to arrange for a youth to continue to attend school, but more often than not youth are unable to continue in their previous school, or enroll in a new one due to their transitional status. Youth report being bored while in DCYF offices and instances of assaultive behavior and property destruction sometimes then follows.

Finally, many of the youth report that placement exceptions negatively impact their self-worth and self-confidence. They report being in a transient situation makes them feel no one wants them and they are unlovable. After long periods in placement exceptions some youth become acclimated to the lifestyle and are then even harder to place, as they prefer the hotel and are no longer interested in the structure and rules of a traditional home or program. These youth have acted in a rational and adaptive manner for their circumstances, but it ultimately negatively impacts their future wellbeing.

A 17-year-old youth was placed in the Department's care due to his defiant and aggressive behaviors. The youth struggled with substance abuse and was diagnosed with ADHD, OCD, and generalized anxiety disorder. The youth spent 50 non-consecutive nights in hotels while awaiting placement at an out-of-state BRS group home. While staying in hotels, the youth allegedly sexually assaulted another youth.

PLACEMENT EXCEPTIONS CREATE AN ADDED BURDEN ON AGENCY STAFF AND AFFECT PRODUCTIVITY AND MORALE

Planning for hotel stays includes assessing each child's needs, finding and reserving hotel rooms, determining adequate staffing in each hotel room for the number of children, taking into account the children's supervision needs, including the possible need for a security guard, providing meals, and organizing transportation. Additionally, the R.A must ensure the DCYF office remains adequately staffed to handle duties such as responding to emergent intakes or placements. Adequately staffing hotel stays as well as the DCYF office is challenging. Community partners, such as law enforcement, have on occasion voiced frustration that afterhours office staff is not always available when needed. Some R.A.s said they maintain a list of daytime staff who are willing to work an additional shift for overtime pay.

Other R.A.s have developed a calendar where day staff sign up for on call shifts should the need for more staff arise.

R.A.s also described the negative impact placement exceptions and daytime youth office supervision have on productivity and worker morale. The case workers assigned to the individual youth feel responsible for monitoring and caring for the children on their caseload who are in the office during the day which impacts their ability to manage their other cases. Supervisors and Area Administrators frequently spend time monitoring these youth as well so that assigned workers do not bear the burden alone. Some offices have a calendar system for staff to monitor youth in the office, at the expense of completing their assigned tasks. A few offices have utilized volunteers to spend time with the youth, while other R.A.s report the behaviors of these youth are too extreme for an untrained volunteer to manage.

R.A.s also said that staff fear being injured by youth, or accidentally injuring a youth should an altercation erupt. Workers also experience dissonance between the reasons why they are called to work with families and children and the reality of executing placement exceptions. R.A.s noted that no one is drawn to this work without an impulse to help people, as generally child welfare case workers are neither well paid nor socially celebrated. Sometimes the youth seem to emotionally and behaviorally deteriorate while in placement exceptions and/or daytime office stays, and staff feel somehow responsible, despite following the protocols that have been established for these situations, and feel they are not fulfilling the call that drove them to the work. They become demoralized and exhausted. R.A.s have found this impacts staff retention, as some workers report upon leaving the agency that the stress and strain of executing placement exceptions and facilitating supervision in the office during the day was too stressful.

A 17-year-old youth with significant mental health issues spent 22 non-consecutive nights in a hotel or DCYF office after being removed from BRS placements due to behavioral issues. The youth has been arrested and placed in juvenile detention for threats against DCYF staff and requires two-to-one supervision due to her assaultive behaviors towards staff. The youth also struggles with suicidal ideations. Due to behavioral issues and assaultive history, finding placement for the youth has been difficult. The youth, now 18-years-old, still remains with no permanent placement and continues to be placed in juvenile detention or a DCYF office.

R.A.s' RECOMMENDATIONS

R.A.s were eager to provide recommendations for improving the current placement exception crisis. Summarized below are solutions identified by R.A.s:

- **<u>Adequately fund the mental health, developmental disabilities, and juvenile justice systems</u>** so there are sufficient placement resources to serve children and their families. A robust community health infrastructure would support children in their homes and avoid the need for out-of-home placement. Similarly, increased funding for the Developmental Disabilities Administration could provide increased in-home care hours for those in need, and expand

placement resources. Our juvenile justice system should establish placement and support services to buttress efforts reducing youth incarceration and safely maintaining children in their community, including post adjudication and/or incarceration.

- **Update foster parent recruitment and training** to reflect the new populations that DCYF is serving and reach individuals who are open to fostering a teenager with special needs or challenging behaviors. This should include recruiting foster parents specifically to meet the needs of young adults in the extended foster care program.

- **Revise the foster care licensing process** to enable relatives, who otherwise would be disqualified based on criminal or DCYF history, to care for a child.

- **Establish a class of "Professional Therapeutic Foster Parents"** who would be trained and compensated to devote their full time and attention to the care of high needs children and youth with mental health conditions and or challenging behaviors. This would provide a family-like placement for these children, decrease the need for congregate care, and increase placement stability.

- **Expand in home services to support families in crisis**, such as the WISe Program[8] which can be offered through DCYF's Family Voluntary Services and enables a child to remain in the family home.

- **Improve collaboration with community partners** to identify the best family intervention strategy that aligns with the type of care and family services available through DCYF as well as its limitations, and other systems and services available to assist and support families.

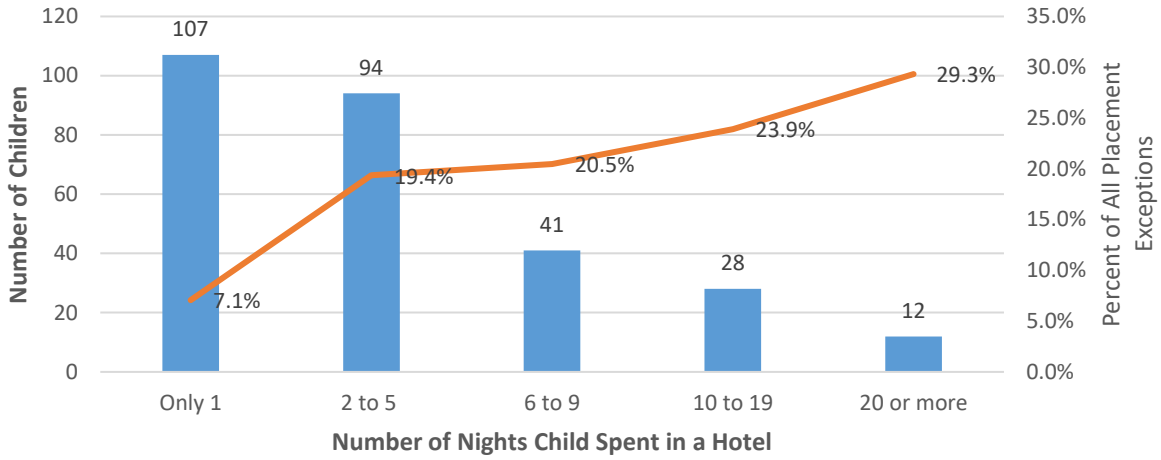
PLACEMENT EXCEPTIONS DATA

A SMALL GROUP OF CHILDREN ACCOUNT FOR THE MAJORITY OF HOTEL STAYS

For most children who experience them, a hotel stay is limited to a few nights before a placement is found. A suitable placement was identified for 71 percent of children within 5 days or less of a placement exception: 107 children spent only a single night in a hotel and 94 children spent 2 to 5 nights. However, 28 children spent 10 to 19 nights and 12 children spent 20 or more nights in hotels. These 40 children spent a combined total of 806 nights in hotels, making up over half of all placement exceptions. The highest number of nights spent in hotels by a single child was 77.

[8] Wraparound with Intensive Services, or WISe, helps children, youth, and their families with intensive mental health care. Services are available in home and community settings and offer a system of care based on the individualized need of the child or youth. https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/wraparound-intensive-services-wise

Figure 3: **Number of Placement Exceptions per Child, 2019**



Youth Who Spent Twenty or More Nights in Hotels

Who are they?

- Twelve youth, ages seven through seventeen, spent at least twenty nights in hotels.
- Six of the youth were identified as Caucasian, five were identified as African American, and one identified as multiracial (Caucasian and African American).
- Seven of the twelve youth were female.

Behavior and Placement History

- Most of these youth (11 out of 12) were noted to have a history of **physically aggressive behaviors**, some towards caregivers and others towards peers, which made finding a placement difficult.
- All 12 of the youth were reported to have **mental health needs**, such as mental disorders, past inpatient psychiatric stays, and history of self-harming behaviors.
- Four of the youth were removed from group care or foster care due to behavioral issues.

Where are they placed now?

- Approximately half of these youth were eventually placed in group care facilities: three are placed in out-of-state facilities and two reside at in-state facilities.
- Three youth have returned home to their parents.
- One youth has been placed with a suitable other.
- One youth has been placed in a foster home.
- One youth is currently in juvenile detention.
- One youth is currently on respite from foster care and continues spending nights in hotels.

DEMOGRAPHICS OF CHILDREN EXPERIENCING PLACEMENT EXCEPTIONS

Of the 282 children who spent at least one night in a hotel or DCYF office, **62.1 percent were male and 37.9 percent were female**. Figure 5 shows that the children who have been placed in hotels tend to be older than the total out-of-home care population.[9]

Figure 4: **Child Gender in Placement Exceptions, 2019**

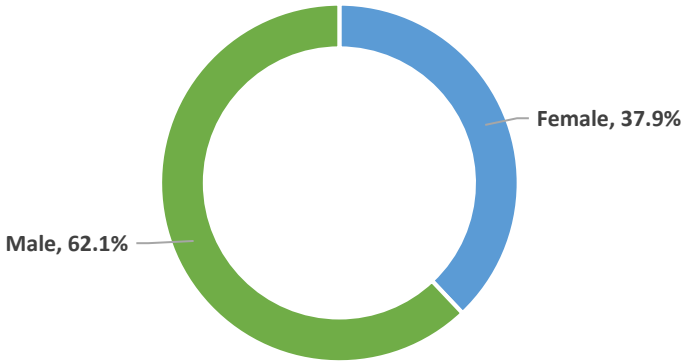
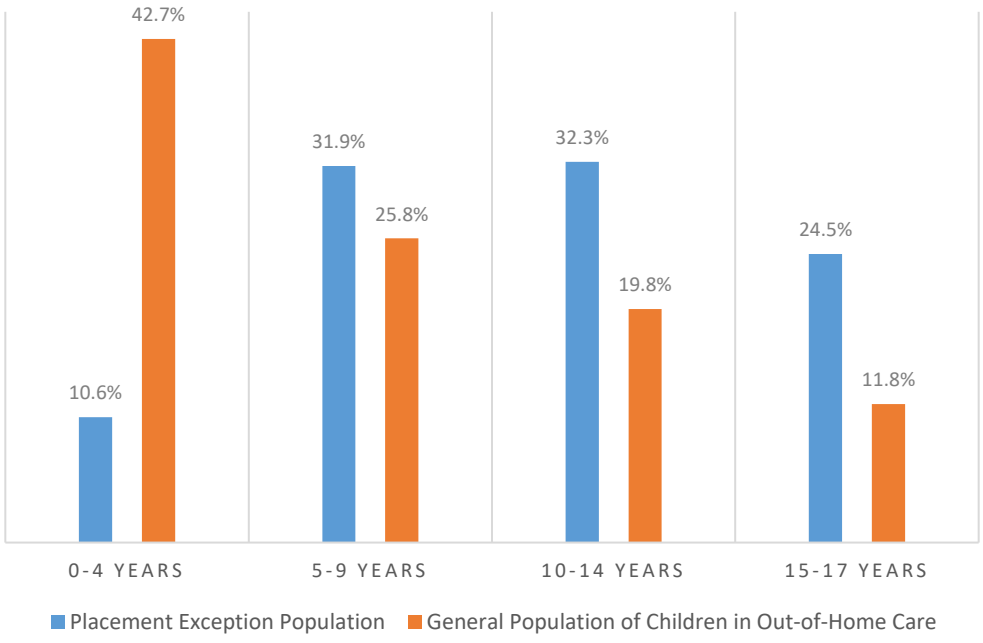


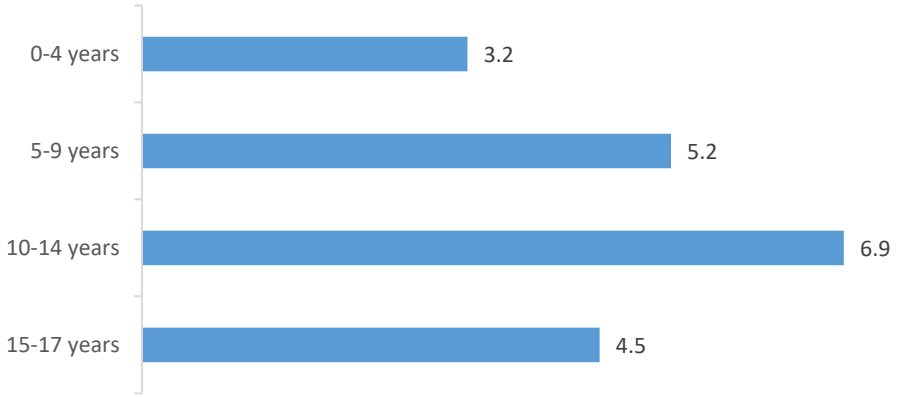
Figure 5: **Child Age in Placement Exceptions, 2019**



[9] Partners for Our Children Data Portal Team. Ibid.

The average number of placement exceptions for these children was five nights. The average number of placement exceptions by age of the child is shown in Figure 6. Children age four and younger spent the fewest nights on average in hotels, averaging 3.2 nights, whereas children ages ten to fourteen averaged just under seven nights in hotels.

Figure 6: **Average Number of Placement Exceptions of Children by Age, 2019**



A REGIONAL ISSUE

This placement crisis continues to be most apparent in DCYF Region 3 (Whatcom, Skagit & Snohomish Counties) and Region 4 (King County): about 90 percent of nights spent in a hotel during the 2019 OFCO reporting year involved children with cases assigned to a DCYF office in Region 3 or 4.[10] Just over 45 percent of Washington households with children are located in these two regions[11] and about 31 percent of children in out-of-home care have cases in Region 3 or 4.[12] However, other regions may use night-to-night foster care placements, which lack stability and permanency.

