OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

An Independent Voice for Families and Children

ANNUAL REPORT
2021

Patrick Dowd, Director
ofco.wa.gov

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To the Residents of Washington State:

I am pleased to submit the 2021 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, 2020 to August 31, 2021. 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 836 complaints and completed 733 investigations regarding 1,110 children. As in past years, concerns about agency conduct and the separation and reunification of families were the most frequently identified issues in complaints. In addition to complaint investigations, OFCO monitors practices and procedures within the child welfare system and makes recommendations to better serve children and families. Systemic issues discussed in this report again include the ongoing use of hotels and office buildings as emergency placements for children. OFCO first reported on this issue in 2015 when 72 children spent a combined total of 120 overnight placements in a hotel or office. Exacerbated by the COVID-19 pandemic, the placement resource crisis has only worsened and this reporting year, 256 children spent a combined total of 2,535 nights in hotels or offices. Children with complex behavioral and mental health needs, who are the most vulnerable, also experience the most placement exceptions. This year, OFCO received several complaints about children who remained hospitalized for mental health issues after they were ready for discharge because the parents were unable to meet the child's needs in the home and there were no available therapeutic placement resources. These situations, as well as children placed in hotels or offices, underscore the need to increase resources to meet the needs of all of Washington's children.

On behalf of all of us at the Office of the Family and Children's Ombuds, I want to thank you for your interest in our work. I am grateful for the leadership and dedication of those working to improve the welfare of children and families and for the opportunity to serve the residents of Washington State.

Sincerely,

P.K. Dowd

Patrick Dowd, JD
Director Ombuds

EXECUTIVE SUMMARY

The OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS (OFCO) works to ensure that government agencies respond appropriately to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. The office also promotes public awareness about state agencies serving children, adolescents, and families, and recommends and facilitates broad-based systemic improvements. The Ombuds carries out its duties in an independent manner, separate from the Department of Children, Youth and Families (DCYF). The Director Ombuds is appointed by, and reports directly to, the Governor. The appointment is subject to confirmation by the Washington State Senate.

This report provides an account of OFCO's complaint investigation activities from September 1, 2020 through August 31, 2021, 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:[1]

Respond to Inquiries:
Provide information on the rights and responsibilities of individuals receiving family and children's services, juvenile justice, juvenile rehabilitation, child early learning, and on the procedures for accessing these services.

Complaint Investigation and Intervention:
Investigate, upon the Ombuds' own initiative or receipt of a complaint, an administrative act alleged to be contrary to law, rule, or policy, imposed without an adequate statement of reason, or based on irrelevant, immaterial, or erroneous grounds. The Ombuds also has the discretion to decline to investigate any complaint. Key features of OFCO's investigative process include:

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

System Oversight and Improvement:

- Monitor the procedures as established by the Department of Children, Youth, and Families (DCYF) to carry out its responsibilities in delivering family and children's services to preserve families, when appropriate, and ensure children's health and safety;

[1] RCW 43.06A and RCW 26.44.030.

- Periodically review the facilities and procedures of state institutions serving children and state-licensed facilities or residences;
- Review child fatalities and near fatalities when the injury or death is suspected to be caused by child abuse or neglect and the family was involved with 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.[2]

WORKING TO MAKE A DIFFERENCE

The placement resource crisis that leaves children in hotels and offices has continued to worsen over the past seven years, with the number of placement exceptions rising every year. The COVID-19 pandemic has only made matters worse, as some foster homes have refused placement of children who pose a risk to others due to the virus. In 2018, there were 1,090 placement exceptions; this number ballooned to 2,535 in 2021. A relatively small number of children, however, make up the majority of hotel and office stays. This year, 64 children spent a combined total of 2,034 nights in a hotel or office, 80% of all placement exceptions. Many of the children experiencing numerous placement exceptions have significant treatment, supervision, and placement needs, and, thus, are more challenging to appropriately place. One child experienced 229 nights placed in a hotel or office.

Earlier this year, news reports described the plight of these children and coercive measures agency staff employed to force youth to accept an available placement or follow staff directions, including providing inadequate bedding in offices, withholding placement at a hotel, and having youth sleep in state vehicles. To gain more information about these problems, OFCO interviewed DCYF workers who supervise placement exceptions and children who have been placed in hotels and offices, and reviewed DCYF case records.

Our investigation confirmed that there were incidents when children spent the night in a state car. This often occurred when a youth was transported to an available placement and refused to go in. Workers stated their supervisors instructed them to remain at the location and encourage the youth to accept the placement, sometimes all night. In some instances, workers reportedly used tactics to make remaining in the car uncomfortable, such as rolling down the windows when it was cold out, to convince a youth to accept placement. Youth also spent much of the night in cars while in transit to a placement located three to four hours away, only to refuse the placement and drive back to the office. Workers and youth also described challenges during hotel or office stays, including medication management; disruptive behavior endangering other children; inadequate bedding supplies and lack of privacy in some

[2] Child Fatalities and Near Fatalities in Washington State, August 2019. Available at: https://ofco.wa.gov/reports-and-data.

offices; difficulty providing balanced, nutritious meals; and a lack of educational and recreational activities for children.

In response to a federal lawsuit filed on behalf of foster children experiencing hotel and office stays, the Department agreed to an order which: prohibits DCYF from having children sleep in cars; prohibits placing children in offices, except in emergency situations when a hotel is not available; requires DCYF to provide healthy food, adequate space, adequate staffing, and support for the child's education and age-appropriate activities; and required the DCYF to submit a plan by September 1, 2021, that will result in an end to placement exceptions. After this order was entered, office stays decreased to 85 in July and fell to two in August. Until placement exceptions are eliminated, the Department should take steps to ensure hotel stays are safe for children and workers and basic needs of each child are met. OFCO recommends that the Department expand training for after-hours workers; increase staffing for placement exceptions; improve medication management practices; and enhance case planning for each child.

This year, OFCO also received several complaints about children who remained hospitalized for mental health issues after they were ready for discharge because the child's parent refused to pick them up. The parents' conduct in these cases did not constitute child maltreatment, but, rather, reflect that parent's inability to meet the child's needs in the home and desire to obtain treatment to address the child's developmental disabilities or mental health issues. The hospitalization of children who are medically cleared for discharge underscores our failure to provide an appropriate array of placement resources and mental health services for our most vulnerable children. Addressing this problem, as well as eliminating placement exceptions, will require coordinated efforts by the DCYF, the Health Care Authority, and the Developmental Disabilities Administration to expand placement resources and services.

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2020 and August 31, 2021, OFCO completed 733 complaint investigations regarding 1,110 children. This year, issues involving the conduct of DCYF staff and other agency services were the most frequently identified complaint issues. Issues involving the separation and reunification of families comprised the next highest category of issues identified in complaints.

OMBUDS IN ACTION

OFCO acts when necessary to avert or correct a harmful action or oversight, or an avoidable mistake by DCYF. Forty-nine complaints prompted intervention by OFCO in 2021. 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 61 complaints.

In 2021, OFCO made 28 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.[3]

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

SECTION I: IMPROVING THE SYSTEM

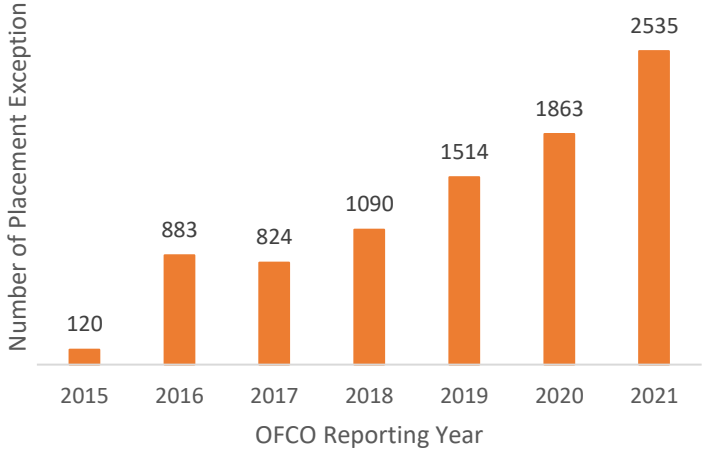
- Placement Exceptions Data
- OFCO Investigation of Placement Exceptions
- Federal Lawsuit and DCYF's Plan to Eliminate Placement Exceptions
- Children with Behavioral or Mental Health Needs are Left in Psychiatric Hospitals After They are Cleared for Discharge

PLACEMENT EXCEPTIONS DATA

HOTELS AND DCYF OFFICES USED AS EMERGENT PLACEMENTS FOR FOSTER CHILDREN

For the past seven years, OFCO has been tracking the Department's use of hotels and DCYF offices as emergency placements, referred to as "placement exceptions," for children. The placement resource crisis has continued to worsen, with the number of placement exceptions rising every year.

Figure 1: **Number of Placement Exceptions**



From September 1, 2020 to August 31, 2021, OFCO received notice of 2,535 placement exceptions involving 256 children. This is a significant increase from 2020 and the most placement exceptions noted since OFCO began tracking placement exceptions. Approximately 70% of the placement exceptions this year occurred in hotels and 30% occurred in a DCYF office. Of the 256 children, 126 experienced placement exceptions in a DCYF office and the vast majority (78%) of these office stays occurred in Region 6.

Figure 2: **Placement Exceptions by Month, 2021**

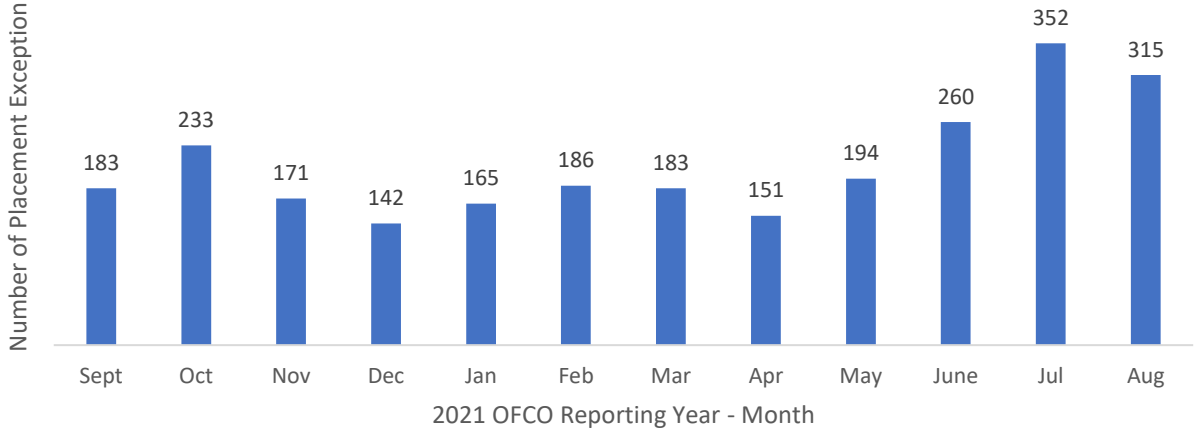


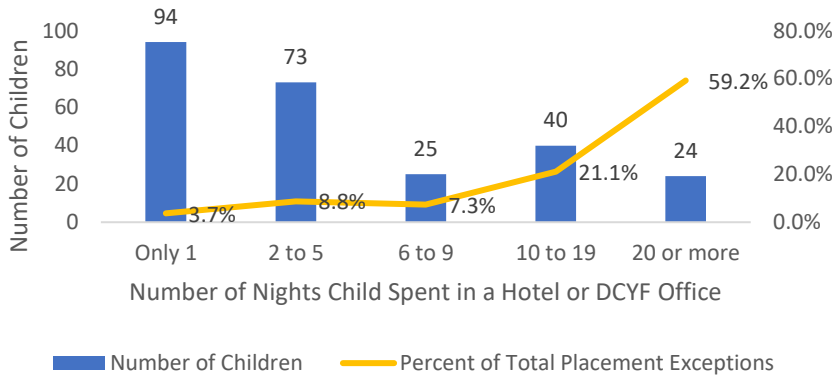
Table 1: **Location of Placement Exceptions, 2021**

	Hotel	Office	Unknown	Annual Total
Region 1	**76**	**0**	**0**	**76**
Region 2	**0**	**0**	**0**	**0**
Region 3	**77**	**10**	**0**	**87**
Region 4	**1347**	**152**	**0**	**1499**
Region 5	**0**	**10**	**0**	**10**
Region 6	**261**	**599**	**3**	**863**

A SMALL GROUP OF CHILDREN ACCOUNT FOR THE MAJORITY OF PLACEMENT EXCEPTIONS

For most children who experience placement exceptions, placement is typically located within a few nights. During this period, a suitable placement was identified for 65% of children within 5 days or less of a placement exception. However, 25% of children (64 children) spent 10 or more nights in placement exceptions. These 64 children spent a combined total of 2,034 nights in hotels or DCYF offices, making up 80% of all placement exceptions. The highest number of nights in placement exceptions reported for a single child was 229 nights.

Figure 3: **Number of Placement Exceptions per Child, 2021**



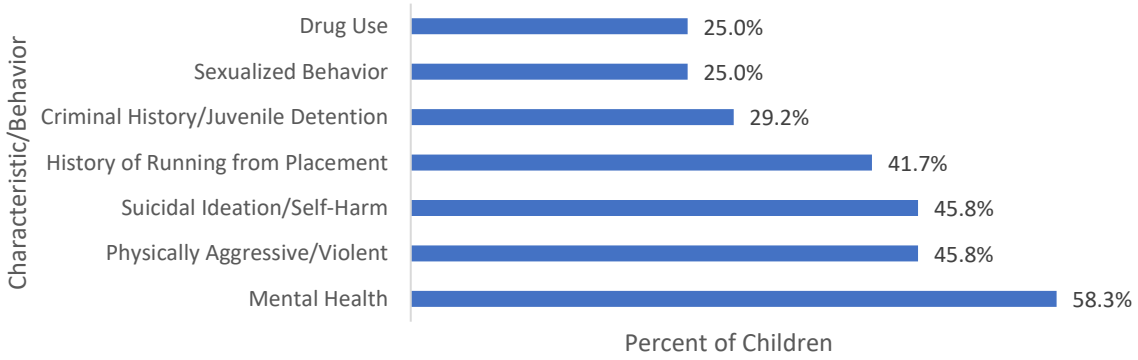
WHO ARE THE 24 CHILDREN WHO SPENT 20 OR MORE NIGHTS IN PLACEMENT EXCEPTIONS?

- Fourteen youth were reported to have mental health needs, such as mental disorders and/or past inpatient psychiatric stays.
- Eleven youth were described as having a history of physically aggressive behaviors.
- Eleven youth were reported to have suicidal ideation and self-harming behaviors.
- Ten youth had a history of running from placement.

Table 2: **Race and Gender of Children Who Spent 20 or More Nights in Placement Exceptions, 2021**

Race		Gender	
American Indian/Alaskan Native	1	Female	9
Black/African American	7	Male	13
White/Caucasian	11	Transgender Female	1
Multi-Racial	5	Transgender Male	1

Figure 4: **Characteristics and Behavior of Children Who Spent 20 or More Nights in Placement Exceptions, 2021**



A 14-year-old child was hospitalized following a mental health crisis where he was aggressive with his family. He did not meet the requirements for inpatient mental health treatment, but he demonstrated some disruptive behavior at the hospital. The child had also previously been placed in detention for assaultive behavior. He has been diagnosed with PTSD, ODD, OCD, and ADHD. The child has significant trauma history, and his family is currently homeless. The child was placed in protective custody as his mother is unable to meet his needs.

WHY ARE THESE CHILDREN EXPERIENCING PLACEMENT EXCEPTIONS?

Nearly all 24 youth were noted to have behavioral concerns, making it difficult to locate an appropriate placement. Three of the youth were discharged from a group facility or detention, and no available placement was identified after their parents refused to pick them up. Many of the youth had high-risk behaviors, such as running from placement. Due to the COVID-19 pandemic, foster homes have continued to refuse placement of children who could pose a risk to others because of potential exposure to the virus. More than half of these youth were reported to have at some point refused placement or refused to cooperate with the rules or screening of a placement. Three of the youth were noted to have strict supervision plans that made it difficult to locate appropriate placement that could meet their needs.

WHERE ARE THESE CHILDREN PLACED NOW?