Table 1: **Placement Exceptions by Region, 2019**

DCYF Region	Number of Placement Exceptions	Percent of Total Placement Exceptions	Percent of Washington Households with Children
Region 1	35	2.3%	12.4%
Region 2	0	--	9.7%
Region 3	317	20.9%	16.9%
Region 4	1042	68.8%	28.6%
Region 5	4	0.3%	16.3%
Region 6	116	7.7%	16.1%

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

[11] Partners for Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 9/18/2019]. Count of All Households with Children. Retrieved from http://www.vis.pocdata.org/maps/hh-populationregions

[12] Partners for Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 9/18/2019]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts

RACIAL DISPROPORTIONALITY

Of the children spending a night in a hotel or office, 20.7 percent were African American/Black, while African American/Black children comprise 15.1 percent of the out-of-home care population in Regions 3 and 4, and 9.2 percent of the out-of-home care population statewide. Five of the twelve youth who spent twenty or more nights in hotels over the course of the year were African American/Black.

Table 2: **Child Race and Ethnicity, 2019**

Race	Placement Exception Population	Region 3 & 4 Out-of-Home Care Population*	Washington State Out-of-Home Care Population **
African American/Black	20.7%	15.1%	9.2%
American Indian or Alaska Native	3.9%	6.8%	4.9%
Asian or Hawaiian/Pacific Islander	3.6%	3.7%	2.3%
Caucasian/White	57.1%	54.9%	62.9%
Multi-Racial	14.6%	20.2%	20.4%
Latino/Hispanic	11.8%	17.2%	19.7%

** Regions 3 and 4 encompasses Whatcom, Skagit, Snohomish, San Juan, Island and King Counties.*
***Partners for Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 9/18/2019]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts*

CHILDREN WITH SIGNIFICANT EMOTIONAL AND BEHAVIORAL PROBLEMS ARE AT HIGHER RISK OF PLACEMENT EXCEPTIONS

Research shows that behavior problems are commonly found among children who have experienced abuse and neglect, and that these behavior problems can have a significant negative impact on foster children's placement and permanency outcomes. Behavior problems contribute to risk for placement and adoption disruption, long-term foster care, and returning to care after reunification with parents.[13] Many of the children who experienced placement exceptions have significant treatment, supervision, and other special needs which pose barriers to locating and maintaining an appropriate placement. Foster families, relatives, or group homes may not feel equipped to care for children with significant needs. Most of these youth were noted to have challenging behaviors that made identifying a placement more difficult.

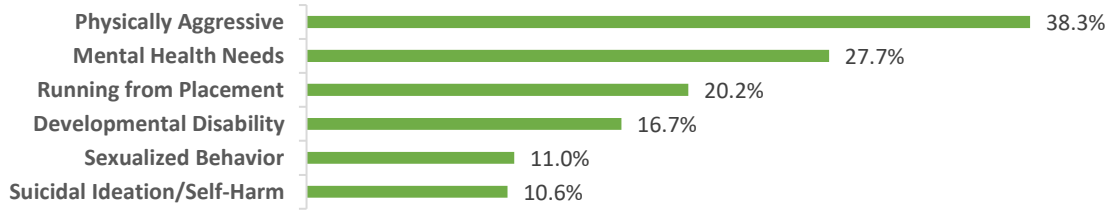
To gather information on youth's history, behaviors, and supervision needs, OFCO reviewed the AIRS email notification of the placement exception (which frequently documents the barriers encountered by the Department in trying to find an appropriate placement for the child); the most recent Child Information and Placement Referral (CHIPR)[14]; and if available, the most recent Comprehensive Family

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

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

Evaluation.[15] OFCO observed several common characteristics among the youth, such as physical aggression, mental health needs, a history of running from placements, and developmental disabilities. Figure 7 displays the most common characteristics among the youth placed in hotels. This data corroborates with challenges posed by placement exceptions as described by the regional administrators.

Figure 7: **Characteristics of Children in Hotel Stays, 2019**



OFCO RECOMMENDATIONS

In addition to the recommendations identified by the DCYF regional administrators, the Department should:

- **Increase "emergent placement services" facility based contracted beds and receiving care foster home resources.** When a child enters care, or disrupts from a foster home, an emergent placement should be available to provide short term care and support. This could eliminate hotel stays, night to night foster care placements, as well as children spending their day in a DCYF office, while a long term placement is pursued.

- **Increase placement resources and coordination between agencies serving children and families involved in:**

  - Mental Health
  - Developmental disabilities
  - Juvenile Justice

  Improved interagency collaboration should ensure families are served by the system designed to meet their needs. Additionally, each system should have adequate placement and treatment resources to support children and families eligible for their services.

- **Recruit, train and support foster parents so they are better equipped to care for children and youth with significant behavioral challenges.** Foster parent recruitment efforts should target individuals who may be interested in caring for adolescents and children with special needs who often are subjected to placement exceptions. These foster parents should receive training, respite and services necessary to support the stability of the child's placement.

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

LEGISLATION PROHIBITS USE OF DETENTION FOR FOSTER CHILDREN MISSING FROM PLACEMENT

STATE LEGISLATURE ELIMINATES THE USE OF JUVENILE DETENTION FOR NONCRIMINAL BEHAVIOR[16] AND RECOGNIZES THE NEED TO EXPAND ALTERNATIVE INTERVENTIONS.

In 2019, the legislature ended the practice of placing youth who have committed status offenses such as not attending school or running from foster care in detention facilities. As of July 1, 2020, no youth may be placed in detention as a contempt sanction or based on a warrant related to a Child in Need of Services (CHINS) or dependency proceedings. Law enforcement must return youth who are in contempt of a dependency order to DCYF custody instead of to juvenile detention.

The legislature recognized that detaining youth for non-criminal behavior is counterproductive, has a disproportional impact on youth of color, and that community based interventions are more effective at addressing the youth's needs. Alternative interventions cited by framers of this legislation include secure, semi-secure, and non-secure out-of-home placement options, community-based mentoring, counseling, family reconciliation, behavioral health services, and other services designed to support youth and families and to prevent the need for out-of-home placement. Additionally, under certain circumstances a youth may require commitment to a secure residential program with intensive wraparound services and the legislature intends to expand the availability of such interventions statewide over the next four years.

This past year, OFCO surveyed county juvenile detention facilities to gain insight on the use of detention for dependent youth who are missing from placement.[17] State wide, from January 1, 2018- December 31, 2018, there were 204 admissions of dependent youth for run warrants, regarding 104 youth, ages 10 -17 years. In King County there were 67 admissions of dependent youth to Juvenile Detention for run warrants, involving 29 youth. Some youth experienced as many as 7 or 8 separate detention episodes for running from placement. Of these 29 youth, there were more females than males admitted: 18 (62%) were female and 11 (38%) were male. The youth ranged in ages from 13-17 years. The average length of admissions was 2.6 days: 9 youth were admitted at least 5 days, with the longest admission 8 days. In reviewing individual cases OFCO found there are some youth who will not voluntarily engage in services and juvenile detention is often used as a "crisis intervention" in an attempt to remove a youth from dangerous and exploitive circumstances and address underlying mental health, substance abuse or behavioral issues.

[16] Chapter 312, Laws of 2019, ESSB 5290.

[17] There are 21 juvenile detention facilities serving the 39 counties in Washington State. OFCO received data from 19 of the 21 juvenile detention facilities.

In 2017, CPS received multiple reports of physical abuse, neglect, and sexual exploitation of a then 15-year-old child. She was initially placed in foster care and received mental health counseling, and wrap around services. A few months after entering state care, she stopped attending school and began running from placement. While absent from placement, she stopped attending mental health counseling and taking prescribed medications. Over the past two years she has had at least eleven short-term stays in juvenile detention after running from placement. Once released, she has been placed in a crisis residential facility or a hotel stay, which then leads to the next run event. The youth reports she uses methamphetamine and heroin. In 2018, a substance use disorder assessment recommended inpatient treatment. Treatment was not obtained, however, as the youth ran within hours of completing the assessment. This now 17-year-old youth's immediate medical needs are accessed when she is in juvenile detention. She has not had regular medical or dental care since September 2017.

OFCO RECOMMENDATION

Provide alternative interventions to serve youth in crisis.

- Expand secure, semi-secure, and non-secure out-of-home placement resources to meet the needs of youth who are an immediate threat to themselves.
- Ensure behavioral health services for children and youth are available in all communities. Washington State ranks 43rd in the nation based on the prevalence of youth mental illness and low rates of access to care.[18]

[18] https://www.mhanational.org/issues/ranking-states#youth_data

CPS INTAKE SYSTEM LEAVES CHILDREN AT RISK

CPS INTAKE: EXCESSIVE CALL WAIT TIMES ENDANGER CHILDREN

Over the past two years, several complaints to OFCO described excessive wait times when calling CPS intake to report suspected child maltreatment. Calls that are not answered promptly are often dropped, resulting in further delay of reporting child safety concerns at best, and possibly no report being made at all. A CPS intake system that cannot accommodate call volume places the safety and welfare of children at risk. Concerns reported to OFCO include:

- A teacher stated that she was put on hold for an hour before she was able to speak with a CPS intake worker. She had two separate reports to make but was told she would have to call back to make a second report due to the volume of calls.

- A medical professional complained about chronic wait times when trying to make a report to CPS intake. Due to the nature of her work she regularly calls CPS intake and frequently waits over 40 minutes before her call is answered. She waited for at least 45 minutes before having to hang up to tend to other work matters.

- A child's relative reported being unable to get through to CPS intake after making repeated calls over a two day period. None of the calls were answered in a timely manner. Out of frustration, the relative even tried calling CPS intake from multiple phone lines over a three hour period. She finally succeeded in making a report to a CPS intake worker.

CPS intake units are the 24 hour gateway to our child protection system. They receive and process reports of child maltreatment and identify emergent child safety reports requiring an immediate response. CPS intake workers must conduct a comprehensive interview with the caller, contact and document collateral sources of information, and conduct a thorough search of agency records in order to decide whether the reported information meets the legal definition of child maltreatment and criteria for agency involvement with the family. If the screening requirements are met, CPS intake must then determine the urgency of a CPS response and how quickly a caseworker must contact the family.[19] Each call may take up to sixty minutes to process, with 10-15 minutes spent with the caller and approximately 45 minutes gathering collateral information and making a screening decision.

The volume of calls CPS intake receives has grown substantially in the past eight years. In 2018, CPS received 126,195 intake reports of suspected child maltreatment, a nearly 40% increase from reports received in 2010.[20] Of the reports received in 2018, 44,667 screened in for a CPS response requiring an initial face-to-face contact with the child within 24 or 72 hours.[21]

CPS intake offices within local communities receive and investigate reports of suspected child abuse and neglect. When a person calls 1-866-END-HARM, they then select their regional intake office from a series of options, or they can call their region's CPS intake office directly.[22] The call is then placed in a

[19] CPS Intake Process https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response
[20] (page 16) https://www.dcyf.wa.gov/sites/default/files/pdf/reports/APSR2015-2019.pdf
[21] A 60% increase over the nearly 28,000 reports requiring a face-to-face response in 2010.
[22] For CPS Intake phone numbers for each region, see https://www.dcyf.wa.gov/safety/report-abuse

queue and is answered in order. A central intake office handles reports on weekends, nights and holidays.

The Department recognizes that CPS intake experiences higher call volumes during peak times and days. In response to increased demands, DCYF has changed certain features of the intake system and has plans for additional improvements. Specifically, calls to CPS central intake (1-866-END-HARM) are routed to the regional office during daytime hours; if a caller is placed on hold, a recording prepares them for the intake, listing information that will be requested by the intake worker. Future efforts to improve CPS intake include: adding a "call-back" feature enabling a caller to request a return call as soon as an intake worker is available; streamlining the intake process when duplicate reports are received regarding the same incident of suspected child maltreatment; and creating an online portal for mandated reporters to submit reports of suspected child abuse or neglect.

OFCO RECOMMENDATION

- **Establish an online CPS reporting system for mandated reporters.** State law requires certain professionals, employees, and volunteer positions to report suspected child abuse or neglect to law enforcement or CPS.[23] Approximately 60% of reports to CPS intake are from mandated reporters. OFCO supports DCYF's efforts to create an online reporting portal for mandated reporters to facilitate the timely reporting of suspected child maltreatment and significantly reduce call volumes to CPS intake. Adult Protective Services has an online reporting system[24] which demonstrates the feasibility and efficacy of an online intake process. Necessary resources should be dedicated for a similar CPS online intake system.

[23] For a complete list of mandated reporters, see RCW 26.44.030

[24] https://www.dshs.wa.gov/altsa/home-and-community-services/report-concerns-involving-vulnerable-adults

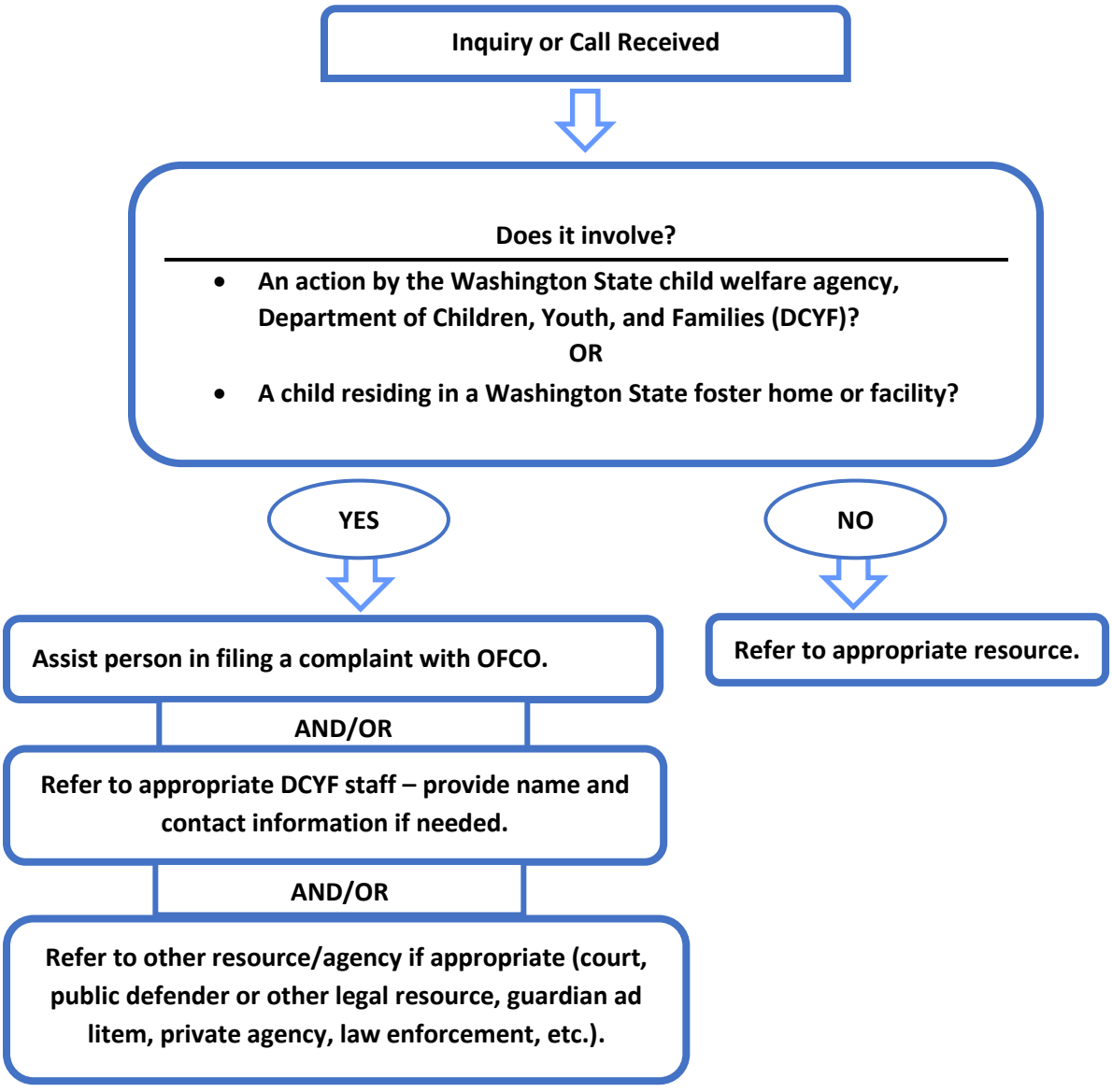
LISTENING TO FAMILIES AND CITIZENS

- Inquiries and Complaints
- Complaint Profiles
- Complaint Issues

INQUIRIES AND COMPLAINTS

The Ombuds 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 the Department of Children, Youth, and Families' process and/or services, or they may want to know how to file a complaint. If OFCO cannot help address a caller's concerns we will refer them elsewhere for information or support.

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



COMPLAINT PROFILES

COMPLAINTS RECEIVED

This section describes complaints filed during OFCO's 2019 reporting year — September 1, 2018 to August 31, 2019. **OFCO received 932 complaints in 2019**,[25] the most complaints received by OFCO in the last ten years. Figure 10 shows that 86.6 percent of complaints were submitted via OFCO's website, 7.3 percent were taken over the phone, and 3.8 percent were submitted through the mail.

Figure 9: **Complaints Received by Year**

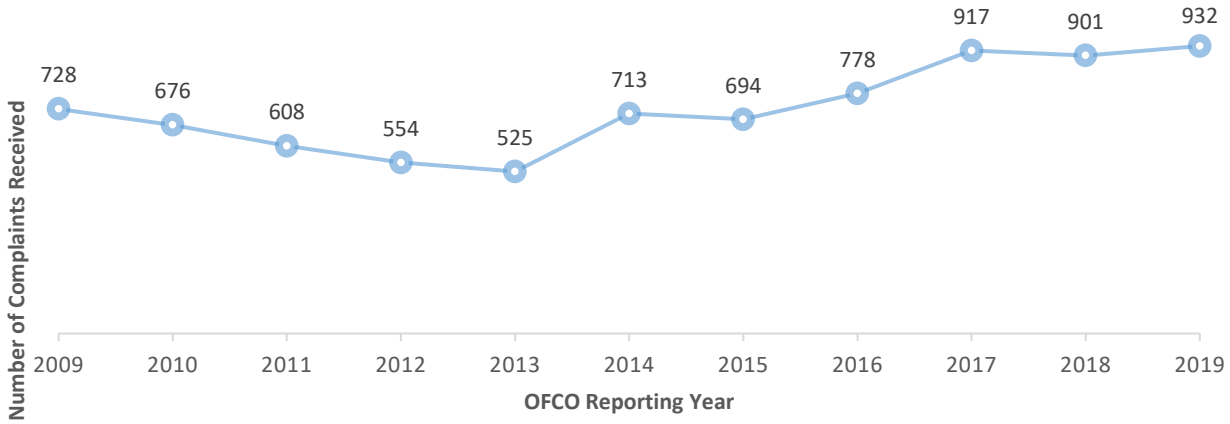
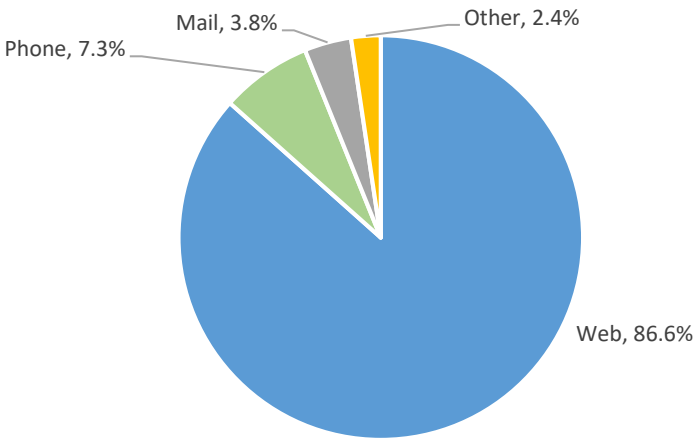


Figure 10: **How Complaints Were Received, 2019**

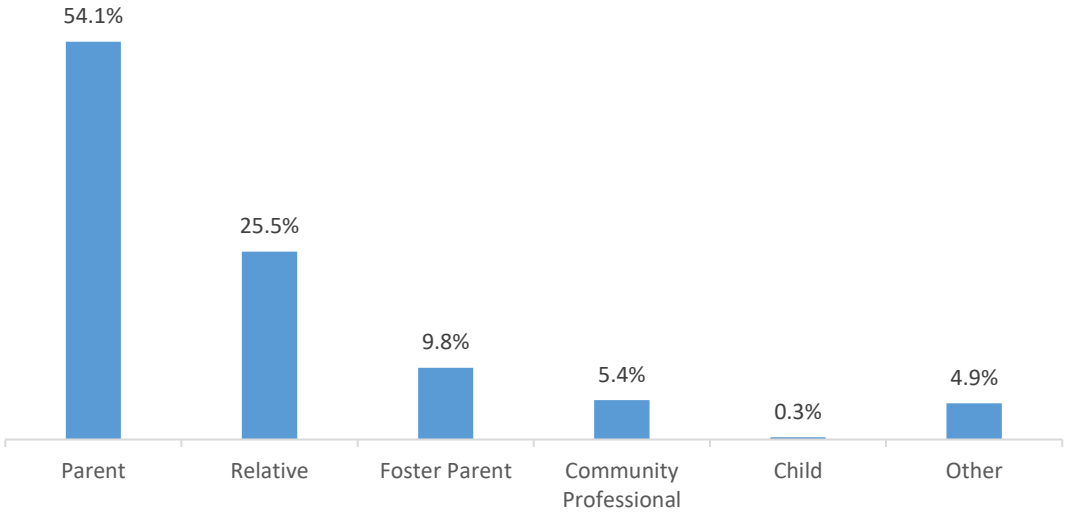


[25] The number of complaints directed at each DCYF region and office is provided in Appendix A.

PERSONS WHO COMPLAINED

Parents, grandparents, and other relatives of the child whose family is involved with the Department of Children, Youth, and Families (DCYF) filed the majority of complaints investigated by OFCO (79.6 percent). Foster parents filed about 10 percent of complaints and community professionals filed 5.4 percent of complaints. As in previous years, few children contacted OFCO on their own behalf.

Figure 11: **Complainant Relationship to Children, 2019**



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

Table 3: **Complainant Race and Ethnicity, 2019**

	OFCO Complainants	Washington State Population[26]	Children in Out-of-Home Care[27]
Caucasian/White	64.6%	79.1%	62.9%
African American/Black	8.2%	4.2%	9.2%
American Indian or Alaskan Native	3.1%	1.8%	4.9%
Asian or Pacific Islander	1.7%	9.8%	2.3%
Multiracial	3.5%	5.2%	20.4%
Other	0.8%	--	--
Declined to Answer	18.1%	--	--
Latino/Hispanic	6.1%	13.3%	19.7%

[26] Office of Financial Management. Population by Race, 2019. http://www.ofm.wa.gov/trends/population/fig306.asp
[27] Partners for Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 9/13/2019]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts

CHILDREN IDENTIFIED IN COMPLAINTS

Of the 1,398 children identified in complaints, 41.2 percent were four years of age or younger and 31.1 percent were between ages five and nine. OFCO receives fewer complaints involving older children, with the number of complaints decreasing as the child's age increases. This closely mirrors the ages of children in out-of-home care through DCYF.[28]

Figure 12: **Age of Children in Complaints to OFCO, 2019**

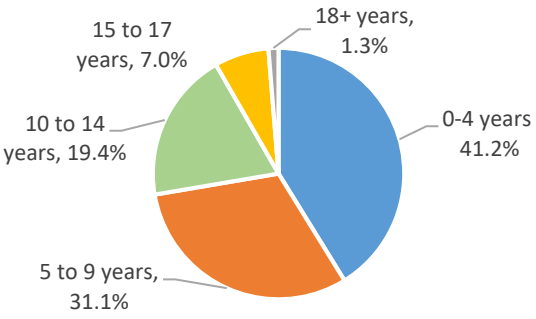


Figure 13: **Age of Children in Out-of-Home Care through DCYF, 2019**

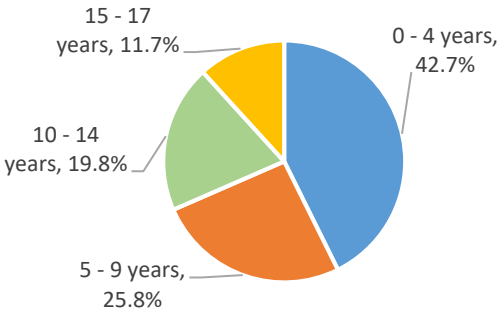


Table 4 shows the race and ethnicity (as reported by the complainant) of the children identified in complaints, compared with children in out-of-home placement through DCYF and the general state population.

Table 4: **Race and Ethnicity of Children Identified in Complaints, 2019**

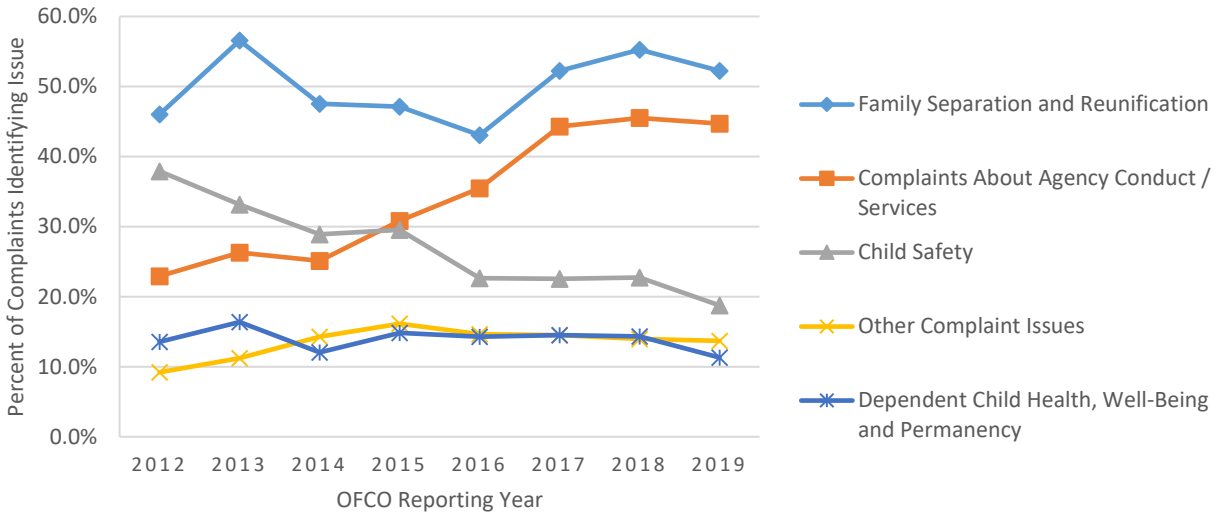
	OFCO Children	Children in Out-of-Home Care[29]	WA State Children (ages 0-19)[30]
Caucasian/White	65.8%	62.9%	73.3%
African American/Black	9.9%	9.2%	4.8%
American Indian or Alaskan Native	4.1%	4.9%	2.4%
Asian or Pacific Islander	1.7%	2.3%	9.1%
Multiracial	16.1%	20.4%	10.4%
Other	0.2%	--	--
Declined to Answer	2.1%	--	--
Latino/Hispanic	14.2%	19.7%	21.7%

[28] Partners of Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 10/20/2019}. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts
[29] Partners for Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 10/20/2019]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts
[30] Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2019. http://www.ofm.wa.gov/pop/asr/default.asp

COMPLAINT ISSUES

Figure 14 displays the categories of issues identified by complainants. Complaints can often be complex and complainants will identify multiple issues or concerns they would like investigated.

Figure 14: **Categories of Issues Identified by Complainants**



FAMILY SEPARATION AND REUNIFICATION

As in previous years, issues involving the **separation and reunification of families** (raised 485 times in complaints) were the most frequently identified in complaints to OFCO. Over half (52 percent) of complaints expressed a concern about separating families and/or not reunifying with parents or other relatives. This category of complaints incorporates a broad spectrum of issues affecting family stability. The most frequently identified concerns include:

- **Failure to provide appropriate visitation** or **contact** between children and their parents or relatives (117 complaints) or **siblings** (7 complaints);
- **Children improperly removed from their parents** (111 complaints) or other relatives (23 complaints);
- Delays in or **failures to reunite family** (91 complaints); and
- **Not placing children with relatives** (85 complaints) or with **siblings** (7 complaints).

CONDUCT OF DCYF STAFF AND AGENCY SERVICES

Issues involving **the conduct of DCYF staff and other agency services** were the next most identified concerns. Complaints about agency conduct or services incorporate a broad range of concerns, including:

- Concerns about **unprofessional conduct** by agency staff (125 complaints) such as **harassment, discrimination, bias, dishonesty or conflict of interest**;
- **Unwarranted or unreasonable CPS interventions** (121 complaints);
- **Communication failures** (98 complaints), such as caseworkers not communicating with parents or relatives;
- **Poor case management, high caseworker turnover, or other poor service** (25 complaints); and
- **Breach of confidentiality** by the agency (21 complaints).

CHILD SAFETY

Complaints involving child safety held constant from 2016 to 2018, but slightly decreased in 2019 by 4 percent. Almost one-third of the 174 child safety complaints concerned **safety risks to dependent children in foster or relative care** (56 complaints). Another 32 percent of child safety complaints alleged a **failure to protect children from abuse or neglect while in their parents' care** (56 complaints). Twenty-six complaints expressed concern about the safety of children being returned to their parents' care and 20 identified safety concerns during parent-child visitation.