Placement has been located for many of the youth; however, as of October 2021, one-third remain without placement and are continuing to spend nights in hotels or one-night foster homes.[4]

Table 3: **Current Placement of Children Who Spent 20 or More Nights in Placement Exceptions, 2021**

Current Placement			
BRS Placement or Group Home	7	Parent	2
Extended Foster Care, Residing on Own	1	Placement Exceptions	8
Foster Home	2	Suitable Other	2
Juvenile Detention	1	Treatment Facility	1

DEMOGRAPHICS OF CHILDREN EXPERIENCING PLACEMENT EXCEPTIONS

Of the 256 children who spent at least one night in a placement exception, approximately 60% were male and 35% were female. The remaining 5% were youth who identified as transgender or other gender.[5]

Although children ages 10 to 17 make up approximately 32% of the total out-of-home care population, they comprise approximately 80% of the children experiencing placement exceptions. As shown in Figure 6, and consistent with previous years, children who experience placement exceptions tend to be older than the total out-of-home care population.[6]

Children ages 10 to 17 also spent the most nights in placement exceptions: Children ages 10 to 14 spent an average of 8.6 nights, and children ages 15 to 17 spent an average of 13.9 nights. The average number of

Figure 5: **Child Gender in Placement Exceptions, 2021**

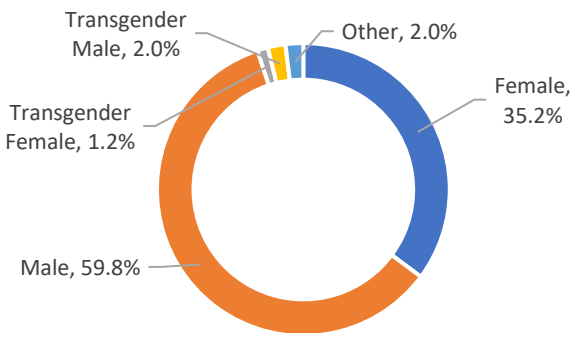
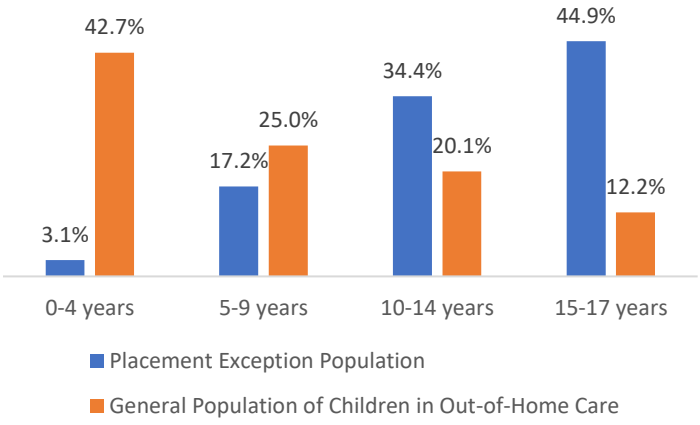


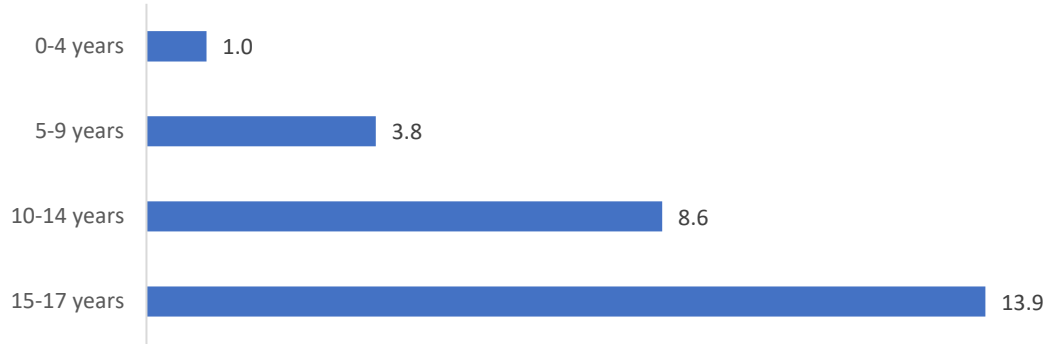
Figure 6: **Child Age in Placement Exceptions, 2021**



[4] Placement information retrieved from FamLink 10/28/2021.
[5] While the DCYF documents the legal and preferred name, and reported pronouns and gender identity of the child, some children may not feel comfortable sharing this information. See, DCYF Policies and Procedures Section 6900.
[6] Center for Social Sector Analytics & Technology (2021). [Graph representation of Washington state child welfare data 10/20/2021]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-countsdownloads.

placement exceptions by age of the child is shown in Figure 7.

Figure 7: **Average Number of Placement Exceptions, 2021**



A REGIONAL ISSUE

Like the previous year, the placement crisis this reporting year was most apparent in DCYF Region 4 (King County) and Region 6 (Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum Counties). Over 93% of placement exceptions this year involved children assigned to a DCYF office in Region 4 or 6. Approximately 45% of Washington households with children are located in these two regions and approximately 39% of children in out-of-home care are placed in Region 4 or 6.[7]

Table 4: **Placement Exceptions by Region, 2021**

DCYF Region	Number of Placement Exceptions	Percent of Total Placement Exceptions	Percent of Washington Households with Children[8]
Region 1	76	3.0%	12.4%
Region 2	--	--	9.7%
Region 3	87	3.4%	16.9%
Region 4	1499	59.1%	28.6%
Region 5	10	0.4%	16.3%
Region 6	863	34.0%	16.1%

[7] Center for Social Sector Analytics & Technology (2021). [Graph representation of Washington state child welfare data 10/20/2021]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.
[8] Center for Social Sector Analytics & Technology (2021). [Graph representation of Washington state child welfare data 10/18/2021]. Count of All Households with Children. Retrieved from http://www.vis.pocdata.org/maps/hh-populationregions.

RACIAL DISPROPORTIONALITY

African American/Black children have been disproportionately represented in the placement exception population. However, the percentage of African American/Black children experiencing placement exceptions has decreased in the past several years.

Table 5: **Child Race and Ethnicity**

Race/Ethnicity	Placement Exception Population	Region 4 & 6 Out-of-Home Care Population[9]	Washington State Out-of-Home Care Population[10]
2021			
African American/Black	10.9%	12.6%	8.9%
American Indian or Alaskan Native	3.1%	3.9%	4.5%
Asian or Pacific Islander	0.8%	3.1%	1.9%
Caucasian/White	59.4%	60.9%	62.9%
Multiracial	25.4%	19.5%	21.4%
Unknown	0.4%	--	--
Latino/Hispanic	15.6%	17.2%	20.6%
2020			
African American/Black	16.4%	13.1%	9.5%
American Indian or Alaskan Native	1.8%	4.4%	4.5%
Asian or Pacific Islander	2.3%	3.4%	2.3%
Caucasian/White	57.7%	60.9%	62.9%
Multiracial	21.4%	19.1%	20.7%
Unknown	0.5%	--	--
Latino/Hispanic	11.4%	17.2%	20.3%
2019			
African American/Black	20.7%	12.9%	9.2%
American Indian or Alaskan Native	3.9%	4.6%	4.9%
Asian or Pacific Islander	3.6%	3.2%	2.3%
Caucasian/White	57.1%	60.2%	62.9%
Multiracial	14.6%	18.5%	20.4%
Unknown	--	--	--
Latino/Hispanic	11.8%	15.3%	19.7%
2018			
African American/Black	20.0%	11.6%	8.9%
American Indian or Alaskan Native	2.1%	4.6%	4.5%
Asian or Pacific Islander	2.1%	3.4%	2.4%
Caucasian/White	54.4%	61.4%	65.5%
Multiracial	19.0%	18.8%	18.7%
Unknown	2.6%	--	--
Latino/Hispanic	11.3%	15.9%	19.4%

[9] Center for Social Sector Analytics & Technology (2021). [Graph representation of Washington state child welfare data 10/20/2021]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

[10] Center for Social Sector Analytics & Technology (2021). [Graph representation of Washington state child welfare data 10/20/2021]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

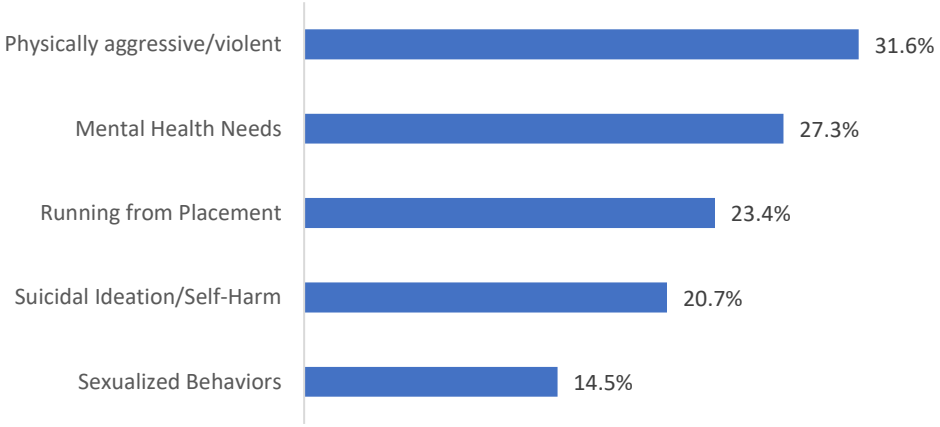
CHILDREN WITH SIGNIFICANT EMOTIONAL AND BEHAVIORAL PROBLEMS ARE AT HIGHER RISK OF EXPERIENCING PLACEMENT EXCEPTIONS

Many of the children experiencing placement exceptions have significant treatment, supervision, and placement needs, which pose barriers to locating and maintaining appropriate placement. Foster families, relatives, or group homes may not feel equipped to care for children with significant needs. Most of the youth experiencing placement exceptions were noted to have challenging behaviors that made identifying a placement more difficult.

To gather information on a youth's history, behaviors, and supervision needs, OFCO reviewed the AIRS email notification of the placement exception, the most recent Child Information and Placement Referral (CIPR),[11] and, if available, the most recent Comprehensive Family Evaluation.[12]

This year, OFCO observed physical aggression, mental health needs, a history of running from placements, and suicidal ideation and/or self-harm as the most common characteristics among youth in placement exceptions. The pandemic has had a significant impact in particular on placing children with a history of running, as many providers are reluctant to accept youth with higher risk of COVID-19 exposure to the household or facility.

Figure 8: **Characteristics of Children in Placement Exceptions, 2021**



[11] 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.
[12] 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.

OFCO INVESTIGATION OF PLACEMENT EXCEPTIONS

INTRODUCTION

Since 2015, OFCO has been investigating and reporting on children sleeping in offices and hotels due to a lack of placement resources. Over the past six years, the problem has only expanded, as the placement resources for high needs children have shrunk. In May and June 2021, a series of King-5 news reports described situations where DCYF workers used coercive measures to force youth to accept an available placement or follow staff directions. These measures included withholding placement at a hotel, providing inadequate sleeping arrangements in a state car, or forcing children to sleep in a DCYF office lacking sufficient bedding or privacy.

OFCO is empowered to investigate administrative acts by DCYF alleged to be contrary to law, rule, or policy. We examined the specific concerns identified by KING-5, as well as other problematic issues related to hotel and office stays. OFCO's investigation focused on DCYF Regions 3, 4, and 6, as the majority of placement exceptions occurred in these areas over the past year. OFCO reviewed case narratives and DCYF notifications regarding placement exceptions and completed interviews with 24 after-hours workers and 8 children to learn more about their experiences during placement exceptions. OFCO did not ask that the children or adults limit their observations to a specific period, thus, the information provided could have occurred prior to this reporting year. One youth, for example, described numerous placement exceptions experiences which occurred from 2016 to 2019.

Our investigation confirmed that, on occasion, children spent most of the night in a state vehicle with a worker. These situations most often occurred when a child refused an available placement and the worker was instructed to wait outside with the child, in the hope that they would accept the placement. This strategy was occasionally successful, but often it was not. In some cases, workers and youth both reported additional measures were employed to make remaining in the car uncomfortable, such as turning on the air conditioner, even if it was cold, not allowing the youth to charge their phone, or not allowing the youth to listen to music, in an effort to convince them to accept placement. Yet, often, the youth had legitimate reasons for refusing an offered placement. Some said they did not feel safe at a placement, based on previous experience, while others said that a placement was too far from their school, job, or community. Almost all the youth interviewed cited crisis residential center (CRC) policies requiring that they surrender their cell phone or device as a reason they refused placement.

The unpredictable nature of placing children in hotels or offices and arranging adequate supervision creates hardship for children, as well as workers. Some workers said they did not have sufficient background information about each child. Workers and children both described instances where a child's medications were not properly secured. Workers discussed frustration over their inability to intervene when a youth acts out and destroys property or engages in behavior that threatens another child or worker.

Several workers noted that practices regarding placement exceptions significantly improved after media attention on this issue. Specifically, workers said that after the media attention, the agency supervisors no longer ordered them to have the children remain in vehicles for extended periods and made bedding supplies more available for office stays.

Additionally, an injunction entered June 29, 2021, in a federal lawsuit filed on behalf of foster children, significantly impacted placement exceptions. The agreed order: prohibits DCYF from having children spend the night in vehicles; prohibits the Department from using offices as an overnight placement

except in emergency situations where a hotel is not available; and required DCYF to submit a plan by September 1, 2021, to end all placement exceptions by November 1, 2021. After this order was entered, office stays decreased to 85 in July, two in August, and zero in September. There have been no incident reports describing a child spending the night in a vehicle since the injunction was entered.

FINDINGS

In Some Cases, Children Spent Most of the Night in a Vehicle

While not authorized by the Department as a placement, children sometimes spent most of the night in a state vehicle. In these instances, workers drove children around for several hours in the evening, waiting for instructions on a possible placement, or, if a placement did not materialize, approval to take the child to a hotel. Longer "vehicle stays" generally occurred when a youth was transported to an available placement and refused to go in. Workers said they were directed to take a child to a placement even when the child said they would refuse the placement. Workers stated they were instructed to sit with youth and discuss why they didn't want to go in and encourage them to accept the placement. Workers would also enlist placement parents or staff to help persuade the children. In some instances, this strategy was successful. Other times, however, it resulted in the youth and worker spending most of the night in the car.

A youth from Spokane had been placed in a CRC in the Seattle area and eventually ran from the placement. When he later returned to this CRC, he was told the bed was given to another youth and the CRC was not taking any more referrals. He turned himself in to the Seattle Police Department, where he waited five hours to be picked up by a caseworker. He was first taken from Seattle to Snoqualmie pass, where he was transferred to a different caseworker and her vehicle at 9:35 pm. He rode with that caseworker as far as Ritzville, where, at roughly 12:00 am, he transferred to the vehicle of a third caseworker and traveled the rest of the way to Spokane.

According to workers, there was no time limit for how long they should wait outside a placement before taking the youth to an office or hotel. One worker said he was directed to stay as long as the placement remained willing to accept the youth. Another worker said she had 5 to 10 car stays where she would stay in the vehicle in the parking lot outside of a CRC all night and take the child back to the office in the morning. She added that sometimes, vehicle stays were used as a punishment. A youth said that on more than one occasion, when she refused placement, the worker turned on the air conditioning all the way, rolled down all the windows, and told her if she refused the placement, she would have to sleep in the car like this. Another after-hours worker confirmed these measures, stating, *"I have been told before to not let them charge their phone… not to keep the heat on… don't let them play music. It's not a practice, it's not something being told across the board by all supervisors. It's usually just a couple of supervisors."*

However, one worker said he would only engage in a brief discussion when a youth refused placement, stating, *"For me, I kind of just ask them, do you want to go to this placement? I will usually ask why they don't want to go. Ask what an ideal placement looks like. My boss might be upset about my not trying to persuade youth to accept placements. But I think no means no."* One worker described parking in front of the placement and staying there the whole night. The worker said the practice stopped earlier this year once the Regional Administrator found out it was occurring. According to another worker, this type of stand-off with a youth often occurred at a CRC; of the youth, the worker said *"usually, a swing shift worker would take them sometime in the evening and be sitting in the car with them in front of the*

facility. I would drive there when my shift started and get there around 1:30. Then I would sit there until 7 am and then drive them back to [the DCYF office]. I don't have a bathroom. The kids don't have a bathroom. Literally driving to find a bathroom. Sometimes we would go into the placement to use the bathroom. The kid would usually fall asleep in the car after I get there. … It sounds horrible. The kids are very comfortable in the car. You can tell they feel safe in there... These kids are used to being on the streets." One youth reported, however, that he did not feel safe sleeping in the car, as they were often parked in areas he considered prone to crime and unsafe.

In some cases, workers were instructed to transport a youth a significant distance to an available placement, only to have the child refuse. For example, a worker in King County said she drove a child from the Seattle area to a CRC in Yakima, which the youth then refused. After unsuccessfully trying to convince the youth to accept this placement, the worker drove the child back from Yakima to the office in King County. A youth reported a similar experience, stating they left the Seattle area around 6 pm and drove to Yakima, even though she told the worker she was not going to accept placement at the CRC, and that she had, in fact, previously run from this placement. They arrived at the Yakima CRC around 9 pm and sat in the vehicle until 1 am, as the youth refused placement. The youth was then taken back to a hotel in the Seattle area around 4 am; a worker woke her up at 7 am to return to the DCYF office. A Whatcom County worker added it is not unheard of to drive a child from Bellingham to Spokane, seven hours one-way, to seek a placement.

Extended hours in a vehicle are difficult for workers to manage. Workers said there was no bedding in the vehicles unless the child had their own blanket. Youth confirmed this. Additionally, there is no restroom access, other than at a gas station or convenience store. One youth reported urinating behind a bush after a placement stated she would only allow her to use the bathroom if she agreed to accept placement, which she refused.

A youth disrupted from her placement and went to a DCYF office for the day to await placement. The youth stated her one request was that she did not want to go to a CRC placement. The youth remained calm all day, until the evening, when she found out the only placement option for her was to go to a CRC. The youth became upset; she damaged property in the office and made threats to caseworkers. The workers called 911 to request assistance managing the child's behaviors; the child then ran out of the building. Law enforcement arrived and found her down the street. The workers explained the situation to law enforcement and asked if they could transport the youth to placement. Law enforcement declined. The youth continued to be upset and, upon returning, barricaded herself in the lobby bathroom. Eventually, law enforcement was able to get the youth out of the bathroom and gave her the choice of going to placement, going outside to sit on the curb to calm down, or running. The youth went outside and sat on the curb, but, when the agency did not provide any other placement options to her, she eventually ran.

On occasion, state vehicles were also used to manage behavior. One youth described workers using cars as a strategy to separate youth to avoid behavior issues. "*After a while they said me and him can't be in the hotel room together, and sometimes try to even keep us from the same hotel. But they didn't have a lot of rooms so if one of us was at the hotel the other had to sleep in the car*." In one case, a youth became disruptive during a hotel stay and a worker drove this youth around to separate him from other children in the hotel room and attempt to de-escalate his behavior. Another youth said that if you left the hotel and later returned, some after-hours-workers wouldn't accept you back and would make you

stay in the car in the hotel parking lot, and stated, "*when I was in the car they wouldn't give me blankets or pillows*." One youth said during an office stay, he entered the staff area, which was against the rules, and was then given a blanket and forced to sleep in a car.

Youth Often Have Valid Reasons for Refusing Placements

After-hours workers and youth described a variety of reasons for children refusing an available placement. Many youths have become acclimated to hotel and office stays; in one instance, a group of children communicated with each other about refusing placements so that they could be together in a hotel or office. Workers said youth feel like there are no rules with after-hours staff, and that they often refuse placement so they can party at the hotel.

The primary reason both youth and workers cited why children refuse CRC placements in particular is because their electronic devices are taken away there. Several youths, understandably, said they do not feel safe without their cell phones. Another youth said she would not even be able to do her homework without her device. Youth also said they did not like the strict rules, and they did not feel safe at the facility in question. Some youth described refusing placement because of a previous, sometimes physical, altercation at that group home or CRC. One worker said a youth refused the group home she was taken to but offered to accept a different one. The worker said her supervisor did not allow her to call other placements.

Another reason youth refuse placement is because they had a negative experience at a certain placement or just don't like the facility. Youth have said they don't feel safe at group homes because they don't trust their own behavior there, stating they know they would run, start using drugs, get into fights, or engage in other high-risk behavior. Children and staff both suggested that, rather than employing workers to drive children to placements they know the children will reject, DCYF could rely on the children's insights into their own behavior to plan for placements the youth will accept.

Some youth have school, jobs, or other ties to their community, and thus refuse an available placement that is outside of it. One worker said not wanting to miss school or work is a valid reason to refuse a placement and that there needs to be a better understanding by the Department of why a child is refusing placement. This worker shared one example of a 17-year-old who was refusing an available placement. When the worker asked her the reason, she said she wasn't familiar with that area and didn't know the bus routes to get to her job. Once the worker looked up information about bus routes and times, she then accepted the placement. Another worker also stressed the need to understand where these youth are coming from and that they don't want to be far away from their community, sharing that one youth refused a placement in Pierce County because he was playing high school football in King County.

After-Hours Workers Don't Always Receive Vital Information About a Child

Many of the children in placement exceptions have experienced significant trauma and have mental health, developmental, and/or behavioral issues. It is essential that after-hours workers have detailed information about each child to provide adequate care. After-hours workers said they receive an e-mail with the child's "Child Information and Placement Referral Form" (CIPR) prior to managing a placement exception. This form provides basic information about the child and includes a description of the child's: general behavior; gender identity and sexual orientation; temperament and physical capacity; developmental functioning; mental health concerns; past victimization/trauma; safety concerns; and any needs that require immediate attention.

However, some workers said they often don't have time to read the plans before the start of their shift, and other times they can't locate the form. One youth, for example, had a self-harming behavior of cutting her neck, but the worker said they could not locate the CIPR form, and therefore did not have this critical information about the child. Workers also said the quality of the information in the CIPR depends on the child's assigned caseworker. One worker explained, in addition to reviewing information in the CIPR, she will look at CPS intakes, case notes, and the child's supervision plan to get more information. However, additional records review by an after-hours worker is not always possible, as some of the children's cases in FamLink are restricted, and after-hours workers are not able to access vital information. In other instances, given the emergent nature of many of the duties of after-hours staff, there is simply not time to complete additional tasks prior to placement.

Workers said they often don't get all the information they need and that communication to after-hours workers needs to be improved. For example, one worker said they are not informed "*if something big happened with a youth, like they assaulted a staff or went to the hospital, there would be no communication sent out about what happened. [It] feels like we are going in blind*." It is also noteworthy that one youth stated that a CIPR can be very misleading; she said that her own CIPR, and those of her friend's, make them sound like "worse kids" than they are, and she believes that this impacts relations with after-hours workers, as well as placement opportunities. Another youth said, "*they just keep adding more [stuff] to your CIPR and then no one will want you anymore, especially foster homes*."

Managing Medications is Challenging

After-hours workers described receiving prescription medications for children from their caseworkers and keeping medications in a locked box. After-hours workers also maintain a medication log documenting when the child received or refused a prescribed medication. The after-hours workers deliver the lockbox and medication log to the next worker taking over supervision at the end of their shift. However, some workers described circumstances where medications were mishandled. One noted that some children have between 10 to 12 medications and only one child's medications will fit in the provided box. This worker said she keeps the medications in a backpack which she keeps close to her but is not able to lock. Workers also said they read pill bottles to determine dosage, but sometimes a child's medication is only in a zip lock bag. Additionally, if a child runs out of medication, after-hours workers are not authorized to refill prescriptions, as this responsibility is handled by the child's assigned caseworker.

Youth also described concerns about medication management. One youth said she was supposed to receive antibiotic medication four times a day, but often would only receive two doses because the

During a hotel placement, a youth grabbed another child's medication, then ran into the bathroom and locked the door behind her. The supervising caseworker heard her attempting to open the pill bottle, so she broke down the door in an attempt to intervene. The worker retrieved the pills from the youth, who then pulled a full-length mirror off the wall and tried to smash it. When workers tried to intervene, she began hitting them, though she did not cause injury. One of the workers called law enforcement and medics to assess the child. The officer who arrived refused to detain the youth because the hotel did not want to press charges against her. The officer also noted that even if the workers were interested in pursuing assault charges, he would not detain the child due to changes in the law relating to arrests. Furthermore, the medics refused to pick up the child despite law enforcement stating they believed she needed a psychological hold. The crisis line also would not send any staff. The workers were left to manage her incident of suicidality and assaultive behavior on their own.

A youth had spent the night in a hotel and early in the morning, the after-hours workers offered him breakfast, which he declined. As they were leaving, however, he told the workers that he did want breakfast and ran into the breakfast area. The youth began grabbing utensils, food items, and hot containers, and ran around the dining area and lobby, attempting to move furniture and acting unsafely and disruptively among the other guests. The security guard present grabbed the youth by the arms to move him away from the area. The youth dropped to the ground and began kicking and yelling for the security guard to let him go. The youth stated he could walk to the car alone, so the security guard let him go. The youth then began running through the parking lot, next to a busy street. A second security guard joined the first, and they were able to stop the youth and briefly get him into the car. However, when the after-hours worker instructed the second security guard to get into the backseat with the youth, the youth climbed into the front seat and jumped out of the car. The security guard outside the car then grabbed the youth, picked him up, and attempted to force him into the back seat. The youth resisted and the security guard appeared to lose control; he threw the child into the back of the car. The child started crying and yelled that his legs were injured, and that the security guard had caused him to hit his head. The caseworker requested the security guard move away from the car and the worker sat with the youth until he calmed down. The worker also told the security guard he had acted unsafely and inappropriately and that she would be reporting him.

workers forgot the rest. Another youth expressed concerns that a worker handed out pills from the prescription bottle without gloves. One worker reported that on occasion, youth have stolen the lockbox and medications.

Youths' Behaviors Can Endanger Themselves, Other Children, and Workers

Workers and youth both described the most common negative behaviors by children as property damage and verbal abuse directed at staff (most workers stated they understand this as a trauma response). However, workers also described situations which create significant safety risks to children and staff, such as physical assaults, youth engaging in self-harm, and drug and alcohol use. One worker said a youth tried to kill himself during a hotel stay she was supervising. Another worker said a youth was high on meth and later passed out in a hotel. The next morning, he showed the worker a loaded gun. Both workers and youth said there are no consequences for the children's actions, and they are rarely held accountable for their behavior. Workers reported their ability to intervene and protect these children, as well as themselves, during placement exceptions is severely limited.

Workers said security guards were sometimes provided at hotel stays depending on specific needs of children in placement. One worker, however, said the security guards often caused more harm than benefit, saying they lacked experience and/or understanding of working with youth. The worker cited one instance when a security guard was escalating a youth's behavior, and the worker needed to intervene to prevent an altercation between the youth and guard. This worker added that some youths are triggered by the presence of a uniformed security guard. One youth, who for a time was required to have a security guard with him during placement exceptions, described an incident where a caseworker had to intervene when a guard was being improperly aggressive, and described another incident where a worker was the one being aggressive, and a guard intervened.

During office stays, youth have destroyed offices, ransacked case files, and stolen state vehicles. Workers said requests for law enforcement assistance are often ignored, and, when officers did respond, it had little impact on the behaviors. One worker described an office stay where several youths became belligerent and began kicking in the door to a restricted office area. After numerous calls to law

enforcement requesting assistance, officers responded but did not intervene. The children asked the officers if it was an arrestable offense, and they said it was not and left. Case records document other situations where workers called law enforcement when a youth's conduct created a risk of harm to themselves or others. One African American youth, however, felt that workers sometimes called the police even when they didn't feel unsafe, to intimidate or punish the youth.

Many workers expressed concerns over alcohol and drug use by youth during hotel and office stays and the possibility that youth are sexually exploited to obtain money, drugs, or alcohol. They noted many negative behaviors occur when children are under the influence of drugs or alcohol. Youth often run from hotel stays and sometimes return under the influence. Workers have responded by calling emergency medical providers to assess the youth; occasionally, the youth are taken to a hospital, other times the youth are assessed as safe and left in the hotel. Workers said there is no protocol for dealing with a youth who is under the influence of drugs or alcohol, and they aren't allowed to search children's belongings or confiscate drugs or alcohol from them. Workers said they simply try to encourage them not to use. The youth affirmed that this is true, discussing that they smoke cigarettes and sometimes marijuana while in hotel stays, and have also admitted to drinking alcohol while experiencing placement exceptions. One youth noted that she did not believe this was appropriate but knew it was their policy not to intervene and took advantage of it.

Workers also said they are often caring for children whose needs exceed the worker's training and experience. One worker said they were on constant suicide watch with one youth and had to remove anything that could be used for self-harm. In other cases, youth have attempted to jump out of moving cars or have grabbed the steering wheel of a moving car from the worker driving. One worker commented, *"When things are getting to that level, we aren't trained for that... We are handling situations way above our skill level and pay grade."*

A youth became agitated while waiting at the DCYF office for a decision about her placement. She began throwing things around the office and making threatening statements to staff. She also reported that she was hearing voices and wanted them to stop. In an attempt to calm the youth down, a worker took the youth outside to get her blanket out of the trunk of the state car. While outside, the youth took three bottles of her medication out of the after-hours worker's backpack, which was not locked or otherwise secured. The youth ran back into the office and locked herself in the bathroom. When she finally left the bathroom, she stated that she had taken all the pills, handing the worker the three empty bottles. She said that she wanted to die because no one cared about her. The after-hours worker notified the supervisor and called 911. The police arrived and she was taken to the hospital by paramedics.

Hotel Stay Description

After-hours workers said that once a hotel stay is approved, they usually get to the hotel between 9 pm and 12:30 am. The "swing shift" after-hours workers arrive at the hotel with the children. Workers often stagger transporting the children to avoid a disturbance at the hotel, with older youth going later at night. Around 12:30 am, the "overnight shift" workers arrive and remain with the children through the night and transport the youths to the office in the morning by 8 am. Generally, there will be up to four youth staying in one hotel room. However, children are frequently placed in adjoining rooms with two workers supervising up to eight youth in two rooms. Workers described the rooms as usually consisting

of two standard size beds with every child having their own bed. Sometimes, they put one or two additional cots in the room.

The after-hours supervisor makes the placement schedule and assigns children to a hotel room. The supervisor must consider each child's history and needs and recognize that some youth should not be placed together. At times, some youth object to being placed in the same room as another child. One youth commented that placement decisions are "brainless" and that requests to not be placed with other youth because of conflict are ignored. One youth described not sleeping for an entire night because, despite asking them not to and explaining why, the agency placed her in the same suite as a youth from a rival gang who intended to assault her. One child said she was usually placed together with her best friend, but the Department eventually stopped placing them together because they briefly ran from placement following a verbal dispute with a worker. The youth said they returned within an hour. Gender is a major factor in room assignments, and male and female children generally do not share the same room. Transgender youth are appropriately placed with other youth of the gender with which they identify. The age of the children also plays a significant role in assigning hotel rooms.

Workers and most youth reported that workers remained awake supervising children during office stays. One youth, however, said that workers sometimes fell asleep, noting that it depended on the group and type of children. *She said, "If they know it's a group of kids they know won't do anything, they will doze off."*

While at a hotel placement, a ten-year-old child became upset when workers tried to encourage her to wind down for bed. She requested the keys to the room so she could leave, but the workers refused. This escalated her further. She hit and bit the workers, threw items around the room, and broke hotel property. While waiting for law enforcement, the youth threatened to kill the workers and attempted to injure them with a pen and a broken hanger. During this time, she was observed to be engaging with an auditory hallucination who she had previously reported told her to kill people. When law enforcement and paramedics arrived, she refused to go with them and ran out of the hotel. Law enforcement chased the child as she ran through the parking lot and headed towards the highway. She was eventually placed in the ambulance and taken to the hospital. Between them, the workers sustained a black eye, multiple bruises, and bite marks.

Office Stays Description

Workers had differing opinions as to whether office stays were used as a punishment. Some workers said offices were used when a youth ran during the day and showed up late at night at the hotel, as this practice reduced disruption for workers supervising the children already in the hotel. Some workers reported offices were also used when necessary to separate a youth who was disrupting others in a hotel.