DEPENDENT CHILD HEALTH, WELL-BEING, AND PERMANENCY

Complaints involving the **health, well-being, and permanency of children in foster or other out-of-home care** also decreased in 2019 (105 complaints). This category includes problems providing children in out-of-home care with **adequate medical, mental health, educational** or other services (identified in 31 complaints). It also includes complaints about **unnecessary or inappropriate placement changes**, as well as **placement instability**, such as multiple moves in foster care or abrupt placement changes (21 complaints). Fourteen complaints raised concerns about **delays in achieving permanency**.

Table 5 on the following pages show the number of times specific issues within these categories were identified in complaints, as well as other complaint issues.

Table 5: **Issues Identified by Complainants**[31]

	2019	2018	2017
Family Separation and Reunification	485	498	477
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	117	116	120
Unnecessary removal of child from parental care	111	131	106
Failure to reunite family	91	98	81
Failure to place child with relative	85	76	94
Other inappropriate placement of child	32	22	33
Unnecessary removal of child from relative placement	23	24	19
Inappropriate termination of parental rights	8	4	8
Failure to provide sibling visits and contact	7	5	6
Failure to place child with siblings	7	13	4
Other family separation concerns	4	5	3
Concerns regarding voluntary placement and/or service agreements	--	4	3

	2019	2018	2017
Complaints About Agency Conduct	415	411	400
Unprofessional conduct, harassment, conflict of interest or bias/discrimination by agency staff	125	100	102
Unwarranted/unreasonable/inadequate CPS intervention	121	131	131
Communication failures	98	98	97
Poor case management, high caseworker turnover, other poor service	25	12	11
Breach of confidentiality by agency	21	34	17
Inaccurate agency records	13	16	13
Unreasonable CPS findings	10	14	26
Family Assessment Response	7	--	--
Retaliation by agency staff (does not include complaints of retaliation made by licensed foster parents)	2	6	3

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

Child Safety	2019 174	2018 205	2017 206
Failure to address safety concerns involving children in foster care or other non-institutional care	56	84	75
Failure to protect children from parental abuse or neglect	56	78	83
Suspected child abuse	30	34	40
Suspected child neglect	26	40	37
Failure to address safety concerns involving children being returned to parental care	26	24	18
Child safety during visits with parents	20	12	17
Children with no parent willing/capable of providing care	6	6	7
Failure by agency to conduct 30 day health and safety visits with child	6	2	5
Safety of children residing in institutions/facilities	2	1	6

Dependent Child Health, Well-Being, and Permanency	2019 105	2018 129	2017 133
Failure to provide child with adequate medical, mental health, educational or other services	31	52	52
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	21	23	41
Unreasonable delay in achieving permanency	14	7	9
ICPC issues (placement of children out of state)	10	11	1
Inappropriate permanency plan/other permanency issues	9	25	16
Placement instability/multiple moves in foster care	7	1	3
Failure to provide appropriate adoption support services/other adoption issues	4	6	4
Extended foster care/independent living services	3	--	--
Inadequate services to children in institutions	3	--	--
Placement not meeting child's unique needs	2	--	--

Other Complaint Issues	2019 127	2018 128	2017 131
Lack of support/services and other issues related to unlicensed relative or fictive kin caregiver	31	23	26
Failure to provide parent with services/other parent issues	26	39	32
Lack of support/services to foster parent/other foster parent issues	25	14	18
Violation of parents' rights	20	30	24
Foster care licensing issues	10	9	17
Violations of ICWA	8	3	--
Children's Legal issues	5	5	4
Foster parent retaliation	2	5	10

TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES

- Investigating Complaints
- OFCO's Adverse Findings

INVESTIGATING COMPLAINTS

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

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

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

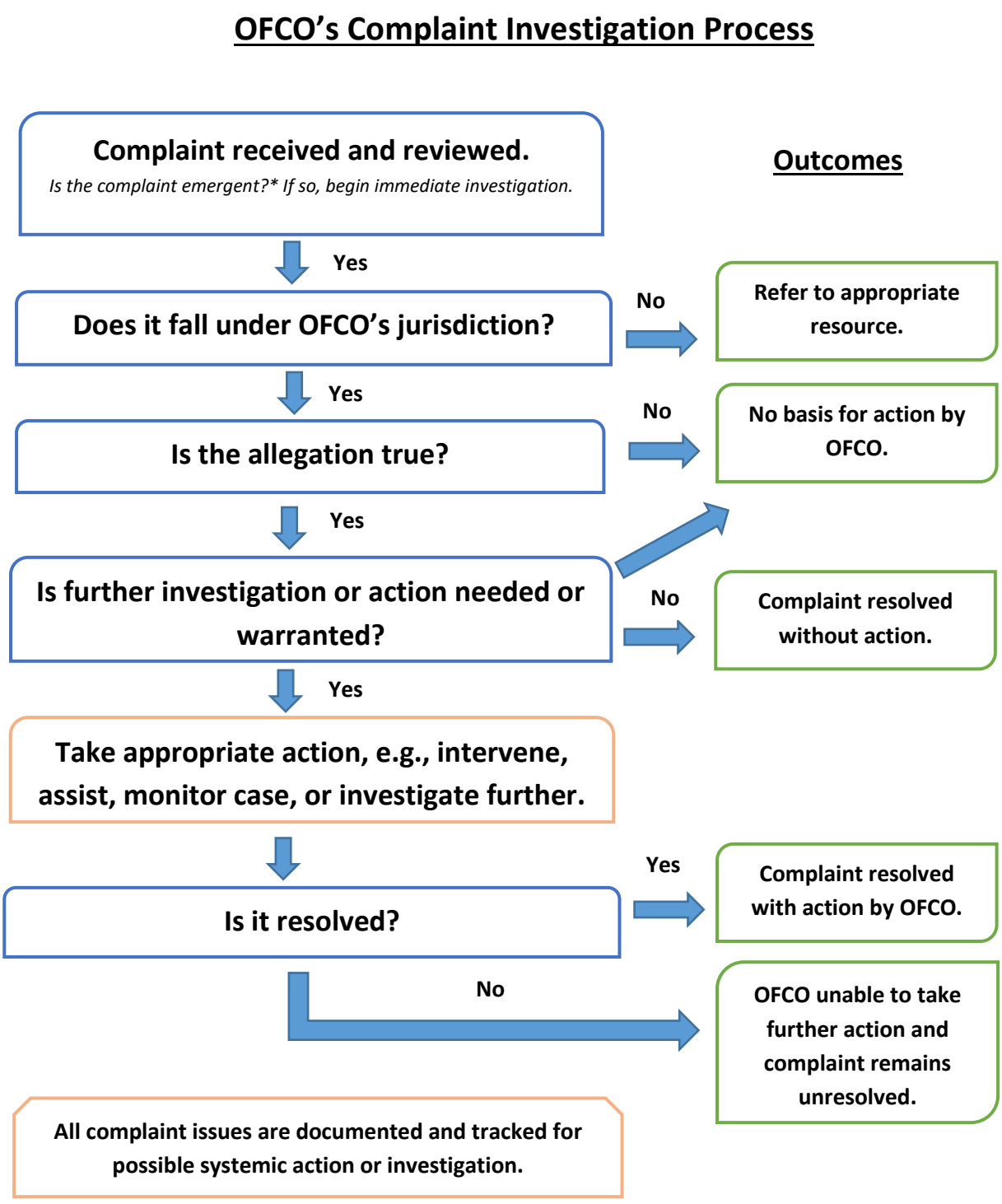
If so, OFCO may respond in various ways, such as:

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

OFCO completed **928 complaint investigations** in 2019. As in previous years, the majority of investigations were **standard, non-emergent investigations** (90.8 percent). Eighty-six complaints met OFCO's criteria for initiating an **emergent investigation,** i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by OFCO could significantly alleviate a child or family's distress. Once a complaint is determined to be emergent, OFCO begins the investigation immediately.

Over the years, OFCO consistently intervenes in emergent complaints at a higher rate than non-emergent complaints. In 2019, **OFCO intervened or provided timely assistance to resolve concerns in 30.2 percent of emergent complaints**, compared with **16.6 percent of non-emergent complaints**.

Figure 15: **How Does OFCO Investigate Complaints?**



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

INVESTIGATION OUTCOMES

Complaint investigations result in one of the following actions:

OFCO Intervention

- OFCO substantiated the complaint issue and intervened to correct a violation of law or policy or to prevent harm to a child/family; OR
- 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

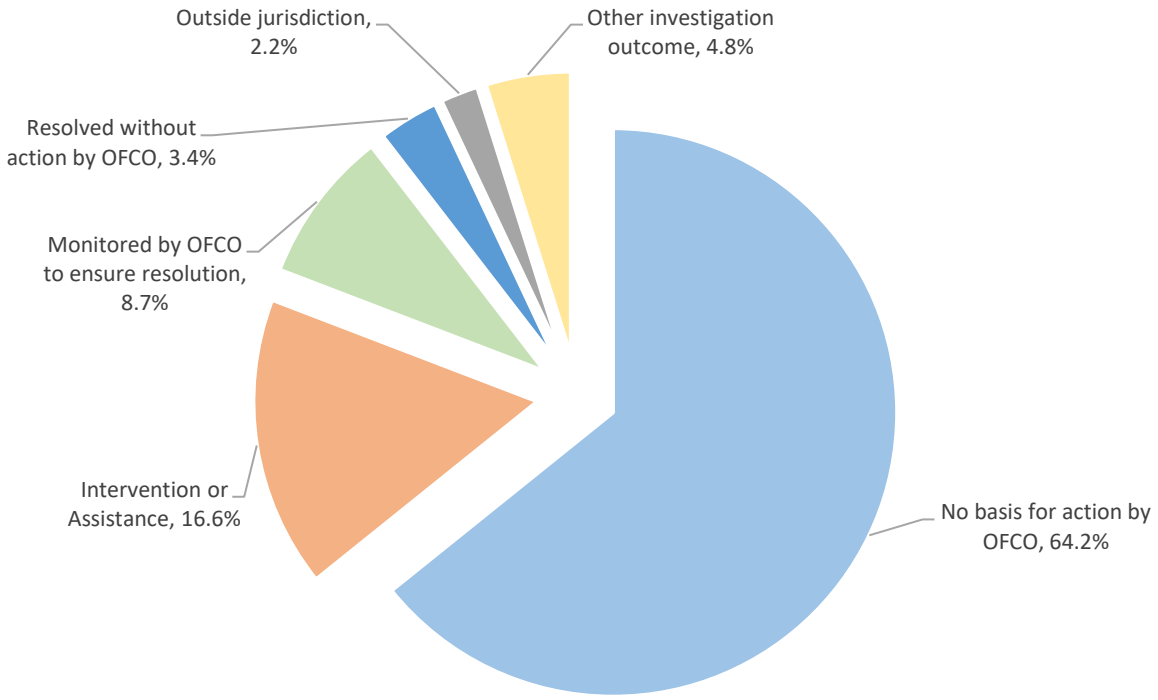
- The complaint involved agencies or actions outside of OFCO's jurisdiction. Where possible, OFCO refers complainants to another resource that may be able to assist them.

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 remained fairly consistent in recent years. OFCO **assisted or intervened** to try to resolve the issue in **16.6 percent of complaints** in 2019 – this represents **154 complaints**. **Eighty-one complaints (8.7 percent)** required careful **monitoring by OFCO** for a period of time until either the identified concerns were resolved, or OFCO determined that there was no basis for further action. OFCO found **no basis for any action after investigating in more than half** of complaints this year (64.2 percent).

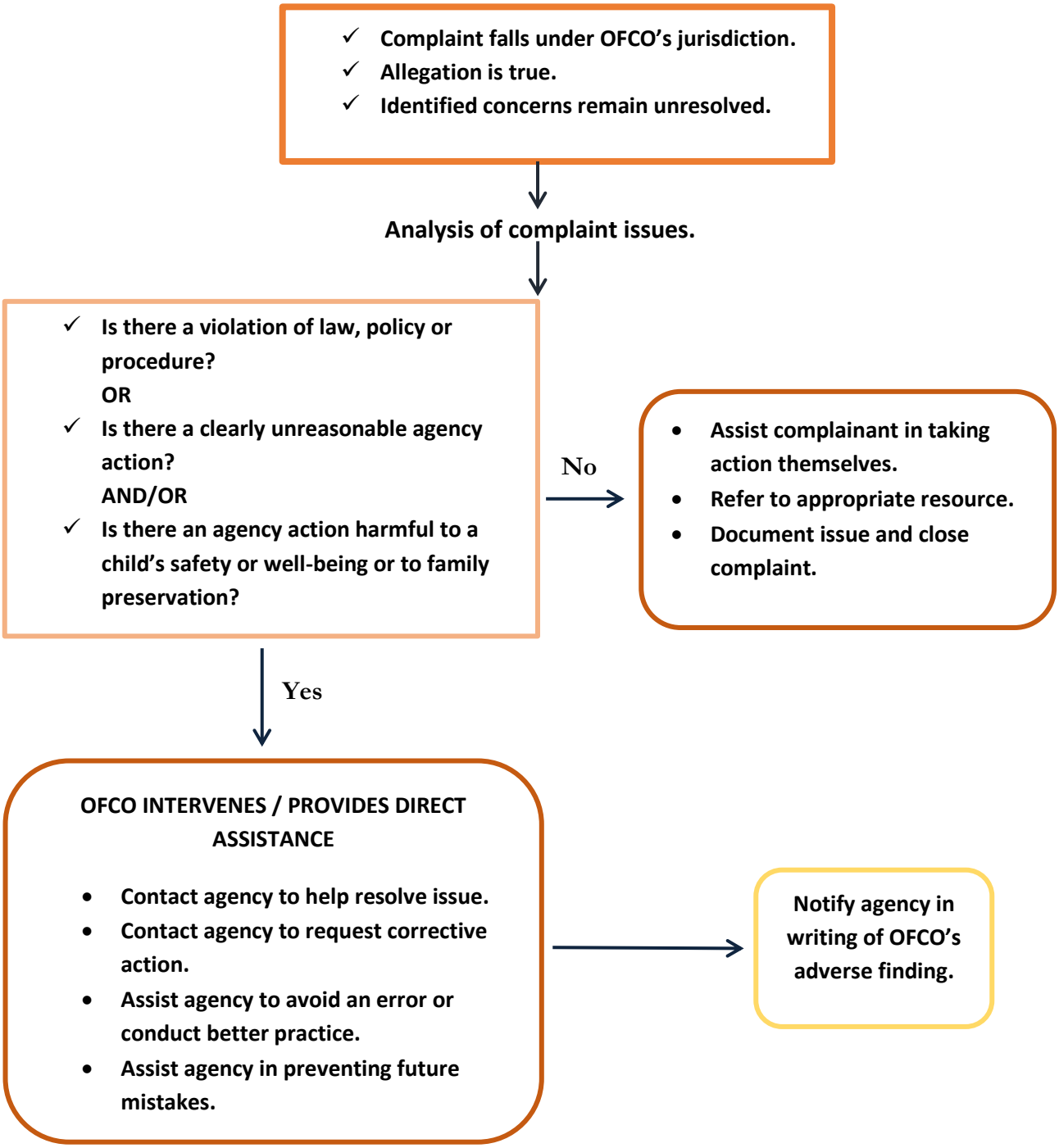
Figure 16: **Investigation Outcomes, 2019**



OFCO IN ACTION

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

Figure 17: **When Does OFCO Take Action?**



OFCO'S ADVERSE FINDINGS

If, after investigation, OFCO substantiates a significant complaint issue, OFCO may make a formal finding against the agency. In some cases, the adverse finding involves a past action or inaction, leaving OFCO with no opportunity to intervene. However, in situations where the agency's action or inaction is ongoing and could cause foreseeable harm to a child or family, the Ombuds intervenes to persuade the agency to correct the problem.

Criteria for adverse findings against the agency:

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

In 2019, OFCO made **47 adverse findings** in a total of 28 complaint investigations. Some complaint investigations resulted in more than one adverse finding. OFCO provides written notice to the DCYF of any adverse finding(s) made on a complaint investigation. The agency is invited to formally respond to the finding, and may present additional information and request a modification of the finding. DCYF provided a written response to all findings but one due to active ligation on that case. In addition to the above 47 adverse findings, OFCO made two other findings that were withdrawn after the Department requested a withdrawal and provided more information to OFCO.

Table 6 shows the various categories of issues related to adverse findings. Over half of all adverse findings in 2019 related to the safety of children (25 findings). These findings include failures to conduct required monthly health and safety visits, inadequate CPS investigations or case management issues, and unsafe placement of a dependent child. One-fourth of all adverse findings involved parents' rights, with delays in completing CPS investigations/CPS FAR or internal review of CPS investigation findings being the most common.

A full list of the adverse findings and the Department's response is summarized in Appendix C.

Table 6: **Adverse Findings by Issue**

	2019	2018	2017
Child Safety	25	18	19
Failure by DCYF to ensure/monitor child's safety			
Failure to conduct required monthly health and safety visits	12	4	6
Unsafe placement of dependent child	6	4	5
Failure to complete safety assessment	5	3	4
Inadequate CPS investigation or case management	2	5	3
Other child safety findings		2	1
Parents' Rights	12	9	11
Delay in completing CPS investigation/CPS FAR or internal review of findings	9	3	9
Failure to communicate with or provide services to parent	2	1	--
Failures of notification/consent, public disclosure, or breach of confidentiality	1	5	2
Other violations of parents' rights			
Family Separation and Reunification	4	3	7
Failure to place child with relative	3	--	2
Failure to provide appropriate contact / visitation between parent and child	1	2	2
Failure to provide contact with siblings	--	1	3
Dependent Child Well-being and Permanency	2	4	4
Other dependent child well-being and permanency finding	2	1	--
Delay in achieving permanency	--	1	3
Failure to provide medical, mental health, education or other services	--	2	1
Poor Casework Practice Resulting in Harm to Child or Family	1	0	3
Inadequate documentation of casework	1	--	2
Poor communication among DCYF divisions (CPS, CFWS, DLR)	--	--	--
Other poor practice	--	--	1
Foster Parent/Relative Caregiver Issues	3	3	8
Other foster parent / caregiver issues	2	3	1
Issues relating to child's removal from foster placement	1	--	7
Other Findings	0	3	0

Number of findings	47	40	52
Number of closed complaints with one or more finding	28	30	36

ADVERSE FINDINGS BY DCYF REGION

Thirty-eight percent of adverse findings made by OFCO in 2019 involved DCYF Region 6. The number of adverse findings are further broken down by office in Table 10 in Appendix B.

Table 7: **Adverse Findings in Complaint Investigations by DCYF Region, 2019**

	Number of Findings	Percent of 2019 Findings
Region 1	1	2.1%
Region 2	7	14.9%
Region 3	6	12.8%
Region 4	9	19.1%
Region 5	6	12.8%
Region 6	18	38.3%

APPENDICES

APPENDIX A:

Complaints Received by Region and Office

APPENDIX B:

Adverse Findings by Office

APPENDIX C:

Summaries of OFCO's Adverse Findings

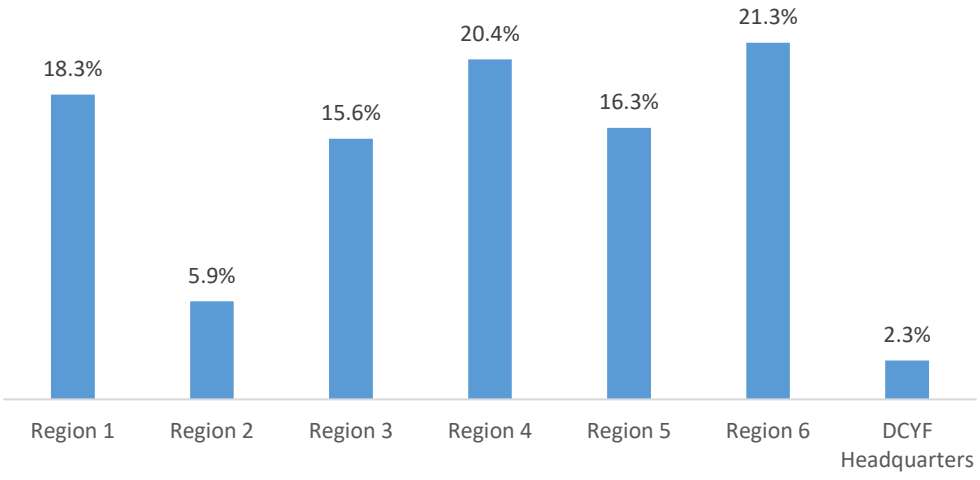
APPENDIX A: COMPLAINT INVESTIGATIONS BY REGION AND OFFICE

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

Table 8: **Populations by DCYF Region**[32]

DCYF Region	Children Under 18 Years Residing in Region	Percent of Washington State Children Under 18 Years
Region 1	219,525	13.2%
Region 2	186,903	11.2%
Region 3	272,251	16.3%
Region 4	454,543	27.3%
Region 5	266,647	16.0%
Region 6	267,033	16.0%

Figure 18: **OFCO Complaint Investigations Completed by DCYF Region, 2019**



[32] Partners for Our Children Data Portal Team. (2018). [Graph representation of Washington state child welfare data 10/21/2019]. Count of All Children. Retrieved from http://www.vis.pocdata.org/maps/child-populationregions .

Table 9: **OFCO Complaint Investigations Completed by Office, 2019**

Region	Office	
1	Spokane DCFS	93
	Moses Lake DCFS	31
	Colville DCFS	12
	Wenatchee DCFS	10
	Clarkston DCFS	5
	Omak DCFS	5
	Colfax DCFS	3
	Newport DCFS	2
	Republic DCFS	1
	DLR (Region 1)	3
2	Yakima DCFS	19
	Richland DCFS	13
	Walla Walla DCFS	6
	Ellensburg DCFS	5
	Goldendale DCFS	5
	White Salmon DCFS	3
	Sunnyside DCFS	1
	Toppenish DCFS	1
3	Smokey Point (Arlington)	35
	Everett DCFS	25
	Lynnwood DCFS	22
	Bellingham DCFS	17
	Mount Vernon DCFS	17
	Sky Valley (Monroe) DCFS	14
	Oak Harbor DCFS	5
	Friday Harbor DCFS	2
	DLR (Region 3)	4

Region	Office	
4	King West DCFS	38
	King East (Bellevue) DCFS	30
	King South-West DCFS	34
	Martin Luther King Jr. DCFS	33
	King South-East DCFS	29
	Office of Indian Child Welfare	14
	White Center DCFS	2
	DLR (Region 4)	4
5	Puyallup DCFS	41
	Tacoma DCFS	40
	Lakewood DCFS	36
	Bremerton DCFS	23
	DLR (Region 5)	7
6	Vancouver-Cascade DCFS	27
	Vancouver-Columbia DCFS	24
	Tumwater DCFS	35
	Kelso DCFS	25
	Centralia DCFS	22
	Aberdeen DCFS	19
	Shelton DCFS	16
	Port Angeles DCFS	11
	Stevenson DCFS	3
	Port Townsend DCFS	2
	South Bend DCFS	3
	Long Beach DCFS	1
	DLR (Region 6)	5
Other	Central Intake Unit	19
	Adoption Support Services	2
	Other agency/Non-DCYF agency	25

APPENDIX B:
ADVERSE FINDINGS BY OFFICE

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

Table 10: **Adverse Findings by Office, 2019**

Region	Office	Number of Findings
Region 1	Wenatchee DCFS	1
Region 2	Goldendale DCFS	4
	Richland DCFS	2
	Yakima DCFS	1
Region 3	Friday Harbor DCFS	3
	Smokey Point DCFS	2
	Everett DCFS	1
Region 4	Office of Indian Child Welfare	3
	King South-West DCFS	3
	King East DCFS	1
	King South-East DCFS	1
	Martin Luther King Jr DCFS	1
Region 5	Puyallup DCFS	3
	Tacoma DCFS	3
Region 6	Vancouver-Columbia DCFS	7
	Vancouver-Cascade DCFS	2
	Centralia DCFS	4
	Kelso DCFS	3
	Aberdeen DCFS	2

APPENDIX C:
SUMMARIES OF OFCO'S ADVERSE FINDINGS

CHILD SAFETY

CPS investigative activities were not completed in a timely manner.

OFCO received a complaint in September 2018 alleging that multiple CPS investigations involving a family were not conducted in a manner consistent with DCYF policies.

In July 2018, CPS received an intake alleging physical abuse of a five-year-old child. The CPS investigator completed the initial face-to-face contact with the child that same day at the child's school, as well as a collateral contact with the child's teacher. The caseworker asked the mother to take the child into the emergency room, which she did. There were no further investigative activities for approximately two months

OFCO contacted the Department about delays completing this investigation and was informed that the caseworker was moving to a new unit and the case would be closed within a month.

In November 2018, a newly assigned caseworker contacted the father for a subject interview and asked him to complete a UA, which the father refused. The investigation remained open in January 2019 at which point the Department invited the parents to a Family Team Decision Making meeting and neither parent showed up. The investigation was closed in January 2019, over six months from when the intake was received.

OFCO found that investigative activities were not completed in a timely manner, the investigation remained open well beyond required timeframes, and the agency did not conduct required health and safety visits. CPS also did not notify subjects as to the outcome of the CPS investigation in a timely manner. In reviewing case records, OFCO also discovered in two other CPS investigations involving this family that the Department had not notified the parents in a timely manner that CPS substantiated allegations of child maltreatment and their right to challenge these findings.

- ***Violation of DCYF Practices and Procedures Guide, 4700:***
  CPS investigations must be completed within 90 days of the date of referral. This investigation remained open for just over 6 months.

- ***Violation of DCYF Practices and Procedures Guide, 2331(4)(b)(viii)***.
  DCYF must conduct monthly health and safety visits with children identified in a CPS investigation open longer than 60 days. In the six months the case was open, the alleged victim was seen for an initial face-to-face visit the day the intake was received and the other

child in the home was seen about 3.5 months after the intake was received. No health and safety visits occurred.

- ***Unreasonable Delay of DCYF Practices and Procedures Guide, 2559B (CPS Investigative Findings Notification)*:** Although this policy does not specify a timeline for notifying the subject of an investigation of the finding, OFCO found the delay in notifying the subjects in the investigations to be clearly unreasonable.

- ***Unreasonable delay: CPS Investigation not completed in a timely manner:***
  The delay in interviewing the alleged perpetrator (four months after the referral was received) and completing other required investigative activities was clearly unreasonable.

DCYF Response:

DCYF indicated that the local office developed weekly action plans for cases that have remained open for more than 60 days and would be implementing the following strategies to improve timeliness and provide consistency in completing health and safety visits:

- Require all workers to complete pending work before transferring to another unit;
- Supervisors will meet with each CPS worker in the office to ensure the workers understand the requirements of DCYF Practices and Procedures Guide 4700;
- Supervisory meetings will be changed from monthly to weekly with the goal of supporting staff to complete cases within 60 days and ensuring health and safety visits are completed on cases that have been open longer than 60 days.

CPS investigative activities were not completed in a timely manner, an investigation remained open beyond required timeframes, and the agency did not conduct health and safety visits.

In July 2018, CPS received a report following a child fatality and concerning the welfare of other children in the home. This report was opened for investigation. In November 2018, OFCO contacted the Department about the lack of documented case activities assessing the safety of these children and was informed that the case worker had not yet entered the case notes, which would be corrected.

Case records show the case worker attempted a home visit three days after the intake was received in July but no one was home. The worker attempted a home visit in September 2018 and again in October 2018, and left a voice message for the mother in November 2018, the day after OFCO contacted the Department. The first contacts with any of the children occurred in mid-November 2018, over four months after the intake was received.

- ***Violation of DCYF Practices and Procedures Guide, 4700:***
  CPS investigations must be completed within 90 days of the date of referral. This investigation remained open for five months.

- ***Violation of DCYF Practices and Procedures Guide, 2331 (b)(viii):***
  Monthly health and safety visits must be conducted with children identified in a CPS case investigation open longer than 60 days. In the five months that the CPS investigation was open in this case, the children were first seen over four months after the intake was received and no health and safety visits occurred.

DCYF Response:

DCYF indicated that the Area Administrator counseled both the assigned worker and the supervisor.

DCYF did not adequately assess a relative before placement.

Following a Family Team Decision Making (FTDM) meeting in mid-October 2016, a newborn was placed with her paternal great grandmother. Notes from this meeting indicate the social worker would run a criminal background check on the great-grandmother and assess the home. An emergent placement NCIC, BCCU, and fingerprinting were all initiated the same day and approved, but an assessment of the home did not occur until two weeks after placement. The Division of Licensed Resources sent a home study packet to the great grandmother in June 2017.

In August 2018, nearly two years after the child was placed in her home, the great grandmother's home study was denied due to her extensive CPS history and misdemeanor criminal history. The great grandmother later passed a private home study and the agency did not seek to change placement due to the success of the great grandmother as a caregiver, the length of time since the great grandmother's history, and other factors.