However, other workers said office stays are used as punishment for refusing placement and said it was very rare that the Department would provide a hotel stay when a child refused an available placement. A worker estimated that children refuse a licensed placement 15-20% of the time and said one youth spent five nights in the office because he refused available placement at a CRC. Another worker discussed a child who was not approved for a hotel because the child refused placement, often ran from care, and was verbally aggressive. The worker believed the decision not to approve a hotel for this youth was based on the supervisor's dislike of the child. An after-hours supervisor said the practice is that if a child refuses placement, that child will stay in the office. She said that agency workers in this region

Two youth waiting in an office for placements began arguing. An after-hours worker stepped in to deescalate the situation, but one of the youths continued to become more agitated. He then started throwing things around the office and at the worker. He also began yelling at and threatening the other youth, who looked frightened. The worker called the supervisor and asked for assistance with calling law enforcement. The agitated youth's behavior escalated as he obtained a sharp object and threatened to kill both the worker and the other child. He charged at them but tripped and fell. The worker then locked themself and the youth being attacked behind a door and called law enforcement again. Law enforcement finally arrived, and the agitated youth barricaded himself in a visitation room. The officer was able to convince the youth to leave the room in which he was barricaded, and he was ultimately arrested.

believe that if a child goes to a hotel, he or she will never want to go elsewhere, which she said feels like a punishment-based approach. Children interviewed said that staying in an office rather than a hotel was a consequence for refusing placement, or for other behaviors such as going on the run, conflict with another youth, property destruction, or disrespecting staff.

Workers and youth said that, generally, there may be one to two children staying in an office at a given time, though in some regions the number could be much higher. The location of sleeping area depends on the office and space that is available to the youth. For example, in the Region 4 Kent office, children can be in the lobby but not in the inner office areas, while at the Region 4 Indian Child Welfare office, children can stay in the visitation center area. One youth said, *"You either get a cot, the floor, or the couch. They are all uncomfortable, even the cot. Sometimes you get a blanket. They are treating us like the trash that we are."* Another youth said she always had a cot but once slept on the floor because of the number of kids staying in the office. She said children also slept on air mattresses. She added that they had blankets, but there were no sheets, and they would be lucky to get a pillow. Youth consistently said that in the DCYF Kent office, where overnights often occurred, there was no privacy from other youth. Children were not allowed in the interior area of the office, so they slept in the lobby area, which has floor to ceiling windows facing the parking lot. The lobby area at this office had bathrooms for the youth to access but no showers. One youth said her "day caseworker" would let her use the shower located in the office interior.

In Region 6, which experienced the highest number of office stays, workers said visit rooms were equipped with futons, couches or cots, and blankets, and they usually didn't have more than four to five kids during an office stay, with one child per visit room. Workers said the bedding was cleaned and washed by caseworkers who took the bedding home and washed it, or by a community volunteer organization who also provided handmade quilts, which were changed out regularly.

A worker in Region 4 said soiled bedding could be an issue. At one time, the washer and dryer at the office were broken, and workers took the children to the laundromat to wash the bedding, or the workers washed it at their own homes.

DCYF Does Not Always Provide Children with Adequate Educational and Recreational Activities

Workers and youth both expressed concern that children in hotel and office stays lack sufficient activities during the day to meet their social, educational, and emotional needs. One worker noted there are many children in placement exceptions with special needs, and there is no accountability for their assigned caseworker to get them into supportive programs during the day. The after-hours workers also noted that the daytime staff need to do more to support these children by getting them to their appointments and providing them with activities. Most youth described having little to do during the

day while they awaited their next placement. One youth expressed apathy towards school, stating he didn't care that he wasn't in school during placement exceptions and that he would just be changing schools anyway. Youth who wanted to go to school, however, found attendance difficult under placement exception circumstances. One youth noted it is hard to go to school if you only had a few hours of sleep and are not able to shower and wear clean clothes before school. Another youth said, although she was enrolled in school, she had no opportunity for online access to complete schoolwork during hotel and office stays. Workers also expressed concern that most children in office or hotel stays were not engaged in school. One youth said she would log on to online school during the day, as her school provided a device, and her day caseworker set up a place for her to work near the caseworker's area in the back of that office. On weekends, youth said that some workers would take children to different activities, while others would not. One youth said workers sometimes took her to the mall to get ice cream, to a 30-minute massage kiosk, or to get her nails done. Other children described workers taking them to a park or to the Family Fun Center.

> A youth was in an office for the day, awaiting news of her placement. She requested to go to the library to use the computer. Her assigned social worker told her that she could not take her to the library during the day but said that the after-hours worker would take her when she got on shift. When the after-hours worker finally arrived at 8:15 pm, she told the youth that she could not go to the library and would stay in the lobby until further notice. The youth became upset and left the building for a few minutes. When she returned to the door, the after-hours worker opened the door and told her again that she would be staying in the office until her placement was confirmed, as directed by the after-hours supervisor. The youth again exited the building and spoke with her assigned caseworker, who was still in the parking lot. When she returned into the office, she still appeared disappointed and upset. The worker heard her exclaiming to herself that she needed to go to the library, and that she had been forced to sit around the office all day and night, doing nothing. She was not allowed to go to the library or use a computer that day.

Children Often Do Not Receive Balanced and Nutritious Meals During Placement Exceptions

Lunch and dinner for children experiencing placement exceptions is provided by the assigned caseworker. Children said caseworkers take them to Safeway to buy food or to a fast-food restaurant. While hotels provide breakfast, both workers and youth said it was inadequate, particularly during COVID. Workers said they often buy meals for children and submit expense reports for reimbursement. Children also complained about the meals provided during office and hotel stays. One child stated that she got most of her food taking walks from the office using vouchers to McDonald's, as this was all the staff would provide for her. She said this food quickly made her feel sick and caused her to gain weight. Another youth said the food they were offered in the office was extremely limited. "*For breakfast they would give us one granola bar, one fruit cup, for lunch a small cup of noodles. Or a bag of chips. And they would say after hours can get you dinner and it would be another noodles cup or a microwave mac and cheese. Some good social workers would buy me food… It totally screwed up my eating patterns. Sometimes they had oranges and bananas, but they would go fast."* Another youth described a lack of coordination around food between DCYF Staff, stating the after-hours worker would say it is the day worker's responsibility to feed us and if they didn't, we wouldn't eat all evening. Youth said that food was also used to reward good behavior or punish negative actions. *"If you weren't doing good, the worker would not take you to McDonalds or Subway and just give you items available at the office like crackers and cup of noodles."*

Some Children Said They Lacked Adequate Hygiene Supplies and Clean Clothes

While some offices have shower facilities available for children, others do not. One youth said the main problem was laundry. *"There was only one day a week for laundry and if you missed your laundry day you would have to wait a whole other week, so I was always wearing dirty clothes even if I didn't miss my laundry day because they didn't have staff to take me."* However, some youth said their caseworkers would take their laundry home and clean it for them. One youth recognized her caseworker's efforts to assure she always had clean clothes, stating, *"My caseworker did laundry all herself, she would come in and do my laundry even on her day off, and check my clothing, if it was too small, she would take me shopping. She made sure I had everything and even packed my bag for me before a hotel stay and text me to make sure I had everything. She has been my caseworker for two years. I love her so much too."* A youth also said the Department provided only little travel size bottles of shampoo and conditioner but not the products she needs, like leave-in conditioner and oil for her hair. She said her worker wouldn't give her money for hygiene supplies because she didn't trust her with it, and caseworkers wouldn't take her to a store to buy products when she did have money, so she felt she was forced to steal even her most basic hygiene supplies due to experiencing placement exceptions.

OFCO RECOMMENDATIONS

The DCYF Exceptional Placement Plan is designed to prevent placement exceptions from occurring. In order to improve management of placement exceptions until this practice is eliminated, OFCO makes the following recommendations.

Create a Sufficient Array of Placement Resources for All Children and Youth

The DCYF Plan to eliminate placement exceptions includes developing an additional 21 BRS intensive mental health beds; 15 BRS treatment foster care beds; development of targeted recruitment for foster homes to serve older youth; and a transitional living program. These efforts to expand placement resources, however, must also address the needs of LGBTQ+ youth. Youth identifying as LGBTQ+ are overrepresented in foster care, some studies estimate 30% of foster youth are LGBTQ+ compared to 11% of the general youth population.[13] LGBTQ+ youth experience poorer school functioning, more substance use, and poorer mental health outcomes compared with heterosexual youth. These disparities for LGBTQ+ youth are exacerbated when they live in foster care or unstable housing.[14] The Department therefore must expand resources that are accepting, affirming, and supportive of each foster youth's sexual orientation and gender identity.

Expand Training for After-Hours Workers

Many of the after-hours workers are less experienced, non-permanent and/or part time employees, and need additional training and support. Training should be ongoing and address topics specific to situations that arise during placement exceptions, including trauma informed care, support for LGBTQ+ youth, suicide/self-harm prevention and intervention, safety and security for staff and youth, behavioral management, substance abuse, mediation skills and de-escalation techniques, and conflict management.

[13] Supporting LGBTQ+ Youth: A Guide for Foster Parents, ACF Children's Bureau (June 2021). https://www.childwelfare.gov/pubPDFs/lgbtqyouth.pdf; LGBTQ Youth in Unstable Housing and Foster Care, L. Baams, PhD, B. Wilson, PhD, and S. Russell, PhD. (March 2019) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6398424/.
[14] Id.

Increase Staffing for Placement Exceptions

OFCO's investigation found that in some situations, after-hours workers were overwhelmed by the demands of caring for numerous children during a placement exception. Children experiencing placement exceptions are often, understandably, at a heightened state of anxiety because of the lack of stability in their lives. To meet the needs of each child during a placement exception and prevent situations that pose a risk of harm, the Department should establish a maximum staff to child ratio of one staff to two children, and there should always be at least two workers always present. The Department should also increase staffing as needed, depending on the specific presentation of each child. To ensure there is an adequate pool of after-hours workers to supervise hotel stays, DCYF should explore hiring after-hours workers as permanent, full time employees, particularly in Region 4 and Region 6. Additionally, the Department should discontinue the practice of placing children and workers in adjoining rooms with the interior door open, as this increases the number of children roomed together.

Improve Medication Management

While some workers said children's medications were securely stored and administered as prescribed, other workers and youth described a medication management process fraught with problems, including medications stored in a worker's backpack, youth accessing and taking another child's medication, and medications stored in a plastic bag with no dosing information available. The Department should thoroughly review medication management practices to ensure that workers are able to securely store all medications in a locked container and have written information about dosage for each child's medication. When necessary, prescriptions should be refilled prior to a placement exception so that a child does not run out of medication.

Enhance Case Planning for each Child Experiencing a Placement Exception

OFCO's investigation identified various gaps in case management that negatively impact children and could be addressed through improved case planning for children staying in a hotel or office. For example, some workers said they did not receive adequate or current information about a child, or they did not have sufficient time to review information prior to a placement exception. Furthermore, children described instances where they did not have clean clothes, hygiene supplies, or balanced meals. The Department's plan to address placement exceptions includes developing more intensive staffing and planning for youth experiencing a hotel stay, including Shared Planning Meetings and Family Team Decision Making meetings. These case planning events should involve the child's case worker, after-hours workers, the child's advocate, and the child, and should address issues including: the child's health and safety; school transportation and academics; services identified for the child; age-appropriate activities on weekends and after-school hours; and balanced and nutritional meals.

FEDERAL LAWSUIT AND DCYF'S PLAN TO ELIMINATE PLACEMENT EXCEPTIONS

In January 2021, Disability Rights Washington (DRW) filed a lawsuit in federal court on behalf of three named plaintiffs and similarly situated foster children against the state Department of Children, Youth and Families (DCYF). The lawsuit alleges, in part, that DCYF has not developed an adequate array of placement options for children in state care, and, as a result, these children are shuttled between hotels, offices, and one-night foster home stays, "essentially rendering them homeless for extended periods of time."[15]

On June 29, 2021, the Court entered an agreed order immediately restricting placement exceptions. The order: prohibits DCYF from having children sleep in cars; prohibits placing children in offices, except in emergency situations when a hotel is not available; requires DCYF to provide healthy food, adequate space, adequate staffing, and support for the child's education and age-appropriate activities; and requires DCYF to submit a plan by September 1, 2021, that will result in an end to placement exceptions by November 1, 2021.[16]

The DCYF Exceptional Placement Plan (DCYF Plan) to eliminate placement exceptions focuses on five strategies:

- Enhanced case staffing procedures with an emphasis on cross system collaboration between child welfare, mental health, and developmental disabilities systems.
- Pre-placement supports for families and youth experiencing crisis including youth engaged with juvenile justice, and local hospitals and family reconciliation services.
- Develop additional placement resources, particularly for children with intensive needs, including 21 Behavior Rehabilitation Services (BRS) Intensive Mental Health (IMH) beds, 15 BRS treatment foster care beds, and targeted recruitment for foster homes to serve older youth.
- Create and expand placement options for 16- to 21-year-old youths, including an Emerging Adulthood Transitional Living Program model, as well as expanding capacity in the Responsible Living Skills Program.
- Reduce barriers facing providers by clarifying agency rules and consistent application focusing on the health and safety of children, meet with potential foster parents and develop plans to address safety concerns, and improve the CPS investigation process of licensed providers that is responsive to feedback from foster parents and providers.

The DCYF Plan is a multifaceted approach to stabilize and avoid placement disruption, prevent children from entering the child welfare system, and increase the array of placement for children and youth. This plan alone, however, will not be sufficient to eliminate hotel, office, or night-to-night stays, as it does not increase the array of placement resources for children with developmental disabilities or mental health needs. Eliminating placement exceptions will require a collaborative effort between state agencies providing services for our most vulnerable children and their families, including Department of Social and Health Services (DSHS), Health Care Authority (HCA), and DCYF.

[15] https://www.disabilityrightswa.org/wp-content/uploads/2017/10/Complaint-Filed-1.29.21.pdf.
[16] https://www.disabilityrightswa.org/wp-content/uploads/2017/10/Order-Granting-In-Part-Preliminary-Injunction.pdf.

IT'S NOT JUST HOTELS AND OFFICES – CHILDREN WITH BEHAVIORAL OR MENTAL HEALTH NEEDS ARE LEFT IN PSYCHIATRIC HOSPITALS AFTER THEY ARE CLEARED FOR DISCHARGE

C. is a 17-year-old youth, he is cognitively delayed and is on the autism spectrum. C. is at a developmental age between 5 and 10 years old. As a young child, he had multiple surgeries removing portions of his brain due to tumors, and, as a result, he is diagnosed with a Traumatic Brain Injury (TBI). C. has a history of behavioral outbursts where he throws rocks, destroys property, yells at, and physically assaults people, and makes suicidal and homicidal threats, such as "I will kill myself" and "I will kill my mom." These outbursts have resulted in psychiatric hospitalization as well as placement in juvenile detention.

C. has a Wraparound with Intensive Services (WISe) team assigned to him and a Developmental Disabilities Administration (DDA) case manager. He has also had Children's Crisis Outreach Response System (CCORS) support staff services in the past.

In June 2021, law enforcement involuntarily transported C. to the hospital after responding to a report of property destruction and threatening behavior. Medical staff determined that C. did not meet the criteria for involuntary treatment and was ready for discharge. Based on his escalating behaviors, his mother was unwilling to care for him in the home and refused to pick him up. Hospital staff then called Child Protective Services (CPS) intake requesting placement.

Following a meeting in late June between the mother, CPS, DDA, and hospital staff, the mother agreed to C's return home with services. This attempt to maintain C. in the home was unsuccessful, as law enforcement again responded to a report that C. was threatening to kill his mother, and officers transported C. to the hospital. The next day, medical staff determined that C. was ready for discharge, and, again, the mother refused to pick him up, as she was unable to meet his special needs in the home. Hospital staff then called CPS Intake and reported that the child is medically cleared for discharge, but his mother is refusing to pick him up.

Over the next few months, CPS, DDA, hospital staff, and other professionals involved with this family conducted weekly meetings to discuss additional services to support C's return home, as well as alternative placements. While C has continued to assault hospital staff, he is considered medically ready for discharge. His mother is unable to have C. return home and is facing eviction due to property damage he caused. DDA has explored placements and states a majority of their adult homes and group homes declined C.'s application, as they are unable to meet his needs. DDA placements that could have had long wait lists. Similarly, C's school district reported their academic placement has a 3 year wait list, to which they submitted C's name. DCYF, for its part, explained that it does not take custody of a child unless there are allegations of child maltreatment, and that a parent's inability to meet a child's needs in this circumstance does not rise to the level of "neglect" or "abandonment." Additionally, DCYF does not have placement resources to meet C's needs. At one staff meeting, the mother was asked if she would consider relinquishing her parental rights to C to force DCYF to provide placement. The mother was offended by this suggestion. While she is unable to care for him at home, she continues to advocate for his welfare and care. C has remained at the hospital for the past four months.