- ***Violation of DCYF Practice and Procedures Guide, 45274 and 6800:***
  Before placement, the caseworker must assess the suitability of the caregiver.
  There was no documentation that a FamLink check or check of other DCYF electronic and hard file records were completed as required by policy. The home study was also delayed and the home study packet was not mailed to the great grandmother until nearly eight months after placement.

DCYF Response:
DCYF acknowledged that neither the walk-through nor a FamLink check were documented in FamLink. However, it was information that arose during the home study assessment process and not necessarily information from the walk through or FamLink that resulted in the home study denial. Nonetheless, the failure to complete them timely were a violation of policy and concerning. DCYF indicated that the local Administrator sent an email to the office staff addressing the requirements of the Department's policies concerning unlicensed placements and background checks.

CPS did not complete investigations or conduct subject interviews, Safety Assessments, or health and safety visits in a timely manner.

Between July 2018 and May 2019, CPS received 11 intakes alleging maltreatment of two non-dependent children. One intake screened in for CPS Family Assessment Response (FAR) and four intakes screened in for CPS investigation:

In October 2018, the school counselor reported to CPS a bruise on one of the children's hand. The intake screened in for a CPS FAR. The social worker completed an initial face-to-face (IFF) interview with the child a couple days after but there was no other documented investigative activities regarding this intake following the IFF until March 2019.

In November 2018, the school counselor reported to CPS the child disclosed physical abuse by his mother's boyfriend. The intake screened in for a CPS investigation. An IFF was completed with the child five days later but there were no other documented investigative activities regarding this intake or the intake from October 2018 until March 2019.

In February 2019, CPS again received a report of a bruise on one of the children and that the child disclosed physical abuse by the mother's boyfriend. An IFF interview was completed with the child a few days later. There were no other documented investigative activities regarding this intake, until March 2019.

In March 2019, the school counselor reported to CPS that the child again disclosed physical abuse by the mother's boyfriend. An IFF was completed the following day. The social worker also met with the child's mother during which the mother said she would be open to in-home services.

In April 2019, the school counselor reported that the child disclosed another incident of physical abuse by the mother's boyfriend. An IFF was completed with the child the next day. The social worker also met with the mother's boyfriend and discussed in-home services.

OFCO found that the interviews of the mother and her boyfriend, who were identified as alleged subjects in multiple intakes, did not occur timely. The social worker spoke to the mother for the first time in March 2019, five months after the initial screened-in intake. Due to delays in the subject interviews, sufficient information was not gathered to assess the safety and risk to the children in a timely manner.

Safety assessments for intakes received in October 2018, November 2018, February 2019, and March 2019 were not initiated until June 2019, beyond the 30 calendar day requirement. Additionally, there was no documentation of face-to-face contact or attempts to make contact with either child in November 2018, January 2019, or May 2019. OFCO contacted the Department in late May 2019 regarding four CPS intakes being open beyond required time frames and the investigations were subsequently closed in early June 2019.

- ***Violation of DCYF Practices and Procedures Guide, 2331 (4)(c)(i):***
  Parents and alleged subjects are to be notified of any allegations of child abuse and/or neglect "at the initial point of contact". The social worker spoke to the children's mother for the first time in late March 2019, five months after the initial screened-in intake, and interviewed the mother's boyfriend in early May 2019, approximately seven months after the initial screened-in intake.

- ***Violation of DCYF Practices and Procedures Guide, 2331(4)(d)(i):***
  *Safety Assessment must be completed within 30 calendar days from the date of the intake.*CPS did not complete the Safety Assessments for the four intakes timely.

- ***Violation of DCYF Practices and Procedures Guide, 4420 and 2331(4)(b)(viii):***
  Monthly health and safety visits must be conducted with children identified in a CPS investigation open longer than 60 days. This case had been open continuously since July 2018; however, there was no documentation of face-to-face contact or attempts to make contact with either child in November 2018, January 2019, or May 2019.

- ***Violation of CA Practices and Procedures Guide, 2331(4)(d)(iv) and RCW 26.44(12)(a):***
  CPS investigation must be closed within 60 calendar days and 90 days respectively, from the date that CPS receives the intake. The investigations of four screened-in intakes received between October 2018 and March 2019 were closed in early June 2019. The investigation of the March 2019 intake resulted in a founded finding against the mother's boyfriend for physical abuse of one of the children.

DCYF Response:
In response to the concerns raised in this case, a training was held for staff in the DCYF office addressing the importance of timely investigations, Safety Assessments, subject interviews, and health and safety visits. DCYF also reported that the supervisor is using data reports to monitor intakes open over 90 days.

DCYF did not thoroughly assess relative caregivers.

The court ordered these children placed with unlicensed relatives over the Department's objections: one child was placed with an uncle and the other child was placed with their grandmother. The caseworker did not refer either relative for a home study until the children had been placed in these homes for 17 months.

During the home study process, DLR identified a number of concerns with both relatives, including recent criminal history, individuals in the home in violation of a no-contact order, and that one of the relative's spouse is a registered sex offender. Due to these concerns, both relative caregivers' home studies were denied in 2017. However, the Department did not notify the court and recommend removal of the dependent children until the spring of 2018.

The court then ordered one child to be removed from the grandmother's home, but ordered the other child to remain in the uncle's care. As a result of these delays, there was an adverse impact on the children's permanency. One child was moved to another relative's home after living with the grandmother for the majority of his life.

OFCO found the delay in completing the background check and home study of unlicensed caregivers to be unreasonable and a violation of DCYF policy. Additionally, there was an unreasonable delay in taking action to remove the children once the home studies were denied.

- ***Unreasonable delay in adequately assessing unlicensed relative caregivers through the timely completion of required background checks and timely referral for home study as required by DCYF Practices and Procedures Guide, 45274 and 6800:***
  The caseworker will provide the unlicensed caregiver with the appropriate forms needed to request a home study. Once the documents have been completed, the caseworker will submit

the required documents to DLR ***within 30 days*** *of the placement.* OFCO found a 17 months delay in completing the background checks of unlicensed caregivers to be unreasonable and a violation of DCYF policy. Additionally, the caseworker did not refer the relatives for a home study until 17 months after the children had been placed.

- ***Unreasonable delay in taking action to move the dependent children from unlicensed relative caregivers following the home study denial. DCYF Practices and Procedures Guide, Section 45274(5).***
  The child must be moved from the placement if the unlicensed caregiver's home study is not approved for that child. The Department did not notify the court and recommend removal of the children in a timely manner following the home study denials.

DCYF Response:
The Department did not dispute OFCO's findings. The Area Administrator implemented a process for tracking home study applications.

DCYF did not adequately assess an unlicensed suitable adult caregiver.

DCYF CPS filed a dependency petition for three children. All three children were placed with the father of two of the children allowing siblings to remain together. The father was not a licensed foster parent, nor related to one of the children.

During the initial walkthrough of the home, the caregiver completed a background check form. Two weeks later, the caregiver's CPS history, which include two prior founded findings of child maltreatment, was discovered and the child was removed from this home. This oversight resulted in a placement change for the child and the agency's opposition to keeping all siblings in the same home was confusing and frustrating to the caregiver.

In this case, OFCO found that DCYF did not adequately assess the unlicensed suitable adult caregiver prior to placing a child in this person's care.

- ***Failure to assess the suitable adult prior to placement as required by Practices and Procedures Guide, 4527 and 6800.***
  The caseworker must . . . verify the completion of required activities . . . including Child Protective Services history checks for each household member. DCYF did not conduct an adequate check of FamLink records and assessing the character, suitability, and competence of the suitable adult caregiver before placing child in the home.

DCYF Response:
The Department agreed with the OFCO's finding and indicated they had taken steps to avoid similar incidents in the future. This includes:

- Requiring caseworkers in this office to review the DCYF policy on background checks;
- Using a checklist to confirm that the assigned caseworker confirmed an unlicensed caregiver's background has been checked and that they reviewed FamLink before placing a child;
- Requiring that any time a child will be placed with an unlicensed caregiver, the assigned caseworker and supervisor must review and complete the placement process together; and

- Training for office staff related to the investigative process before a child can be placed with an unlicensed caregiver.

Inadequate assessment of relative caregiver and monthly face-to-face health and safety visits did not occur.

In March 2018, DCYF filed a dependency petition on a 16-year-old who was abandoned by his parents. The youth was placed with suitable adult caregivers from mid-March 2018 until early June 2018 when he moved in with his adult siblings. Prior to these placements, the Department held Family Team Decision Making meetings (FTDMs) and completed background checks on the caregivers. In September 2018, the youth informed the Department that he was no longer living with his adult brother and was now living in his uncle's home. The following day, the DCYF supervisor met with the youth and his uncle at the uncle's home. The uncle denied having any criminal history and reported that the youth could stay with him as long as he needed.

OFCO found that there was no documentation that adequate assessment of the uncle occurred once DCYF learned of the placement. Additionally, there was no documentation that the youth's uncle was ever referred for a home study.

The youth's uncle had CPS history involving his own children and was also identified as a perpetrator of alleged sexual abuse of a niece. While the youth was placed with his uncle, CPS received seven intakes regarding the uncle's children. One of the four intakes screened in for CPS Family Assessment Response with concerns about the uncle's mood swings, drug use, and exposing his children to pornography.

During health and safety visits following placement with his uncle, the youth also reported concerning information about his uncle, including locking the youth out of the home and charging the youth rent. The youth was moved from the uncle's home in late January 2019 after a FTDM, during which the youth reported multiple concerns about his placement including that he was not allowed access to the shower or bathroom at times, inadequate food, concerns about his uncle's mood swings, and rats in the home.

- ***Violation of DCYF Practices & Procedures Guide, 4527:***
  When a child is placed with a relative or "suitable other", the Department must complete a Background Authorization form; Child Protective Services (CPS) history checks for each household member; character, competence and suitability assessment; and assess the caregiver's ability and willingness to provide a safe home and meet the child's various needs; a walkthrough of the caregiver's home and property; and a Home Study referral within 30 calendar days of the start of placement. DCYF did not assess the relative caregiver's ability to provide safe care to the child to meet his needs on an ongoing basis. There is no documentation that the uncle was ever referred for a home study.

- ***Violation of DCYF Practices & Procedures, 4260(7)(a):***
  DCYF must document in FamLink a child's move within three business days of the move.
  The dependent youth's placement with his uncle was not documented in FamLink.

- ***Violation of DCYF Practices & Procedures, 4420(3):***
  DCYF must conduct monthly face-to-face visits with out-of-home caregivers. There is no documentation following DCYF's initial contact with the child and his uncle in September 2018 or further in-person contact with the uncle. Because the Department did not conduct monthly visits with the uncle between October 2018 and January 2019, the agency missed opportunities to address the concerns later raise by the youth.

DCYF Response:
The Department concurred with the findings and noted that a new supervisor had been assigned to the case with the expectation that she manage her unit while also covering this case. The Department reported that the supervisor should not have been expected to cover this case and supervise a unit. The Deputy Regional Administrator has communicate new expectations regarding cases that need coverage due to a vacancy. The office management team would also review policies and expectations, specifically as it relates to assessing and monitoring suitability of placements.

CPS investigative activities were not completed in a timely manner, the investigation remained open beyond required timeframes, and the agency did not conduct required health and safety visits.

In April 2018, in response to a report of domestic violence involving the presence of a child, law enforcement arrested the father and advised the mother to take the child to the hospital and not allow the child to see her father until CPS made contact with the family. Law enforcement reported this incident to CPS and the intake screened in for CPS investigation.

The CPS investigator attempted to see the 10-year-old child within required time frames and finally located the child in school for an initial face-to-face interview one week after the intake was received. The social worker interviewed the mother in June 2018. The subject interview and collateral contacts occurred in July and August 2018. In August 2018, the case was reassigned to another social worker who subsequently conducted investigative interviews and requested and received the police reports from the incident. The newly assigned social worker also conducted a health and safety visit with the child in mid-August 2018, two days prior to the investigation being closed.

- ***Violation of DCYF Practices and Procedures Guide, 2331(4)(b)viii:***
  Monthly health and safety visits must be conducted with children identified in a CPS case investigation open longer than 60 days. In this case, the CPS intake was received in early April 2018. There was no documentation that a health and safety visit occurred with the alleged victim in June 2018 or July 2018. The child was seen in August 2018 prior to case closure.

- ***Violation of DCYF Practices and Procedures Guide, 2331(4)(d) iv and RCW 26.44 (12)(a):***
  DCYF must complete the investigative assessment on all investigations within 60 calendar days and 90 days respectively, from the date that the intake is received. The intake was received in early April 2018 and the investigative assessment was completed and approved in mid-August 2018. The investigation was open for 135 days.

- ***Unreasonable delay - Investigative activities were not completed timely:***
  The interview of the subject (father) and completion of other required investigative activities, such as collateral contacts, did not occur until approximately four months after the intake was received. This delay was unreasonable.

DCYF Response:
The Department concurred with the findings and reported that the local office experienced significant vacancies during this time and addressed performance issues specifically with the assigned worker and the unit. The Department noted the Area Administrator developed an action plan intended to increase case closures within required time frames.

CPS did not conduct a Safety Assessment or engage a family in the Family Assessment Response (FAR) in a timely manner.

CPS received an intake alleging physical abuse of a seven-year-old in the home of her father and stepmother. The intake was screened in for CPS Family Assessment Response (FAR).

A CPS social worker and a police officer conducted an initial face-to-face with the child the following day. Following the child interview at school, the social worker and police officer contacted the child's stepmother and called the father to speak with him about the allegations.

The next documented contact with the family was an unannounced visit to the family home over two months later. During this visit, the social worker gathered comprehensive information about the family to assess child safety and the family's needs and strengths. Several days later, the social worker returned to the family home with various household items to assist the family. The case was approved for closure the next month, 113 days after the intake was received.

OFCO found that the two month delay in engaging the family in FAR to identify services or support to be clearly unreasonable, especially given that a FAR case must generally be closed within 45 calendar days from the date of the intake.

- ***Violation of DCYF Practices and Procedures, 1120(1)(a):***
  Safety Assessment must be completed within 30 days of receipt of the intake.
  The Safety Assessment was not completed within 30 days. The Safety Assessment was initiated and approved over two months after the intake was received.

- ***Delay in engaging the family in the Family Assessment Response program, DCYF Practices and Procedures, 2331(4) and RCW 26.44.030(13):*** *Per policy, a FAR case must be closed within 45 calendar days from the date the intake was received, unless the parent or caregiver consents to the case remaining open for up to 120 calendar days.* There was more than 60 days delay in engaging the family in FAR.

DCYF Response:
The Department acknowledged that the FAR case was not completed within policy timelines. They noted that the FAR program experienced an increase in cases during the three month period that the Department received this intake and was unable to enlist help from other units due to vacancies. In response to this finding, all staff in the local office attended a mandatory training on Safety

Assessments and that the Area Administrator would conduct a monthly audit of Safety Assessments until the local office achieves compliance with timelines.