This past year, OFCO has received several complaints about children hospitalized for mental health issues who are ready for discharge but can't go home, alleging that DCYF is failing to provide placement for them when it is contacted by their providers. In some of these cases, the child's parent is refusing to pick them up; in others, the child is refusing to return home. Children unnecessarily remaining in a

hospital is harmful to the children in multiple ways: the children are not being provided the least restrictive placement possible, and the children cannot receive needed services, attend school, or engage in normal childhood activities. The hospitalization of children who are medically cleared for discharge underscores our failure to provide an appropriate array of placement resources and mental health services for our most vulnerable children.

Most of these OFCO complaints do not allege child abuse or neglect. Rather, they allege that the parent's inability to meet the child's needs in the home is related to the child's developmental disabilities or mental health issues. These parents are not abandoning their child, as they do not intend "to forego, for an extended period, parental rights or responsibilities."[17] Rather, their refusal to pick their child up from the hospital is an effort to obtain placement and services that are currently unavailable. CPS is focused on responding to allegations of child abuse or neglect, and families should not be forced into a system designed to address child maltreatment in order to obtain care and services for a child with developmental disabilities, mental health, or behavioral health issues.

The lack of placement resources for children exiting emergency psychiatric hospitalization also contributes to the number of children who end up in hotels or offices. As discussed in this report and previous OFCO reports, most children who experienced 20 or more nights in placement exceptions have unmet mental health needs. Similarly, a study conducted by DCYF found that ". . . suicide or self-harm, disability-related medical coverage, mental health diagnosis, substance use disorder, co-occurring substance use and mental health, pervasive developmental disorder and multiple mental health and/or developmental diagnoses were at least twice as prevalent in youth with a placement exception when compared to the rest of the out-of-home population."[18]

OFCO RECOMMENDATIONS

Increase Supports for Caregivers and Youth at Risk of Placement Instability

As discussed in this report and previous OFCO reports, children experiencing numerous placement exceptions most often have significant behavioral health needs. While the number of hotel and office stays have increased over the past several years, there has been a decline in the use of Behavioral Rehabilitation Services (BRS) placements. BRS providers have been unable to maintain capacity and, in some cases, have closed due to an inability to retain or hire qualified staff. Further, foster homes often rely on case aides to assist with behavioral or personal care needs of some children. This service has also declined as pay rates have not kept pace with the employment market. Increasing capacity for BRS placements as well as case aides supporting children and caregivers is critical to meeting the placement needs of all children in state care and eliminating hotel and office stays.[19]

Expand Health Care Authority and Developmental Disabilities Administration Services for Children

Many of the strategies in DCYF's plan to eliminate placement exceptions discussed in this report will also help alleviate emergency room boarding. For example, the plan includes: establishing a memorandum of understanding with hospitals to coordinate responses with families, and clarifying the Department's role and responsibility; enhanced case staffing procedures for youth experiencing placement exceptions; improving cross system collaboration with the Health Care Authority (HCA) and Developmental

[17] RCW 26.13.34.030; RCW 26.44.020.
[18] DCYF Exceptional Placement Report & Recommendations, (Dec. 2020) p. 4.
[19] DCYF 2021-23 First Supplemental Budget Session, Policy Level -PC- Placement Continuum BRS, https://abr.ofm.wa.gov/.

Disabilities Administration (DDA); and expanding Behavioral Rehabilitation Services (BRS) placement beds, as well as BRS Treatment foster care placements.

These measures alone, however, will not solve this problem. The solution requires adequate funding to allow DCYF, HCA, and DDA to expand placement resources and in-home services to serve these children and support their families.

Approve Funding to Expand CLIP Services

The HCA administers the Children's Long-term Inpatient Program (CLIP), serving children ages 5 to 17 who are diagnosed with a serious psychiatric illness, are a risk to themselves or others, or are gravely disabled. There are currently five CLIP inpatient psychiatric facilities statewide with a total of 84 beds.[20] Current CLIP bed capacity does not meet the demand. Children and youth wait between 30 to 120 days or longer for admission to a CLIP program. Wait times have steadily grown over the past few years. In 2019, 63% of youth waited 30 days or more for CLIP admission. In 2021, 76% of children waited 30 days or longer before entering a CLIP program. Limited access to CLIP services results in children waiting in inappropriate settings such as hospital emergency rooms, juvenile detention facilities, or hotels and DCYF offices. In order to meet current needs and future demands, the HCA estimates an additional 42 contracted community-based CLIP beds, at an annual cost of $15,040,000.[21] DCYF estimates that 25 additional CLIP beds alone are needed to meet the needs of dependent children and youth.[22] OFCO recommends that the legislature authorize and empower HCA to create these additional CLIP beds. In addition to providing timely access to CLIP services, increasing capacity will decrease costs associated with out-of-state treatment for children and boarding children in hospital settings while they await CLIP placement.

Allocate Funds to Establish Residential Crisis Stabilization Program

Youth experiencing behavioral health crises have few options. These children may not require a hospital level of care yet, yet they are unable to return home. As a result, these youths experience homelessness or night-to-night care and are referred to DCYF as their parents are unable to manage their behavioral health issues during a crisis, or they are left in emergency rooms or psychiatric hospitals, even though they do not meet the criteria for continued hospitalization.

To address this gap in the continuum of care for children, the HCA and DDA are requesting funding to create two 16-bed Residential Crisis Stabilization Program (RCSP) facilities. This program is designed to help youth experiencing a crisis who do not meet inpatient acute hospital or psychiatric hospital admission criteria and support and stabilize children with a "No Wrong Door" approach. The program includes therapeutic interventions utilizing a trauma informed approach, support from behavioral health professionals, access to medication management, and recreational activities and education services. DDA will provide continued stabilization services for DDA enrolled youth once the RCSP clinical team determines the youth no longer require inpatient level of care and that home and community-based services are appropriate. If a youth is unable to return to a lower level of care with outpatient services in their home or community, the RCSP clinical team recommends a longer term setting, such as a Children's Long-term Inpatient Program (CLIP) or CLIP Habilitative Mental Health (HMH) bed.[23]

[20] https://www.hca.wa.gov/about-hca/behavioral-health-recovery/childrens-long-term-inpatient-program-clip.
[21] HCA 2021-23 First Supplemental Budget Session, Policy Level -GT- CLIP program, https://abr.ofm.wa.gov/.
[22] Id. p. 5.
[23] DSHS/DDA 2021-23 First Supplemental Budget Session, Policy Level -DV- Joint Request with DCYF and HCA; Wash. State Health Care Authority 2021-23 First Supplemental Budget Session, policy Level -GF- Continuum of Care, https://abr.ofm.wa.gov/.

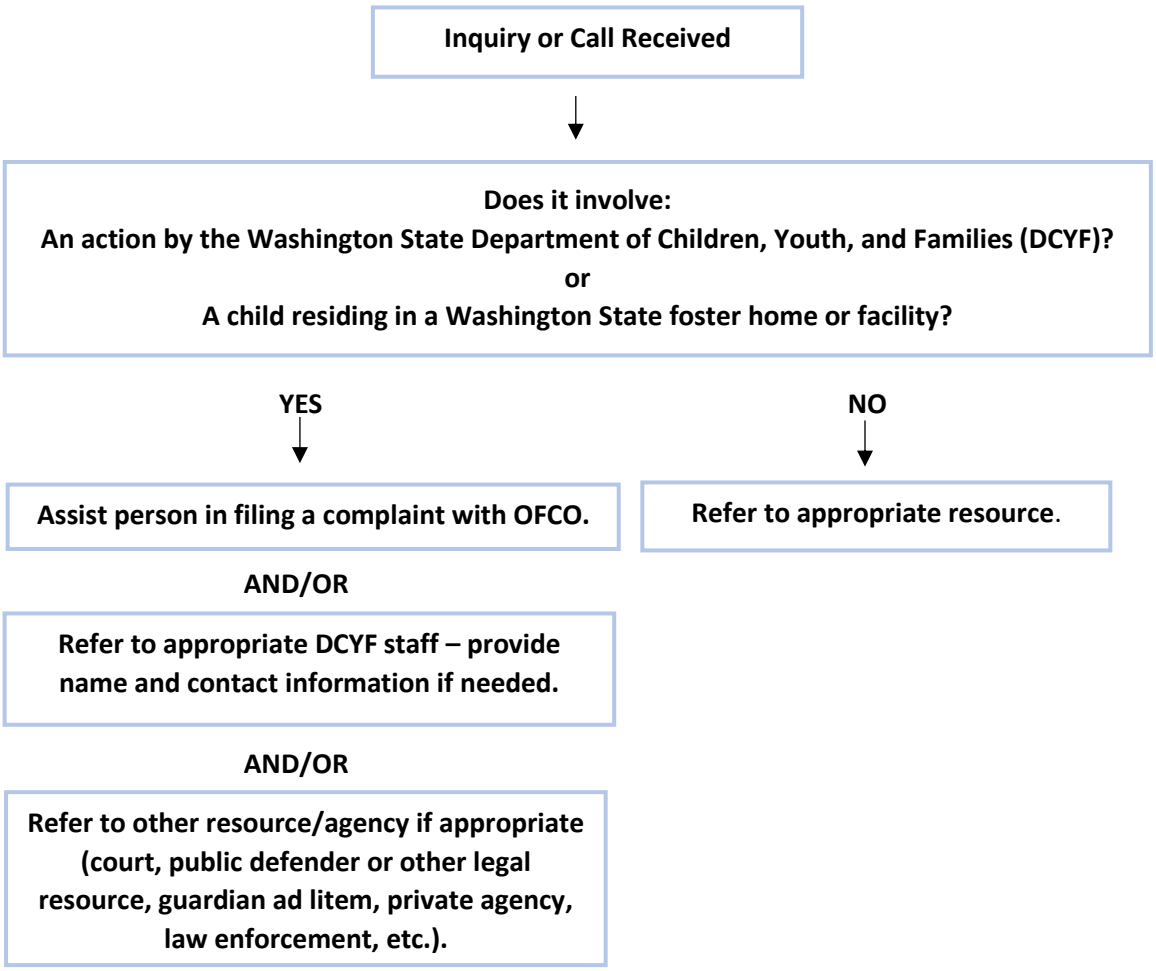
SECTION II: LISTENING TO FAMILIES AND CITIZENS

- 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 address a caller's concerns, the caller will be referred elsewhere for information or support.

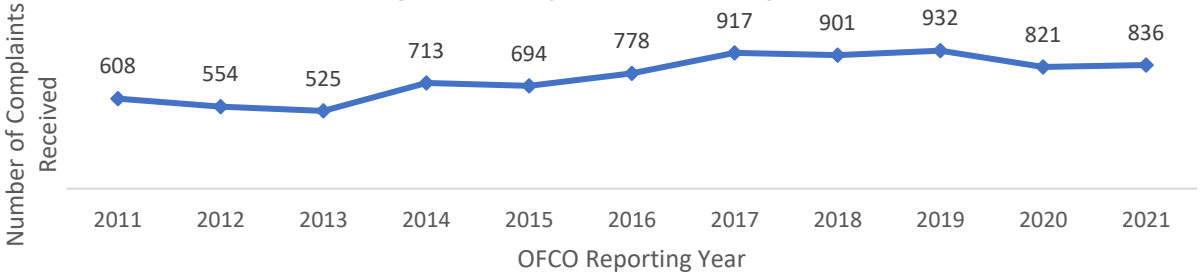
Figure 9: **What Happens When a Person Contacts OFCO?**



COMPLAINT PROFILES

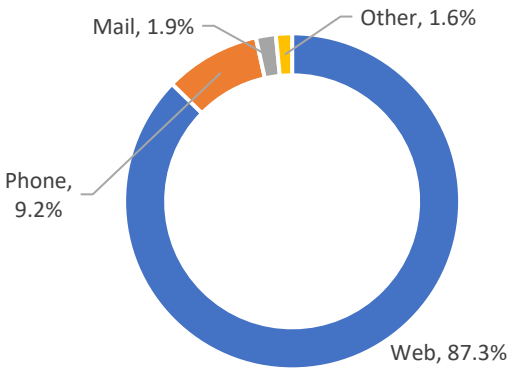
COMPLAINTS RECEIVED

Figure 10: **Complaints Received by Year**



This section describes complaints filed during OFCO's 2021 reporting year: September 1, 2020 to August 31, 2021. OFCO received 836 complaints during this reporting year.[24] The majority of complaints received by OFCO were submitted via OFCO's website.

Figure 11: **How Complaints Were Received, 2021**

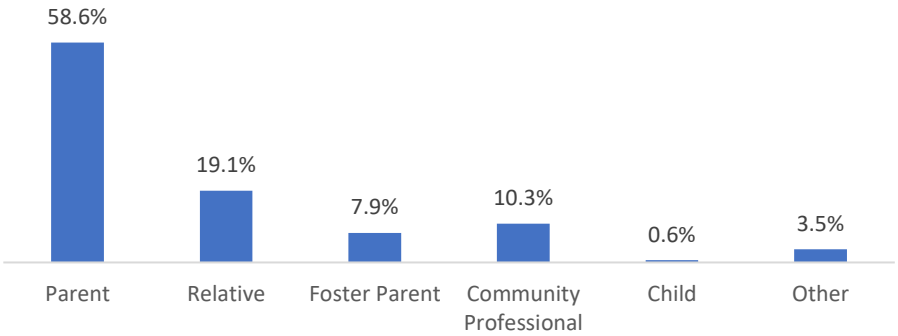


PERSONS WHO COMPLAINED

Parents, grandparents, and other relatives of the child whose family is involved with DCYF filed the majority of complaints investigated by OFCO (77.7%). As in previous years, few children contacted OFCO on their own behalf.

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

Figure 12: **Complainant Relationship to Children, 2021**



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

Table 6: **Complainant Race and Ethnicity, 2021**

Complainant Race and Ethnicity	OFCO Complainants	Washington State Population[25]	Children in Out-of-Home Care[26]
Caucasian/White	66.5%	78.7%	62.9%
African American/Black	8.5%	4.2%	8.9%
American Indian or Alaskan Native	3.5%	1.8%	4.5%
Asian or Pacific Islander	1.4%	10.0%	1.9%
Multiracial	6.6%	5.3%	21.4%
Other	0.7%	--	--
Declined to Answer	12.8%	--	--
Latino/Hispanic	7.4%		20.6%

CHILDREN IDENTIFIED IN COMPLAINTS

Of the 1,110 children identified in complaints this year, approximately 70% were nine years of age or younger. Consistent with previous years, 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.

Table 7: **Age of Children in Complaints to OFCO and Out-of-Home Care through DCYF, 2021**

Child Age	Percent of Children in OFCO Complaints	Percent of Children in Out-of-Home Care through DCYF[27]
0-4 years	35.0%	42.7%
5-9 years	34.6%	25.0%
10-14 years	20.2%	20.1%
15-17 years	8.5%	12.2%
18+ years	1.7%	--

Table 8: **Race and Ethnicity of Children Identified in Complaints, 2021**

Race/Ethnicity	OFCO Children	Children in Out-of-Home Care[28]	Washington State Children (ages 0-19)[29]
Caucasian/White	63.7%	62.9%	72.2%
African American/Black	7.1%	8.9%	5.1%
American Indian or Alaskan Native	3.1%	4.5%	2.4%
Asian or Pacific Islander	1.1%	1.9%	9.9%
Multiracial	24.1%	21.4%	10.4%
Other	0.1%	--	0.0%
Declined to Answer	0.9%	--	0.0%
Latino/Hispanic	18.6%	20.6%	21.9%

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

[26] Center for Social Sector Analytics & Technology (2021). [Graph representation of Washington state child welfare data 10/20/2021]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

[27] Ibid.

[28] Ibid.

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

COMPLAINT ISSUES

Figure 13 displays the categories of issues identified by complainants. Complaints can often be complex, and complainants may identify multiple issues or concerns they would like investigated. This year, issues involving the conduct of DCYF staff and other agency services were the most frequently identified in complaints made to OFCO. The number of complainants expressing these kinds of concerns has increased through the years. This year, over half (54%) of complainants expressed these concerns, an eight percent increase from last year. The most frequently identified concerns include:

- Unwarranted or unreasonable CPS interventions (158 complaints);
- Concerns about unprofessional conduct by agency staff, such as harassment, discrimination, bias, dishonesty, or conflict of interest (100 complaints); and
- Communication failures, such as caseworkers not communicating with parents or relatives (80 complaints).

Figure 13: **Categories of Issues Identified by Complainants**

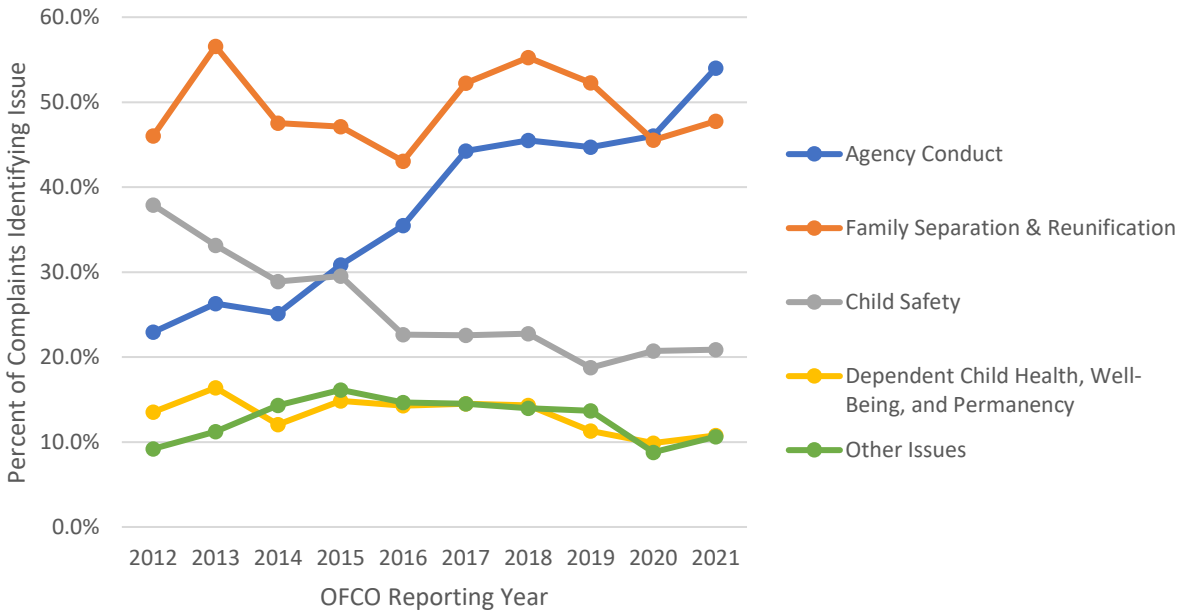


Table 9 on the following pages show the number of times specific issues within these categories were identified in complaints, as well as other complaint issues.

Table 9: **Issues Identified by Complainants**

COMPLAINTS ABOUT AGENCY CONDUCT	2021	2020	2019
	396	382	415
Unwarranted/unreasonable/inadequate CPS intervention	158	144	121
Unprofessional conduct, harassment, conflict of interest or bias/discrimination by agency staff	100	129	125
Communication failures	80	58	98
Breach of confidentiality by agency	24	26	21
Inaccurate agency records	10	8	13
Unreasonable CPS findings	10	3	10
Poor case management, high caseworker turnover, other poor service	10	8	25
Retaliation by agency staff (does not include complaints of retaliation made by licensed foster parents)	4	3	2
Family Assessment Response	6	12	7

FAMILY SEPARATION AND REUNIFICATION	2021	2020	2019
	350	378	485
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	89	78	117
Failure to reunite family	87	68	91
Unnecessary removal of child from parental care	81	123	111
Failure to place child with relative	48	54	85
Other inappropriate placement of child	21	17	32
Unnecessary removal of child from relative placement	14	27	23
Failure to provide sibling visits and contact	4	1	7
Failure to place child with siblings	2	1	7
Inappropriate termination of parental rights	2	4	8
Other family separation concerns	2	3	4

CHILD SAFETY	2021	2020	2019
	153	172	174
Failure to protect children from parental abuse or neglect	57	64	56
Suspected child neglect	*32*	*41*	*26*
Suspected child abuse	*25*	*23*	*30*
Failure to address safety concerns involving children in foster care or other non-institutional care	53	60	56
Failure to address safety concerns involving children being returned to parental care	23	29	26
Child safety during visits with parents	9	8	20
Failure by agency to conduct 30 day health and safety visits with child	1	3	6
Safety of children residing in institutions/facilities	1	1	2

DEPENDENT CHILD HEALTH, WELL-BEING, AND PERMANENCY	2021	2020	2019
	79	73	105
Failure to provide child with adequate medical, mental health, educational or other services	27	24	31
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	25	12	21
Unreasonable delay in achieving permanency	14	18	14
Placement instability/multiple moves in foster care	5	8	7
ICPC issues (placement of children out of state)	4	2	10
Placement not meeting child's unique needs	2	1	2
Failure to provide appropriate adoption support services/other adoption issues	1	2	4
Extended foster care/independent living services	1	1	3

OTHER COMPLAINT ISSUES	2021	2020	2019
	78	82	127
Failure to provide parent with services/other parent issues	28	28	26
Violation of parents' rights	20	16	20
Lack of support/services and other issues related to unlicensed relative or fictive kin caregiver	11	17	31
Lack of support/services to foster parent/other foster parent issues	6	7	25
Foster parent retaliation	5	2	2
Foster care licensing issues	5	7	10
Violations of ICWA	3	4	8

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

- Investigating Complaints
- OFCO in Action – 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:

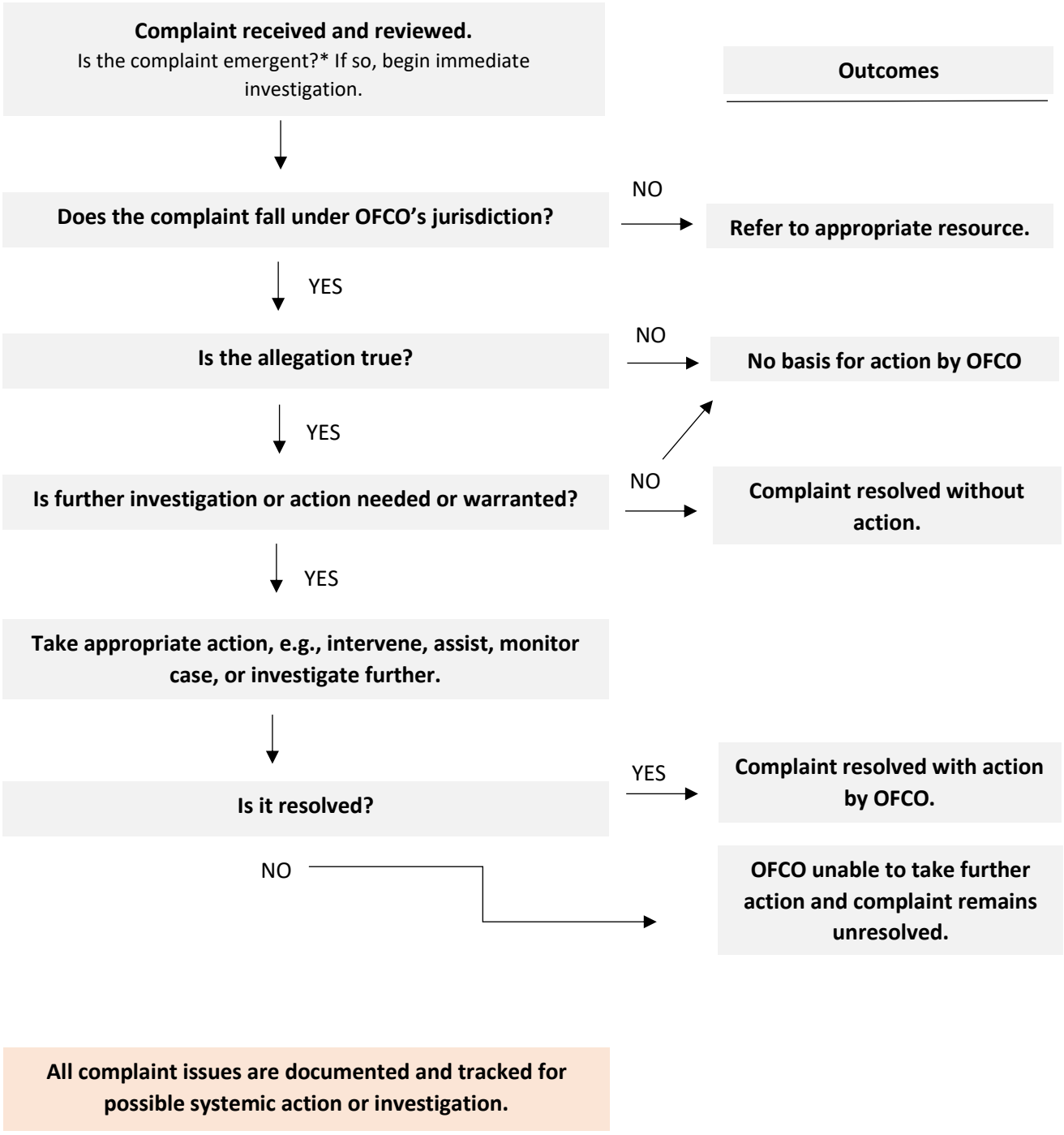
- Where OFCO finds that the agency is properly carrying out its duties, the Ombuds explains to the complainant why the complaint allegation does not meet the above criteria, and helps complainants better understand the role and responsibilities of child welfare agencies.
- Where OFCO makes an adverse 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 helps to resolve the concerns.

This reporting year, OFCO completed 733 complaint investigations. As in previous years, the majority of investigations were standard, non-emergent investigations (78.7%). About one out of every five complaints (21.3%) met OFCO's criteria for initiating an emergent investigation.

Historically, OFCO has intervened in emergent complaints at a higher rate than non-emergent complaints. However, this year, OFCO intervened or provided timely assistance to resolve concerns at approximately the same rate in emergent complaints (14.7%) and non-emergent complaints (15.1%).

OFCO's COMPLAINT INVESTIGATION PROCESS

Figure 14: **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).

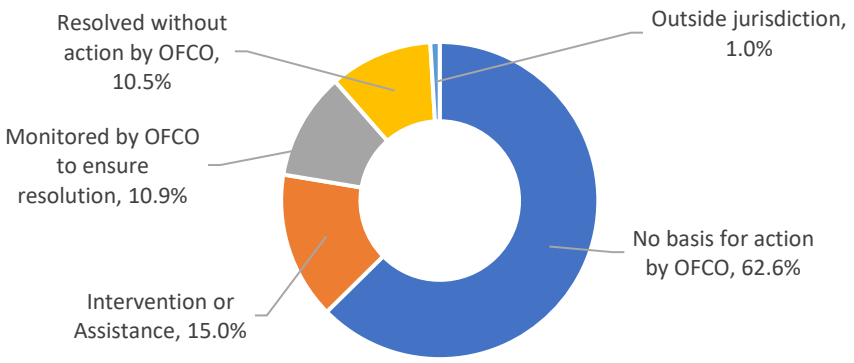
Outside Jurisdiction

- 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).

Figure 15: **Investigation Outcomes, 2021**

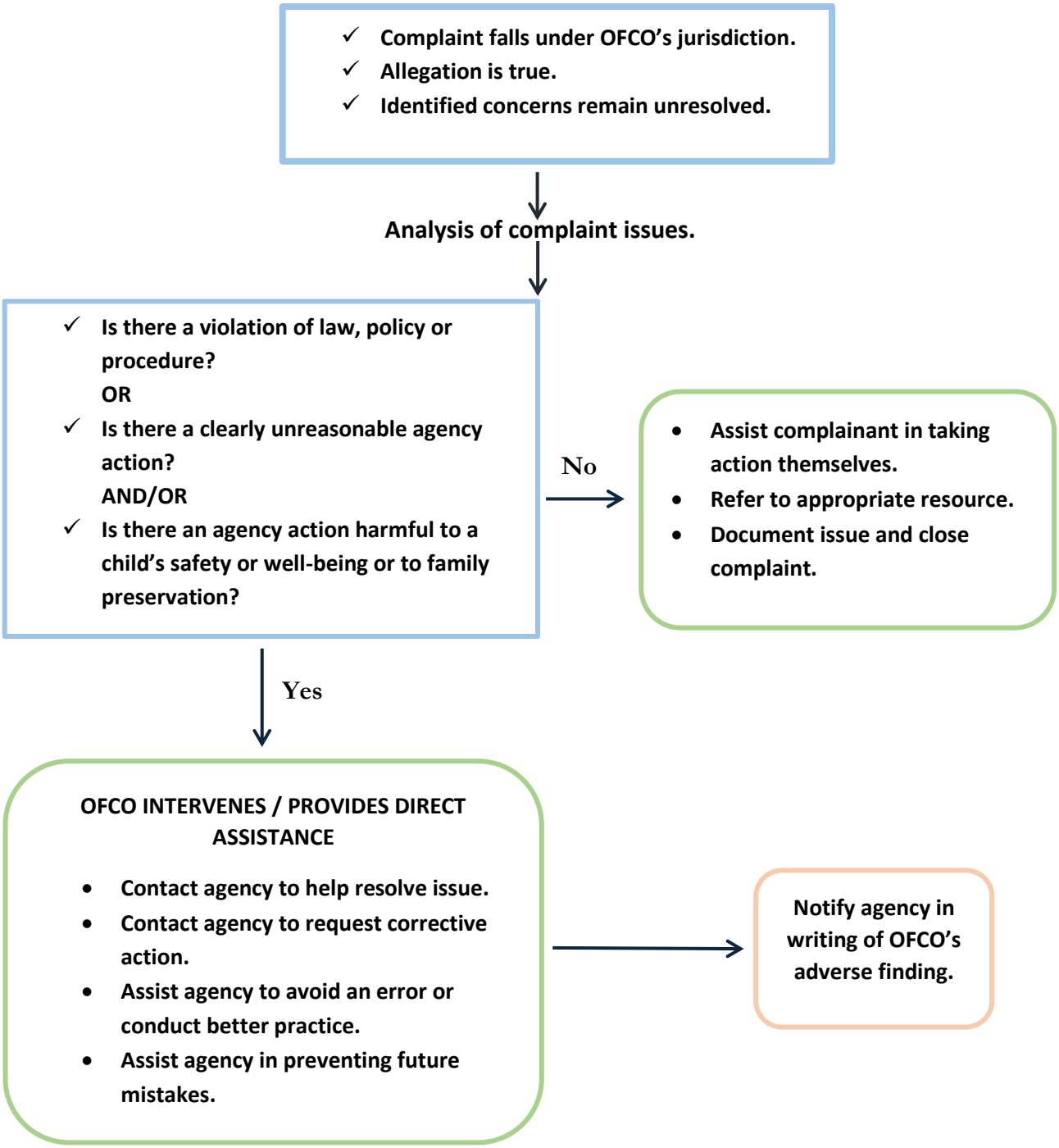


Investigation results have remained mostly consistent in recent years. In 2021, OFCO assisted or intervened to try to resolve the issue in 15% of complaints (110 complaints). OFCO monitored 80 complaints (10.9%) for a period of time until the identified concerns were resolved or OFCO determined that there was no basis for further action. No basis for any action was found in the majority of complaints this year (62.6%).

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 16: **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 2021, OFCO made 28 adverse findings in a total of 16 complaint investigations. OFCO provides written notice to DCYF of any adverse finding(s) made on a complaint investigation. The agency is invited to formally respond to the finding and may present additional information and request a modification of the finding. This year, DCYF provided a response to all findings. In addition to the 28 adverse findings, OFCO made four other findings that were withdrawn after the Department provided more information to OFCO and requested a withdrawal.

Table 11 shows the various categories of issues in which adverse findings were made. Findings most often related to the safety of children (11 findings).

Of the 28 adverse findings made, 12 findings (42.9%) involved DCYF Region 4. The number of adverse findings by office are further broken down in Appendix B.