The safety of a child in the home was not timely assessed, CPS FAR cases were open beyond required time frames, and the agency did not conduct required health and safety visits.

In January 2019, CPS received a report of physical abuse of a 10-year-old child by her mother and stepfather. The intake identified that there was also a 13-year-old in the home. The intake screened in for CPS FAR.

The FAR social worker conducted an initial face-to-face interview with the child three days later and met with the mother and stepfather who reported that they had been working with a mental health therapist for the child. The social worker contacted the mother there days later to get an update regarding the child's mental health treatment needs. There was limited documentation of case activities for the next month, other than the completion of the safety assessment. The social worker conducted a face-to-face interview with the 13-year-old child in the home and a collateral contact with a friend of the mother's nearly two months after the intake was received.

In April 2019, CPS received an intake from the mental health therapist reporting that the child texted her mother had hit her. The intake screened in for CPS FAR. An initial face-to-face interview was conducted with the 10-year-old within the required time frames. The social worker interviewed the 13-year-old child at school one week after the intake was received. The case remained open with limited documentation of case activities in May and June 2019 with the exception of an inquiry from the father asking if the assessments had been completed so he could request the CPS records.

OFCO contacted the Department in July 2019 and asked about the status of the case. The case was then reviewed with the supervisor, a health and safety visit was completed, and the case was closed.

- ***Violation of DCYF Practices and Procedures Guide, 2332(2)(b) and DCYF Practices and Procedures Guide 1120(1)(a):***
  All children in the home not identified as victims must be seen face-to-face prior to the completion of the safety assessment and a safety assessment must be completed on all screened in CPS intakes no later than 30 calendar days from the date of the intake. The safety assessments for both intakes were not completed timely. The safety assessment for the first intake occurred more than one month later and over three months later for the second intake. Additionally, the 13-year-old child in the home was not interviewed prior to the completion of the safety assessment.

- ***Violation of DCYF Practices and Procedures Guide, 2332(3)(e):***
  DCYF must conduct monthly health and safety visits with children identified in a CPS FAR case open longer than 60 days. In the six months the case was open, the 10-year-old child was seen for initial face-to-face visits timely after the intakes were received then for one health and safety visit prior to the case closing. The 13-year-old child was seen face-to-face two months after the initial intake, briefly after the second intake, and once more prior to closing.

- ***Violation of DCYF Practices and Procedures Guide, 2332 (4):***
  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(13). Neither intakes were closed within the required time frames. The case was closed six months after the initial intake and three months after the second intake.

DCYF Response:
DCYF indicated that workload and staffing issues regarding intake volume in the local office contributed to the issues in this case. However, vacancies had recently been filled which would likely improve practice in that office. Additionally, the Area Administrator would meet with CPS and FAR supervisors weekly to review data and develop strategies and weekly action plans to reduce the number of overdue cases.

Health and safety visits did not occur.

A 12-year-old child had been in out-of-home placement since June 2017. Due to emotional and behavioral difficulties, the child experienced multiple placements. The child had several hotel stays and had been placed in over 10 foster homes including therapeutic foster homes. The child was placed at an out-of-state residential treatment center in mid-August 2018.

Between mid-August 2018 and late December 2018, the worker documented that health and safety visits by a state case worker where the child resided occurred in late September 2018, late October 2018, and early November 2018 by an ICPC worker. There was no other information included about the health and safety visits.

In December 2018, Washington State CPS intake received a report that law enforcement was investigating alleged sexual abuse of this child by another resident. The social worker contacted the treatment facility for more information regarding the investigations and was informed that there were two different law enforcement investigations occurring: one where the child told police he was raped by another resident and a second where the child may have been a witness to sexual touching among other residents.

After speaking with the social worker, OFCO found that monthly face-to-face visits had in fact not occur with the child between mid-August 2018 and late December 2018. The social worker was under the false assumption that the other state's social service agency was involved and that a social worker was assigned to complete health and safety visits with the child. Had health and safety visits occurred, DCYF would have had more information from the youth and the facility staff regarding safety concerns that were raised during that time.

- ***Violation of DCYF Practices and Procedures Guide, 4535(4)(f) and 4420(2):***
  For out-of-state placements of dependent children, DCYF must follow Health and Safety Visit with Children and Monthly Visits with Caregiver and Parents policy (4420). This may include contracting with an out-of-state provider to perform documentation of these visits to ensure the child's needs are met. Children in DCYF custody must receive private, individual face-to-face health and safety visits every calendar month. In this case, a timely request for courtesy

supervision to conduct health and safety visits with the child was not made and health and safety visits did not occur between mid-August 2018 and late December 2018.

DCYF Response:
The Department did not dispute OFCO's findings.

Health and safety visits did not occur.

In July 2019, OFCO received a complaint alleging that the assigned DCYF social worker had not been to the relative placement to conduct a health and safety visit with four dependent children for over three months. The complaint stated that the worker last saw the children at their placement in February 2019 and there was no in-person contact with the children until the DCYF supervisor conducted a home visit in mid-June 2019.

OFCO reviewed records and noted that the social worker's case narratives described health and safety visits with the children at the relative placement in March 2019, April 2019, and May 2019. OFCO noted the case narratives from the visits in April and May were exactly the same and the visit in May was documented to have occurred on Memorial Day, a state holiday. OFCO clarified with the complainant that the relative caregiver had not had a visit from the social worker on Memorial Day or any of the other days documented.

OFCO contacted the Department to discuss the concerns about the veracity of the notes documenting the health and safety visits and learned that the social worker is no longer assigned to this case.

- ***Violation of Policy (DCYF Practices and Procedures Guide, 4420(2):***
  Failure to conduct required health and safety visits with a dependent child. Health and safety visits did not occur.

DCYF Response:
The case was reassigned to a different case worker and the supervisor visited the children. The local office implemented random quality assurance checks with caregivers and the supervisor reviewed health and safety requirements with staff.

CPS investigation and safety assessment did not occur in a timely manner and required health and safety visits did not occur.

In February 2019, CPS received an intake reporting a near fatality of a two-year-old. The intake alleged that the child's parent did not fill a prescription for the child's illness, causing the child to be in respiratory distress. The assigned worker completed the initial face-to-face and subject interview the following day. However, there was no documentation of other investigative activities between February 2019 and early June 2019. OFCO contacted the agency in June 2019 regarding the investigation remaining open beyond the required timeframes, the safety assessment not being completed timely, and the agency not conducting required health and safety visits.

- ***Violation of DCYF Practices and Procedures Guide, 4420 and 2331(4)(b)(viii):*** *Monthly health and safety visits must be conducted with children identified in a CPS case investigation open longer than 60 days.* There was no documentation that a health and safety visit occurred in May 2019 and July 2019.

- ***Violation of DCYF Practices and Procedures Guide, 2331 4(d)(i):*** *Safety assessment must be completed within 30 calendar days from the date of the intake.* A safety assessment was not completed within 30 calendar days from the date of the intake. The safety assessment was completed in July 2019, six months after the intake screened in.

- ***Violation of DCYF Practices and Procedures Guide, 2331(4)(d)(iv) and RCW 26.44(12)(a):*** *CPS investigations must be closed within 60 calendar days and 90 days respectively, from the date that CPS receives the intake.* The investigation remained pending.

DCYF Response:
Following OFCO's contact with the agency, the Area Administrator met with the assigned social worker and supervisor and directed the social worker to complete a health and safety visit, call medical collaterals, and complete the safety assessment. DCYF's response indicated that workload prevented completion of the required tasks on this case; however, a work plan had been developed to ensure work be completed timely.

CPS did not conduct monthly health and safety visits and a safety assessment was not completed.

CPS intake received a report that a father, who is also a Level 2 registered sex offender, was being investigated by law enforcement for rape of a child who is now 18 years old. The intake noted law enforcement was concerned for possible sexual abuse of other children in the father's home. CPS held a Family Team Decision Making (FTDM) and participants agreed the children would continue to reside with the mother and the father would move out of the home and have no unsupervised contact with the children. This case was opened in October 2018 and OFCO found that the only documented health and safety visit was in February 2019. Additionally, the safety assessment had not occurred. After OFCO contacted the Department in June regarding these concerns, the worker attempted to schedule a health and safety visit with the mother and completed the safety assessment, seven months after the intake was recieved.

- ***Violation of DCYF Practices and Procedures Guide, 4420 and 2331(4)(b)(viii):*** *Monthly health and safety visits must be conducted with children identified in a CPS case investigation open longer than 60 days.* This case was opened in October 2018 and, as of mid-June 2019, the only documented health and safety visit was in February 2019.

- ***Violation of DCYF Practices and Procedures Guide, 2331 4(d)(i):***
  Safety assessment must be completed within 30 calendar days from the date of the intake. A safety assessment for the intake was not completed within 30 calendar days from the date of the intake. A safety assessment was completed seven months after the intake screened in.

DCYF Response:
In response to OFCO's adverse findings, DCYF indicated that law enforcement made a specific request that the assigned CPS worker have minimal contact with the family due to an ongoing criminal investigation. This request contributed to the delay in completing the safety assessment. DCYF reported that the Area Administrator would be consulting with the Regional Administrator to develop a plan and seek legal advice for cases in which law enforcement requests limited or no contact with families. Additionally, the Area Administrator discussed the requirements for health and safety visits and safety assessments with the assigned CPS supervisor and the CPS supervisor has implemented procedures to ensure health and safety visits and safety assessments are completed as required.

CPS did not refer a relative caregiver for a home study in a timely manner and failed to communicate with an incarcerated parent.

An eight-year-old dependent child resided in the same foster home for two and a half years before moving to the home of an unlicensed relative in September 2017. A few months after the child was placed in the relative's home, CPS received two screened out intakes regarding physical discipline of the child. OFCO had been monitoring this case due to a previous adverse finding made relating to sibling visits.

OFCO contacted the supervisor in November 2018 because the unlicensed relative caregiver still had not been referred for a home study and that there had been no documented contact in the past year with the child's father who was incarcerated. DCYF policy requires unlicensed caregivers to be referred for a home study within 30 days of the child's placement. In this case, a referral was not made until 14 months after placement. Additionally, DCYF policy regarding communication with parents states that all parents involved in a dependency must receive monthly visits unless an exception exists. There was no documentation over the past year that any contact was made or attempted with the father.

After OFCO brought this to the attention of the supervisor, the supervisor sent a letter to the father and provided the relative caregiver with the home study paperwork and referred the relative for a home study.

- ***Violation of DCYF Practices and Procedures Guide, 45274(c):***
  This policy requires the Department to refer relatives for a home study within 30 days of placement in order to further assess the character, competence, and suitability of the caregiver. A home study referral was not made until 14 months after placement.

- ***Violation of DCYF Practices and Procedures Guide, 4420:***
  Parents involved in a dependency proceeding must receive face-to-face monthly visits with the majority of visits occurring in the parent's home unless an exception exists.
  DCYF failed to communicate with the father of the child.

DCYF Response:
The Department did not dispute OFCO's findings. The Department noted that in addition to referring the relative caregiver for a home study and attempting contact with the father, the Regional Administrator sent an email to all staff in the region reminding them of the requirement to complete timely home study referrals. Related policies would be discussed at an all staff meeting.

CPS did not conduct monthly health and safety visits.

In June 2018, CPS received an intake alleging possible negligent treatment of four children. The intake screened in to the CPS Family Assessment Response (FAR). Although the initial face-to-face with all four children occurred timely, there were no other documented case activities between the beginning of August 2018 and October 2018. Supervisory notes in July 2018, August 2018, and September 2018 noted that the case was ready for closure.

In October 2018, the caseworker documented speaking to a school counselor who noted that one of the children witnessed seeing the mother stab the father in the arm in September 2018. The worker completed a health and safety visit with the family mid-October, nearly four months after the intake screened in for FAR.

- ***Violation of DCYF Practices and Procedures Guide, 4420, Health and Safety Visits with Children and Monthly Visits with Caregiver and Parents, and 2332 (3)(e):*** *DCYF must conduct monthly health and safety visits with children identified in a CPS case investigation open longer than 60 days.* There was no documented meeting between the children and the worker for a four month period.

DCYF Response:
DCYF responded that it is implementing the following at the office:

- Supervisor will review all FAR cases open longer than 60 days to ensure health and safety visits have been completed;
- Supervisor will document in supervisory reviews the date the most recent health and safety visit occurred;
- Supervisor will facilitate a discussion with caseworkers about policies 4420 and 2232;
- Area Administrator will provide the policies to every FAR and CPS social service specialist;
- Area Administrator will randomly review cases on a monthly basis to ensure adherence to policies.

CPS did not conduct monthly health and safety visits.

In early June 2018, CPS received an intake alleging physical abuse of two children by the mother's partner. The intake screened in to CPS FAR and the initial face-to-face with both children was completed at school in a timely manner. During this contact, neither child disclosed abuse.

Over the next month, CPS received two more intakes on the family. Both intakes screened in for a CPS investigation and the initial face-to-face contact with the children for both intakes occurred in a timely manner.

From August 2018 to October 2018, there was no documentation of any other investigative activities. However, supervisory case notes entered during this period indicated the case was ready to close. In mid-November, the case was finally closed even though there was no documentation that the children had been seen since July.

- ***Violation of DCYF Practices and Procedures Guide, 4420, Health and Safety Visits with Children and Monthly Visits with Caregiver and Parents, and 2332(3)(e):*** *DCYF must conduct monthly health and safety visits with children identified in a CPS case investigation open longer than 60 days.* In this case, a worker saw these children in June 2018 and July 2018 for the initial face-to-face interviews. There is no documentation of face-to-face contact or attempts to make contact with either child in September 2018, October 2018, or November 2018.

DCYF Response:
DCYF responded that it is implementing the following at the office:

- Supervisor will review all FAR cases open longer than 60 days to ensure health and safety visits have been completed;
- Supervisor will document in supervisory reviews the date the most recent health and safety visit occurred;
- Supervisor will facilitate a discussion with caseworkers about policies 4420 and 2232;
- Area Administrator will provide the policies to every FAR and CPS social service specialist;
- Area Administrator will randomly review cases on a monthly basis to ensure adherence to policies.

DCYF did not conduct health and safety visits within one week of a dependent child's placement change.

In July 2018, an intake alleging physical abuse of a one-year-old in the care of his mother screened in for CPS investigation. The child was removed from his mother in August 2018 and temporarily placed in a short-term foster home and then moved to a new foster home. The assigned Child and Family Welfare Services (CFWS) worker completed a health and safety visit two days after the new placement. Two months later, the foster family asked for the child to be moved. In October 2018, the child was placed in his third foster home. Case narratives document that the CFWS worker completed the health and safety visit the same day while transitioning the child between foster homes. In mid-November 2018, the worker documented completing a health and safety visit for the child at the Children's Administration office prior to his parent's visit. The next documented health and safety visit occurred when the worker transported the child in mid-December to his fourth foster home.