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

Table 10: **Adverse Findings in Complaint Investigations by DCYF Region, 2021**

DCYF Region	Number of Findings	Percent of 2021 Findings
Region 1	2	7.1%
Region 2	--	--
Region 3	1	3.6%
Region 4	12	42.9%
Region 5	6	21.4%
Region 6	7	25.0%

Table 11: **Adverse Findings by Issue**

	2021	2020	2019
CHILD SAFETY	**11**	33	25
Inadequate CPS investigation or case management	3	6	2
Failure by DCYF to ensure/monitor child's safety Failure to conduct required monthly health and safety visits	4	15	12
Inappropriate CPS finding (Unfounded)	2	--	--
Failure to complete safety assessment	1	11	5
Other child safety findings	1	1	--
POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY	**7**	4	1
Inadequate documentation of casework	5	--	1
Other poor practice	2	4	--
PARENTS' RIGHTS	**6**	19	12
Delay in completing CPS investigation/CPS FAR or internal review of findings	4	15	9
Failures of notification/consent, public disclosure, or breach of confidentiality	1	3	1
Failure to communicate with or provide services to parent	1	1	2
DEPENDENT CHILD WELL-BEING AND PERMANENCY	**1**	2	2
Unnecessary change of child's placement	1	--	--
FAMILY SEPARATION AND REUNIFICATION	**1**	4	4
Failure to provide appropriate contact / visitation between parent and child	1	--	1
FOSTER PARENT/RELATIVE CAREGIVER ISSUES	**1**	2	3
Licensing issues	1	--	--
OTHER FINDINGS	**1**	3	--

NUMBER OF FINDINGS	**28**	67	47
NUMBER OF CLOSED COMPLAINTS WITH ONE OR MORE FINDING	**16**	28	28

SECTION IV: APPENDICES

- Appendix A: Complaint Investigations by Region and Office
- Appendix B: Adverse Findings by Office
- Appendix C: Summaries of OFCO's Adverse Findings

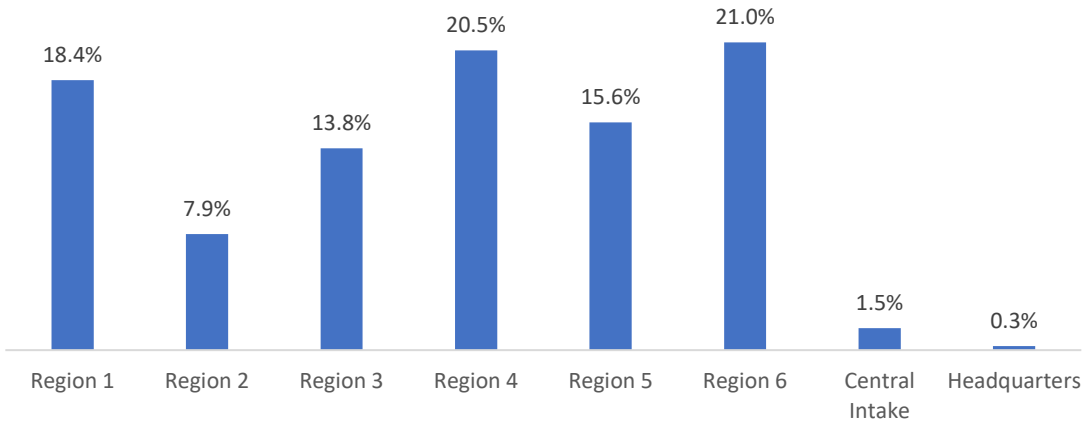
APPENDIX A: COMPLAINT INVESTIGATIONS BY REGION AND OFFICE

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

Table 12: **Populations by DCYF Region, 2021**[30]

Region	Children Under 18 Years Residing in Region	Percent of Washington State Children Under 18 Years
Region 1	219,521	13.2%
Region 2	186,902	11.2%
Region 3	272,249	16.3%
Region 4	454,542	27.3%
Region 5	266,647	16.0%
Region 6	267,027	16.0%

Figure 17: **OFCO Complaint Investigations by DCYF Region, 2021**



[30] Center for Social Sector Analytics & Technology (2021). [Graph representation of Washington state child welfare data 10/22/2021]. Count of All Children. Retrieved from http://www.vis.pocdata.org/maps/child-populationregions.

Table 13: **OFCO Complaint Investigations Completed by Office, 2021**

Region			DCYF Office	
Region 1	Clarkston	4	Region 1 - DLR/CPS, Safety & Monitoring	3
	Colfax	1	Region 1 - Licensing Division, Assessment	1
	Colville	5		
	Moses Lake	22		
	Newport	1		
	Omak	4		
	Republic	1		
	Spokane Central	38		
	Spokane ICW	9		
	Spokane North	15		
	Spokane Valley	26		
	Wenatchee	5		
Region 2	Ellensburg	9	Region 2 - DLR/CPS, Safety & Monitoring	1
	Goldendale	2		
	Richland (Tri-Cities)	16		
	Toppenish	2		
	Walla Walla	13		
	White Salmon	2		
	Yakima	13		
Region 3	Bellingham	14	Region 3 - Adoptions	2
	Everett	16	Region 3 - DLR/CPS, Safety & Monitoring	1
	Friday Harbor	1	Region 3 - Licensing Division, Assessment	1
	Lynnwood	16	Region 3 - Regional Intake	1
	Mount Vernon	19		
	Oak Harbor	4		
	Sky Valley (Monroe)	8		
	Smokey Point (Arlington)	18		
Region 4	King East (Bellevue)	21	Region 4 - Adoptions	3
	King South East (Kent)	19	Region 4 - DLR/CPS, Safety & Monitoring	1
	King South West (Kent)	35	Region 4 - Licensing Division, Assessment	1
	King West (Seattle)	22	Region 4 - DEL Licensing	1
	Martin Luther King Jr.	25		
	Office of Indian Child Welfare	15		
	West Seattle	7		

Region			DCYF Office	
Region 5	Bremerton	19	Region 5 - Adoptions	1
	Lakewood	16	Region 5 - Centralized Services	1
	Parkland	26	Region 5 - Licensing Division, Assessment	1
	Puyallup	23		
	Tacoma	27		
Region 6	Aberdeen	23	Region 6 - DLR/CPS, Safety & Monitoring	2
	Centralia	13	Region 6 - Licensing Division, Assessment	6
	Forks	1	Region 6 - Regional Intake	2
	Kelso	25		
	Long Beach	1		
	Port Angeles	10		
	Port Townsend	3		
	Shelton	11		
	South Bend	2		
	Tumwater	15		
	Vancouver-Cascade	15		
	Vancouver-Clark	3		
	Vancouver-Columbia	22		
Other	Central Intake	11		
	Headquarters	2		
	Non-DCYF/Other	11		

APPENDIX B: ADVERSE FINDINGS BY OFFICE

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

Table 14: **Adverse Findings by Office, 2021**

Region	DCYF Office	Number of Findings
Region 1	Clarkston	2
Region 2	--	--
Region 3	Mount Vernon	1
Region 4	King East	1
	King South-East	3
	King South-West	1
	Martin Luther King	5
	Office of Indian Child Welfare	2
Region 5	Bremerton	3
	Parkland	1
	Tacoma	1
	Region 5 Licensing Division	1
Region 6	Kelso	2
	Port Angeles	3
	Vancouver-Columbia	2

APPENDIX C: SUMMARIES OF OFCO'S ADVERSE FINDINGS

CHILD SAFETY

DCYF failed to conduct required health and safety visits, and the investigation was not closed timely.

OFCO initiated an investigation in response to a notification of a case of recurrent maltreatment. OFCO's concern stemmed from a lack of documentation of case activity.

In April 2020, CPS received an intake alleging that the mother, who was pregnant, was unable to protect her children from her physically abusive boyfriend. The intake screened into CPS FAR. In May 2020, a second intake alleging that the mother failed to protect her children during a domestic violence incident also screened into CPS FAR. The two CPS FAR intakes were transferred to investigation after a third intake was received and screened in for a non-emergent CPS investigation.

The assigned worker completed the initial face-to-face with the children in May 2020. The mother signed a safety plan but reported she would not follow it and declined services offered by the Department. There was no documentation of any health and safety visits in July and August 2020, and the case closed in August 2020.

Violations:

- **DCYF Policies and Procedures Guide, 4420 and 2331(4)(b)(viii) mandate that monthly health and safety visits be conducted with children identified in a CPS case investigation open longer than 60 days.**

  The case was opened April 2020. An initial face-to-face was completed in May 2020 due to the new intake that screened in; however, no health and safety visits were completed in July or August 2020.

- **DCYF Policies and Procedures Guide, 2331(4)(d)(iv) and RCW 26.44(12)(a) mandate that CPS close investigations within 60 calendar days and 90 days respectively from the date that CPS receives the intake.**

  The investigation was not completed within the required timeframes as the investigation closed 131 days after the first intake was received, 105 days after the second, and 103 days after the third.

DCYF Response:

DCYF reported that the local office's CPS FAR unit had only one worker who was able to respond to the field at the time the case was open, but that the timeliness of completed work in the unit had greatly improved since. Additional training was provided to workers to address policy, timelines, and quality of investigations. The unit supervisor developed a plan to monitor ongoing case work and ensure timely completion of casework.

DCYF failed to contact a family within prescribed timeframes and did not complete a health and safety visit with the child after transfer of the case to Family Voluntary Services.

In July 2020, an intake alleging physical abuse of an infant screened in for CPS Investigation. The intake alleged that the infant sustained a buckle fracture to their leg. The following day, a second intake screened in for investigation after a skeletal survey revealed an unexplained rib injury that was in the process of healing. The assigned worker completed the initial face-to-face with the child that same day.

The following week, the parents agreed to participate in services and signed a safety plan that allowed the child to remain in their care, supervised by a paternal grandparent who resided in the home. The worker noted that the plan would be reviewed in August 2020, but the CPS investigation was closed without completing the review.

A Family Voluntary Services (FVS) worker was assigned in late August, but the case was reassigned to a new FVS worker in early September 2020 after the initial worker resigned. Shortly after the new assignment, the worker contacted the family, but the case closed shortly thereafter without additional work.

Violations/Unreasonable:

- **DCYF Policies and Procedures Guide, 3000(3)(a)(iii) mandates that the FVS worker make an initial private health and safety visit with all children within 10 days of the transfer.**

  The case was initially assigned to a FVS worker in late August 2020, and the newly assigned worker contacted the family in September 2020. The case was closed shortly after without a completed health and safety visit.

- **DCYF Policies and Procedures Guide, 3000 (3)(a)(ii) directs the FVS caseworker to make contact with the family within seven calendar days from the date of the case transfer from CPS.**

  There was no documentation of any contact with the family between the date of the case transfer and the date of the newly assigned FVS caseworker's initial contact with the family.

- **The Department did not reassess the infant's safety as indicated in the safety plan.**

  Given the severity of the injuries to the infant, OFCO found it unreasonable that the Department did not follow their own plan. The parents were only allowed supervised contact with the child during the duration of the safety plan. However, there was no documentation that the paternal grandparent was ever contacted to ensure that the family was following the safety plan. Once the plan lapsed, there was no follow through to address safety concerns. Instead, the case was closed without further assessment.

DCYF Response:

DCYF indicated that the initial FVS worker reported to their supervisor that contact with the family and a health and safety visit had been conducted, but the worker failed to document these activities before their departure from the Department. Subsequent review revealed that the worker likely did

not have contact with the family. By the time this was discovered, a new worker had been assigned. The Department agreed that a home visit was required prior to case closure. As a result of the adverse finding, the local area administrator met with the FVS and CPS supervisors to review the transfer requirements in FVS Policy 3000, with the expectation that the supervisors review the policy with their units. The area administrator also scheduled to meet with the FVS unit to reinforce the policy. A meeting was held with all CPS and FVS staff to discuss the development and monitoring of safety plans.

DCYF unreasonably allowed a father to supervise visitation of a child with the mother, despite knowing there was a no-contact order in place.

OFCO received a complaint alleging that DCYF knowingly tolerated and enabled the ongoing violation of a no-contact order between parents of a seven-year-old child. OFCO found that DCYF was allowing the father to supervise visitation with the mother, despite knowing that there was a no-contact order in place prohibiting contact with the mother. The Department reported throughout the case that there was a no-contact order between the parents, but the ongoing caseworker documented in many of the health and safety visits that the father was supervising the mother's visits. OFCO particularly noted that on one occasion, the worker documented driving the child and father to the mother's home to facilitate one of the visits.

- **DCYF acted unreasonably under the circumstances:**
  It was clearly unreasonable for DCYF to knowingly allow the ongoing violation of a no-contact order between the parents of a child by permitting and facilitating the father, who was constrained by the no-contact order, to supervise the mothers' visits.

DCYF Response:
DCYF reported that the worker on the case was new and did not understand the significance of violating a no-contact order. The Department immediately changed the visitation plan that gave the father responsibility to supervise the visits.

DCYF did not properly screen in and investigate an allegation of physical abuse.

DCYF received an intake alleging that a 12-year-old child was choked by his father. The report to CPS Intake was secondhand, and there was no information on whether the child's breathing was obstructed or for how long. For this reason, the intake screened into CPS Family Assessment Response (FAR) instead of CPS Investigation. The following day, a CPS FAR worker interviewed the child about the allegation. During the interview, the child disclosed that he was choked by his father and he was unable to breathe while it was happening. The child also disclosed that the choking left a mark. Despite the child's disclosure, the case proceeded with the FAR pathway. The worker communicated with the detective investigating the assault throughout the case and closed the case two months later without findings as is required within the FAR pathway. The father is now reportedly being charged with Assault in the Second Degree.

Violation:

- **DCYF Policies and Procedures Guide, 2332(5) describes that a FAR case must be transferred to CPS Investigation if there is indication of severe maltreatment or abuse by a parent or caregiver.**

  The intake should have been transferred to CPS Investigation once the agency was aware that the father had restricted the child's breathing and left a more than transitory mark on the child.

DCYF Response and OFCO Withdrawal of Finding:

OFCO initially made two findings against the Department on this case. In addition to the above-mentioned violation of DCYF Policies and Procedures Guide, 2332(5), OFCO initially found that the Department violated RCW 26.44.030(12)(b)(vi)(C) for failing to screen the allegation of physical abuse into CPS Investigations given the criminal conduct alleged in the intake.

The Department agreed that the case should have been transferred to CPS Investigation as described in DCYF Policies and Procedures Guide, 2332(5), but argued that there was no violation of RCW 26.44.030(12)(b)(vi)(C) as there was limited information at the point of intake. There was no specific allegation of obstruction to breathing; no report of marks, bruising or injury; and no timeframe for when the alleged incident occurred. The Department believed that the intake worker followed practice expectations and requested a withdrawal of the finding. After reviewing the Department's response, OFCO withdrew the finding of violation of RCW 26.44.030(12)(b)(vi)(C) as the report to CPS intake was secondhand and did not provide additional information beyond the child's statement that they were choked by their father.

In response to the finding, the local area administrator arranged for the FAR workers in that office to review the Use of Force document that speaks to risk factors in strangulation cases, as well as the policy regarding the transfer of cases from FAR to Investigations. To ensure that the intake is assigned to the appropriate program, the local area administrator requested that the supervisor staff the case with the area administrator upon receipt of an intake assigned to FAR alleging strangulation.

The Department failed to make a founded finding of neglect.

In June 2019, DCYF received an intake alleging that the child had observed child pornography in the home of their relative placement, a licensed foster parent. DCYF conducted an investigation and the child disclosed that they were disturbed by the pornography and that they had run from the placement after discovering it. Despite confirmation of the relative placement's possession of the child pornography by law enforcement and the child's disclosure, the investigation closed as unfounded, noting that the child was not aware of the child pornography prior and stating that the child was neither negatively impacted by the pornography, nor a victim of it.

Violation:

- **RCW 26.44.020 and WAC 388-15-009 define negligent treatment or maltreatment as "an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety."**

The relative placement possessed child pornography while they were the licensed caregiver for the child. The child disclosed they were disturbed and left placement in response to seeing the child pornography. The relative placement's conduct constituted a clear and present danger to the child's health, welfare, and safety, and the CPS investigation should have concluded with a founded finding for negligent treatment.

DCYF Response:

The Department disagreed with OFCO's finding and requested a withdrawal. The Department argued that neither state law or policy requires the Department to reach a particular conclusion or to make a particular finding following a CPS or a Licensing Division/CPS investigation. The Department explained that the evidence collected in the investigation did not meet the legal definition of "negligent treatment or maltreatment." The Department noted that the child was moved to a different home quickly, and the relative caregiver's foster family home license was revoked. OFCO disagreed and maintained its position that the circumstances did meet the legal requirement of negligent treatment.

OFCO did not withdraw the finding.

DCYF did not conduct monthly health and safety visits and did not complete the FAR assessment in a timely manner.

In July 2020, a CPS intake alleged that a stepmother was using a child's urine to pass a urinalysis test. The intake screened into CPS FAR. Two days later, an initial face-to-face was conducted at the father's residence where the child was interviewed but made no disclosures.

The next documented activity in this case was a supervisory case note one month later, stating that the case had been reassigned and listing tasks for follow up. A supervisory case note entered the following month noted that there had not been any updates since the previous supervisory review, that the case had been open over 60 days, and that a mandatory monthly health and safety visit was needed. There were similar case supervisory review entries in October, November, and December 2020. No health and safety visits were recorded for these months.