- ***Violation of DCYF Practices and Procedures Guide, 4420 (2)(a):***
  The first health and safety visit must be conducted within seven days of initial placement or any change of placement. Placement of a child is not considered a health and safety visit. There was no documentation that the DCYF worker completed health & safety visits within seven days of two separate placements.

DCYF Response:
DCYF reported that the case worker was new and the assigned worker's supervisor did not realize the worker was coding the placement change as a health and safety visit. The worker and supervisor were counseled about the issue and the local Area Administrator sent a reminder email to all staff in her area reminding them about the requirements of Practices and Procedures Guide, section 4420.

DCYF did not refer a suitable adult caregiver of a dependent child for a home study in a timely manner.

A newborn was placed with an unlicensed caregiver over the Department's objections. DCYF did not refer the caregiver for a home study until over a year and a half later. Nearly two years after placement, the home study was finally completed and was denied due to character and suitability concerns. After residing in the caregiver's home for almost two years, the child was removed.

- ***Violation of DCYF Practices and Procedures Guide 45274(2)(c):***
  The Department is required to refer unlicensed relatives or suitable persons for a home study within 30 days of placement in order to further assess character, competence, and suitability of the caregivers. DCYF did not conduct a home study within the required timeframes. DCYF did not refer the caregiver for a home study until over a year and a half after placement.

DCYF Response:
DCYF concurred with OFCO's finding and indicated that the local office implemented strategies to ensure home study referrals are made.

FAMILY SEPARATION AND REUNIFICATION

Failure to pursue relative placement for a child in foster care.

DCYF filed a dependency petition in relation to an 11-year-old child. Shortly after the dependency petition was filed, the CPS caseworker unsuccessfully attempted to contact the child's aunt who was listed as the child's emergency contact. The child was placed in licensed non-relative foster care in early September 2018. In early October, the aunt emailed the CPS caseworker stating she was interested in placement of the child, and also identified another relative who was interested. The CPS caseworker informed her that the case was transferred to a CFWS caseworker and provided a link for the relative to electronically submit a request for a background check.

The aunt completed the background check form that same day and contacted the CFWS caseworker by phone and email but did not receive a reply. There was no further contact with this aunt until two months later when she again emailed the CPS and CFWS caseworkers asking about the status of her request for placement. The CFWS supervisor responded that the CFWS caseworker left the position and the supervisor was not aware the aunt had not been contacted. The CFWS caseworker had not forwarded the background check summary form to the Background Check Clearance Unit as required by DCYF policy. The child remained in licensed non-relative foster care for three months even though there was an available relative who was interested in placement.

- ***Violation of DCYF Practices and Procedures Guide 4527:***
  Kinship Care: Search for, placing with supporting relatives and suitable other persons requires DCYF to make efforts to locate relatives when a child is placed in out-of-home-care, notify known relatives when a child is placed in out-of-home care, and prioritize kinship placements

when there are no safety concerns. DCYF did not make efforts to pursue a relative placement option. The child remained in non-relative foster care for approximately three months when there was an identified relative who could have potentially taken placement of the child and who also identified other possible family options.

DCYF Response:
The Department did not dispute OFCO's adverse finding and provided a list of strategies the office was using to ensure timely completion of background checks and pursuit of relative placements. This included addressing these issues at an all-staff meeting and following up with supervisors so they could address the topic during supervisory reviews. The Area Administrator requested training from the Alliance for Child Welfare Excellence and was considering adding this topic to the office's Performance Improvement Plan.

DCYF did not provide court-ordered visits.

In September 2017, the Department filed a dependency petition on two children due to allegations of parental neglect and the living conditions of the home. The children were placed with their paternal aunt and uncle. A dependency dispositional order entered in mid-December 2017 provided that the mother have two visits per week for two hours and liberal telephonic/skype visits. In June 2018, the mother missed three visits and as a result, the visit provider discontinued services. The mother continued to have telephone contact with the children but in-person visits did not occur. In August 2018, the mother was incarcerated. The caseworker attempted to take the children to visit the mother while she was in jail but was unable to due to visitor capacity. In early October 2018, the mother met with the caseworker after her release and an in-person visit with both children occurred mid-October. No parent-child visits occurred over the next two months.

OFCO contacted the assigned supervisor and caseworker in December 2018 about the lack of parent-child visits. DCYF stated a referral for the mother's supervised visits was not sent by the previous caseworker and that a new referral was made but a visit provider had not yet been identified.

- ***Violation of court-ordered visits between the mother and children.***

DCYF Response:
DCYF indicated that the previous social worker referred the case to a visitation contractor in early October 2018, prior to the case transfer but that a visitation providers had not accepted the referral. The new worker made arrangements to supervise all-day visitation with the mother which would address any make-up visitation due to the mother. Additionally, the caregivers are becoming licensed with a child-placing agency and that child-placing agency should be able to assist with visitation as well.

DCYF did not conduct a comprehensive relative search.

In November 2016, CPS received a report that an incarcerated mother gave birth. CPS filed a dependency petition, notified the alleged father and upon release from the hospital, the child was placed in foster care and then with a unlicensed person identified by the mother. Less than a week later, the Department received a call from the alleged father's adult daughter requesting placement of her half-sibling. However, the child remained in her current placement. In September 2017, the alleged father signed the paternity acknowledgement forms in court and established paternity.

OFCO found that there was no documented follow up with the paternal relative even after the father established paternity. Failure to exercise due diligence and identify the half sibling as a potential placement adversely impacted the child as the opportunity to place her with her half sibling was missed.

- ***Violation of DCYF Practices and Procedures Guide, 4250(6)(a) & 4527(2)(b):***
  When placement of a child is necessary, DCYF is required to exercise diligence to identify all adult relatives, including relatives of half siblings, within 30 days after a child is removed from the custody of the parents. The DCYF social worker must search for appropriate relatives to care for the child prior to consideration of placement in other types of out-of-home care. Specifically, when "paternity has been established at a later date an extended relative search referral will be sent to the NAIR unit within five calendar days of learning that paternity was established." (CA Practices and Procedures Guide, Section 4527(2)(b)(vi)(E))
  The half sibling contacted the Department within one week of the child being placed; however, there was no documented follow up with the relative even after the establishment of paternity.

DCYF Response:
DCYF requested that OFCO withdraw this finding as the placement was made in accordance with the parents' preference. The suitable other placement had initially been approved to provide respite for the grandparents who had been caring for the child but were not able to be a long-term placement. Additionally, the suitable other's residence was near the child's brother which allowed weekly visits to occur. The mother had also expressed that she felt the child would not be safe with the alleged father's relatives.

OFCO did not withdraw the finding. OFCO noted that the focus of OFCO's investigation and finding was not on the child's current placement but on the Department's ongoing duty to conduct a comprehensive relative search.

DCYF noted that action was taken in the local office as a result of this case to improve relative search practices. Specifically, the assigned supervisor and local Area Administrator discussed the importance of conducting relative searches throughout the life of a case.

DCYF did not conduct a relative search.

In late September 2017, an intake screened in for CPS-Risk Only after it was reported that both mother and child tested positive for amphetamines and opiates at birth. A Family Team Decision Making (FTDM) meeting was held two days later during which the maternal grandmother stated she was not a placement option as she was caring for another grandchild, the infant's sibling. Shortly after, the Department spoke to a paternal aunt who stated she would be a placement if the child wasn't placed with the parent's proposed placement. At shelter care, the Court placed the infant with the parent's proposed suitable adult placement.

OFCO found that at no point in the dependency did the caseworker submit a relative search referral to the NAIR unit as required. It was not until the child became legally free and the case was transferred to adoptions in February 2019 that the adoptions worker requested a relative search. The

child was ultimately removed from the suitable adult caregiver and placed with paternal grandparents.

- ***Violation of DCYF Practices and Procedures, 4527:***
  The Department must complete and document relative search activities throughout the life of a case. The assigned caseworker must conduct an ongoing search for relatives when a child is not placed with a relative and contact the Native American Inquiry and Relative Search Unit (NAIR) whenever a relative search is needed. Relative search activities are only discontinued when a permanent plan for the child has been completed. The caseworker never submitted a relative search referral to the NAIR unit as required.

DCYF Response:
DCYF reported that the local office developed an action plan. Case transfer staffings from CPS to CFWS will also include a review of whether a relative search referral was made on the case.

DEPENDENT CHILD WELL-BEING AND PERMANENCY

DCYF improperly disclosed a dependent youth's private medical information.

A dependent youth began taking birth control pills and discussed this with the assigned worker. The child's caregiver said she informed the assigned worker that this information was not to be shared with the father, per law and the child's wishes. According to the caregiver, the assigned worker nonetheless shared this information with the father, who then used this information to cause discomfort to the youth through comments to her and by sharing the information with their community.

- ***Violation of RCW Chapter 70.02.***
  RCW 70.02 governs health care information access and disclosure and extends the obligation to protect health information to people other than health care providers who obtain or use health care information. In areas where minors are granted the authority to make their own health care decisions, they are also granted the authority to make decisions regarding the disclosure of this information. The worker assigned to this case improperly shared private health information with a parent who did not have a right to that information.

DCYF Response:
DCYF declined to agree that the assigned worker's disclosure violated RCW Chapter 70.02, but did agree that the disclosure was inappropriate under the circumstances and contrary to its policies, without identifying those policies. DCYF stated that the worker on the case was new and erroneously believed she was obligated to provide this information to the parents. The supervisor trained and counseled the new worker and clarified the Department's confidentiality expectations regarding family planning.

PARENTS' RIGHTS

DCYF did not complete a CPS investigative assessment in a timely manner.

In mid-December 2018, DCYF received an intake alleging that a mother failed to protect two children from physical and sexual abuse. The intake screened in to CPS investigation with a 24-hour response. An initial face-to-face meeting was conducted the next day. In January and February 2019, CPS engaged in various investigative activities including conducting a subject interview and contacting collateral sources. In January and April 2019, the mother asked CPS about the status of this investigation and CPS' finding. In May 2019, OFCO spoke with the CPS supervisor about the delay in completing this investigation. The investigation was closed and the mother was notified of CPS' investigative finding, five months after the investigation began.

- ***Violation of DCYF Practices and Procedures Guide, 2540, Investigative Assessment:*** *The investigative assessment must be completed in FamLink within 60 calendar days of CA receiving the intake. Furthermore, RCW 26.44.030(12)(a) states that in no case shall an investigation extend longer than 90 days from the date the report is received.* This investigative assessment was completed over five months after receipt of the intake.

DCYF Response:
To address and improve the timely completion of investigative assessments, CPS supervisors in the local office would be reviewing investigative assessments that might be overdue and provide the assigned workers with specific work plans and coaching.

DCYF did not provide court-ordered written updates of the child's progress, health, and well-being to the child's father.

In January 2017, the court ordered that DCYF provide the father of a dependent child with monthly updates as to the child's progress, health, and well-being by mail. The child's father had been sentenced to fifteen years of imprisonment two years prior. The father was given monthly updates during most of 2017, however, the updates appeared to have stopped in December 2017.

OFCO spoke with the CFWS supervisor and caseworker in mid-February 2019. The caseworker confirmed that written monthly updates to the child's father had not been sent. The caseworker had been assigned to the case for more than one year; however, only four reports had been sent to the child's father. The caseworker reported that they would have the written monthly update completed and sent to the child's father by the end of February 2019; however, no monthly update was provided.

- ***Violation of court order: DCYF did not provide court-ordered monthly written updates of the child's progress, health, and well-being to the father.***

DCYF Response:
DCYF reported that the caseworker was new and was unaware of the required frequency or that the progress reports were court-ordered. The caseworker was directed to send progress reports to the father no later than 15th of each month. Additionally, the Area Administrators discussed with the local supervisors and directed them to provide copies of dependency orders to their new workers and review the orders with them.

FOSTER PARENT/RELATIVE CAREGIVER ISSUES

DCYF did not notify relative caregivers of a court hearing, provide caregivers with the Caregiver's Report to the Court form, or provide the Child's court report to the caregivers.

Due to a history of untreated and chronic parental substance abuse, domestic violence, and general neglect concerns, DCYF filed a dependency petition on a five-month-old infant in October 2018. The infant was placed with a paternal aunt and uncle in December 2018. The first dependency review hearing was scheduled for February 2019 but the child's relative caregivers were not notified of the hearing, nor given the opportunity to submit a Caregiver's Report to the court. The relative caregivers received the court report only after contacting the DCYF supervisor in late March 2019 to voice concerns they had not received court reports and nor timely communication from the social worker. Upon receiving the court report, the relative caregivers learned that the social worker included inaccurate medical information about the child. Because they were not informed of the court hearing or provided with the Caregiver's Report to the Court Form, they were unable to share accurate medical information with the court.

- ***Violation of DCYF Practices & Procedures Guide 4313:***
  DCYF Did Not Notify Relative Caregivers of Court Hearing, Provide Caregivers with the Caregiver's Report to the Court form (DCYF 15-313), or Provide the Child's Court Report to the Caregivers.

DCYF Response:
DCYF acknowledged the importance of communicating with relative caregivers and stated that the supervisors will be adding a review of this policy to the agenda for their upcoming unit meetings due to having many new staff.

DCYF placed a child in an unlicensed foster home.

CPS received an intake alleging neglect of one-year-old twins and an infant. The intake screened in for CPS-FAR intervention. A few hours later, a second intake screened in for CPS investigation as law enforcement placed the three children in protective custody after the mother admitted to thoughts of abusing them. Afterhours workers responded to law enforcement's request and placed the twins in one foster home and the infant with a different provider. About one week later, it was discovered that the infant's provider was unlicensed. The infant was removed from the home.

OFCO found that the provider's previous foster license was closed and the provider's new foster care application was pending. The child was adversely impacted due to this unnecessary change in placement.

- ***Violation of CA Practices and Procedures Guide 4250,(4)(a):***
  The Department must place a child with licensed caregivers if an approved kinship caregiver or suitable adult is not available. The infant was placed with a provider who was not licensed which caused the child's emergent removal from their home.

DCYF's response:
DCYF did not seek modification of the finding and explained that there was an error in communication. The caregiver family was listed as licensed in the log of licensed providers and the staff relied on that log in order to make a placement after hours. DCYF would examine the communication pathways in the local office to ensure that the listing of available placements is accurate and updated regularly.

OFCO STAFF

Director Ombuds

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

Senior Ombuds

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

Ombuds

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

Ombuds

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

Ombuds

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

Special Projects/Database Coordinator

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