In January 2021, the CPS supervisor interviewed the father at home and the stepmother was interviewed via phone. A second home visit was conducted with the stepmother and children by another caseworker; no concerns were noted. An interview was conducted with the mother by phone prior to the FAR case being closed.

OFCO contacted the CPS supervisor, and the supervisor confirmed that the case was assigned to the caseworker who completed the initial face-to-face contact. The caseworker then went on leave and did not document their contact with the family, which led to the case being open beyond required timeframes.

Violations:

- **DCYF Policies and Procedures Guide, 2332(3)(e) requires face-to-face health and safety visits be conducted with children identified in a CPS FAR case open longer than 60 days.**

CPS FAR did not complete required monthly health and safety visits while the FAR case was open.

- **DCYF Policies and Procedures Guide, 2332(4) states "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."**

  CPS FAR did not complete the FAR assessment in a timely manner.

DCYF Response:
The Department did not seek modification of this finding. The Department explained that the worker assigned to complete the assessment took an unexpected leave. The case was assigned to another worker who then resigned. The Department acknowledged that the required tasks were not properly completed.

The office had struggled with staff vacancies resulting in a case backlog and the area administrator developed a plan to manage the backlog. The area administrator noted to staff the expectations for monthly health and safety visits on all open FAR cases open past 60 days. New processes were put in place to ensure timely completion of required tasks. The area administrator dedicated two supervisors to close remaining backlog. Staff from other offices also assisted with case closures.

DCYF did not close a CPS investigation timely, complete required health and safety visits, or complete required collateral interviews.

In late 2020, DCYF received an intake alleging that a parent and her three children were living with a registered sex offender; the intake screened into CPS for a risk-only investigation. A worker went to the parent's home within required timeframes and completed interviews with the parent, her partner, and the children. The children were only seen one additional time in May 2021, and the case was closed at this time as well.

Violations:

- **DCYF Policies and Procedures Guide, 2331 (4)(d)(4) and RCW 26.44(12)(a) mandate that CPS investigations be closed within 60 calendar days and 90 days respectively, from the date that CPS received the intake.**

  This case was closed roughly five months after DCYF received this intake.

- **DCYF Policies and Procedures Guide, 2331 (4)(b)(viii) requires that DCYF conduct monthly health and safety visits with children identified in a CPS investigation open longer than 60 days.**

  The children were assessed at the end of December 2020, then not again until the end of May 2021.

- **DCYF Policies and Procedures Guide, 2331 (4)(g)(iv) states that the assigned caseworker must interview professionals and other persons who may have knowledge of the child,**

parent or legal guardian, or the allegations of child abuse or neglect including, but not limited to, non-custodial parents, relatives, and other people living in the home.

The agency did not interview the referent, the other parent of the children, the relative who lived in the home, or any other collaterals regarding this allegation.

DCYF Response:
DCYF did not request a modification of this finding; it acknowledged that the required activities were not completed. The agency noted that during the time of the investigation, the office employed only two active CPS investigators. The case was transferred to another office to complete a final health and safety visit and close out. The agency also reported that the initial office was working on a system to monitor case closures (among other data elements) and had started tracking cases on a shared drive that was being monitored by a quality assurance manager, who provided feedback to supervisors on timeframes.

POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY

DCYF did not document efforts to audio record an initial face-to-face interview, nor create near verbatim documentation of the interview.

OFCO received a complaint alleging that a CPS social worker pressured an alleged child victim to disclose physical abuse by her father and that a school counselor who sat in on the interview raised this concern to law enforcement. Although OFCO confirmed that the school counselor did report concerns to law enforcement about the interview, OFCO did not substantiate this allegation. OFCO's ability to fully review this concern was instead hampered, as CPS did not audio record the child's interview nor create near verbatim documentation of the interview. Without an audio recording or near verbatim documentation, OFCO was unable to conclude that the CPS social worker said or did anything that could be construed as leading, suggestive, or influencing the child.

Violations:

- **DCYF Policies and Procedures Guide, 2333 (5)(b) and 2350(d) require that DCYF "make reasonable efforts to audio record child interviews" when the investigation involves allegations of physical or sexual abuse.**

  There was no documentation of efforts to audio record the initial face-to-face interview with the alleged child victim.

- **DCYF Policies and Procedures Guide, 2350(1)(e) require the DCYF caseworker to "use near verbatim documentation when conducting the interview and audio recording is not possible or appropriate."**

  The documentation of the initial face-to-face was a summary of the interview and not a near verbatim recording of the questions asked and answered.

DCYF Response:
The Department noted that investigatory interviews are required to be audio recorded but initial face-to-face interviews are not. The initial face-to-face was not intended to be an investigatory interview, and the worker was not out of compliance with policy. The worker noted that the case was being forwarded to the local police department for a subsequent forensic interview at the local child advocacy center. However, the child advocacy center was unable to perform the forensic interview due to COVID-19 closure. When the child advocacy center reopened, law enforcement did not refer for the forensic interview. If the forensic interview had occurred, the case would have been compliant with policy. Since it did not, DCYF did not request a modification of this finding. The supervisor reviewed the policy of audio recording all physical and sexual abuse interviews with the worker.

DCYF did not properly investigate an allegation of sexual abuse.

From May 2019 through June 2019, DCYF received three intakes regarding a family, including an intake alleging sexual abuse of an eight-year-old child by their stepfather. The investigation of these intakes closed in early August 2019; however, there was no information in the Investigative Assessment regarding any investigatory work on the allegation of sexual abuse. Further review of DCYF's tracking system revealed little documentation of any investigatory work on the sexual abuse allegations. Additionally, there was no documentation that an interview with the child or a discussion with the subject regarding this allegation ever occurred. A case note indicated that law enforcement would be conducting a forensic interview. Law enforcement requested that the worker wait to meet with the child until after the interview had been completed. However, there was no documentation that this interview occurred.

Violations:

- **DCYF Policies and Procedures Guide, 2331(4)(b) and 2333(4)(c) require that the agency complete a comprehensive interview of the child victim within 10 calendar days of receipt of the intake, unless it is completed during the initial face-to-face contact.**

  The child was never interviewed regarding the sexual abuse allegation. No interview by law enforcement was documented in DCYF's tracking system or the Investigative Assessment.

- **DCYF Policies and Procedures Guide, 2334 describes the procedures that must be observed in conducting a timely and adequate subject interview in a CPS investigation.**

  There was no documentation of DCYF conducting a subject interview or requesting one and being denied. No interview by law enforcement was documented in DCYF's tracking system or the Investigative Assessment.

- **DCYF Policies and Procedures Guide, 2331(4)(b) requires that children in the home who are not identified victims must be assessed for present danger and assessed to gather information for the safety assessment.**

  There was no documentation that the other children in the home were interviewed regarding the sexual abuse allegations or assessed for related offenses against them. It was unknown if any of the children could have reported corroborating or exculpating information or would have reported additional offenses.

DCYF Response:
The Department concurred that the documentation was inadequate. The Department confirmed that the victim did receive a forensic interview by law enforcement, and the local office requested law enforcement documentation for inclusion in the case record. The local office planned to provide additional training to the CPS unit related to the adverse findings. Additionally, the area administrator planned to provide additional oversight related to the transfer and closure of CPS cases in the local office.

DCYF closed an Investigative Assessment with an unfounded finding, despite evidence to support a founded finding.

In August 2019, DCYF received an intake alleging sexual abuse of a child by the father. The intake screened in for a CPS investigation with a 24-hour response time. In December 2019, DCYF closed the Investigative Assessment as unfounded. Reviewing the case notes, OFCO found that in the course of the investigation, the child victim made detailed disclosures to the investigator and to law enforcement. However, the Investigative Assessment did not contain a full description of the case activity as recorded in the case notes and did not explain the reasoning for why the allegations were unfounded.

OFCO contacted DCYF for more information regarding the Investigative Assessment and the unfounded outcome. The acting area administrator reported that the unfounded finding was erroneously selected and was the result of a "clicking error." The acting area administrator agreed that the evidence supported a founded finding and stated that the agency would update the outcome and re-send the findings letter.

- **DCYF acted unreasonably under the circumstances:**
  DCYF acted unreasonably under the circumstances by closing the Investigative Assessment with an unfounded finding, despite adequate evidence to support a founded finding of sexual abuse, including a detailed disclosure by the child to the investigator. Further, the Investigative Assessment was not sufficiently completed and should not have been approved without more information and an explanation of the reasoning behind the conclusion.

DCYF Response:
The Department did not seek modification to the finding. The local area administrator reviewed the case and agreed that the child did make disclosures in the comprehensive interviews. The Department explained that the supervisor and the caseworker met to discuss the finding and felt the case did not meet the definition of "sexual gratification." However, the supervisor missed details of the case and as a result, approved the Investigative Assessment with an unfounded finding. After being contacted by the child's mother, the supervisor reviewed the case in more detail and spoke with OFCO. The supervisor then concluded that the case should have led to a founded finding.

As a result of the inaccurate finding, the area administrator had a discussion and a coaching session with the caseworker and supervisor to ensure all documentation is reviewed when making a findings decision, and that other resources (Quality Practice Specialist, Assistant Attorney General, other

triage, or consulting staff) be utilized in the future if there is uncertainty regarding a finding. The finding was updated in DCYF's tracking database and updated finding letters were sent to all parties.

CPS did not close an investigation timely, and the investigator did not interview collateral contacts.

In September 2020, CPS received an intake regarding an open CFWS case alleging neglect of two children who were placed with a relative caregiver. Three days following the initial face-to-face with the children, a Family Team Decision Making meeting was held, and it was determined that the children would be moved due to the condition of the home.

For two months after the initial face-to-face, the only documentation was monthly supervisor reviews that noted the worker needed to interview the subject and the Family Preservation Services worker prior to closing the case. Although the investigation had not been closed yet, the outcome of a founded finding for neglect was documented. Documentation indicated that the worker made attempts to contact the relative caregiver in December 2020 but was unsuccessful. It was not until January 2021 that the subject interview was completed, and the investigation was closed.

Violations:

- **DCYF Policies and Procedures Guide, 2331 (4)(d)(iv) and RCW 26.44 (12)(a) mandate that CPS investigations must be closed within 60 calendar days and 90 days respectively, from the date that CPS receives the intake.**

  The investigation was open for over 100 days.

- **DCYF Policies and Procedures Guide, 2331 (4)(g)(iv) requires caseworkers and LD CPS investigators to interview collateral contacts.**

  CPS did not interview collateral sources, such as the Family Preservation Services provider who had knowledge of the allegations of CA/N.

DCYF Response and OFCO withdrawal and modification of findings:

OFCO initially made an additional finding that the Department did not interview the relative caregiver in a timely manner as required by DCYF Policies and Procedures Guide, 2331 (4)(c)(i). The Department explained that this policy relates to the alleged subject being notified of allegations at the initial point of contact. The Department argued that this expectation was met as the relative caregiver was notified of the intake on the day the intake was received. OFCO agreed that the Department complied with the notice requirement and withdrew the finding.

OFCO also initially made a finding that the worker did not document activity within ten calendar days as required by DCYF Policies and Procedures Guide, 6600 (2). There was no documentation of the conversation between the worker and the Family Preservation Services provider. The Department disagreed with this finding and argued that the collateral contacts were documented in monthly supervision notes and in the CFWS case file. OFCO explained that while the CPS investigation reviewed the information obtained during the CFWS case, including information from the Family Preservation Services provider, CPS did not conduct a collateral contact interview the Family

Preservation Services provider. OFCO modified the finding to reflect that CPS did not interview collateral sources who had knowledge of the allegations of CA/N. The Department reported that the CPS unit that handled this investigation was advised by the CPS supervisor on ways to document case activity when a case is open more effectively with CFWS and CPS simultaneously.

The Department agreed that the case did not meet timely case closure expectations. The Department explained that at the time of the intake, the local office's CPS program was adversely affected by staffing challenges, which was addressed by hiring new staff.

DCYF did not notify a parent that she was the subject of an investigation or interview her specifically regarding the allegations against her.

In early 2021, DCYF received an allegation from a child's parent that her developmentally disabled teen had been molested by her now former partner, and the child had become pregnant. Due to the parent being protective, the allegation was screened out to law enforcement. Shortly thereafter, law enforcement contacted DCYF with the information again, alleging that the partner had been acting as a parent at the time of the abuse; on this basis, DCYF screened the allegation into CPS, naming only the mother's former partner as a subject, due to the mother continuing to present as protective. The assigned worker came to the family home, interviewed the child, and spoke with the mother in her role as the child's parent.

Between the end of January and the beginning of April, DCYF documented little casework on this matter. A supervisory case note in March indicated that the mother was not following up on needed medical and mental health services for the youth, and if she continued in this vein, the assigned worker may need to call in a new intake related to that neglect. Soon after, the caseworker told the mother that she needed to see the child once more before closing the case. The mother obtained an attorney and, through her attorney, asked if she was a subject and if so, what the allegations were. The agency refused to provide this information to her. The case closed and only then was the mother able to discern that she had been a subject of the investigation. OFCO contact with the agency revealed that the mother was added as a subject during the process of closing the investigation into the former partner.

Violations:

- **DCYF Policies and Procedures Guide, 2331 (4)(c)(i) and RCW 26.44.100 (2): Parents and alleged subjects are to be notified of any allegations of child abuse and/or neglect "at the initial point of contact" while also not jeopardizing the investigation and maintaining confidentiality and the safety of the child.**

  The mother was not initially a named subject in the investigation, but the worker and supervisor explicitly refused to inform her after she was added as a subject and what the allegations against her were.

- **DCYF Policies and Procedures Guide, 2334 (1)(a) requires CPS to conduct individual and face-to-face interviews of each subject.**

After the mother was added as a subject, she was not interviewed as to the allegations, nor given any opportunity to respond.

DCYF Response:
The Department did not seek a modification of this finding. The agency responded that, instead of adding the mother as an alleged subject after the initial intake was received and the investigation had begun, a new intake should have been created when concerns arose regarding mother's lack of protection. It acknowledged that the mother had not been informed of the change or interviewed regarding it. In response, the area administrator met with the caseworker to clarify the involved policies, including subject interviewing, the need for transparency with families, and the need for subject interviews. In addition, the local supervisors were advised that in all subsequent cases with concerns that arise during an investigation that a non-offending parent is not protective, that a new intake must be made to address the allegations. The office also planned an updated training on Structured Decision Making.

DEPENDENT CHILD WELL-BEING AND PERMANENCY

DCYF did not conduct an ongoing relative search.

In March 2017, DCYF received an intake alleging that parents had neglected their two children by leaving them with paternal grandparents who were not able to care for them without additional support. The intake screened in for a non-emergent CPS investigation.

During the initial contact, the paternal grandparent informed the CPS social worker that they had been caring for the children for six months, but due to their age, they would not be able to be a long-term placement. The paternal grandparent requested help until a potential adoptive family was identified. Two weeks after the initial contact, the paternal grandparent reported that they were struggling to care for the children. DCYF offered to remove the children that day, but the grandparent indicated they did not want the children moving around in foster care and requested the children stay there until a permanent placement was found. The children remained in relative care with the paternal grandparents until June 2019 when they were placed with a prospective adoptive family.

An initial relative search in October 2017 identified the maternal grandparents who expressed interest in placement and contact with the children. However, there was no documentation of follow up with the maternal grandparents to discuss their interest or to identify other potential maternal relatives. There was also no further documentation of contact with another identified maternal relative and no documentation of subsequent relative search activities after October 2017. However, the children were later abruptly moved from the prospective adoptive family to a maternal aunt's home in August 2020.

Violation:

- **DCYF Policies and Procedures Guide, 4527 requires DCYF to continue the search for relatives when a child disrupts from placement, and twelve months have passed since the previous relative search and the child is not currently placed in kinship care.**

There was no follow up with the maternal grandparents regarding their interest in caring for the children or to identify other maternal relatives. There was also no documented follow up with the maternal relative who was identified during an attempt to contact the mother. There was no documentation of subsequent relative search activities after October 2017. This had an adverse impact on the children as placement with the maternal aunt could have occurred earlier had an ongoing relative search been conducted and maternal relatives were contacted. Instead, the children were suddenly moved from what they believed was their permanent home with their prospective adoptive family to their maternal aunt's home.

DCYF Response and OFCO Withdrawal of Finding:

The Department acknowledged that it did not make efforts to conduct a relative search on the maternal side of the family on an ongoing basis. The local office conducted an all-staff meeting and the local area administrator reviewed the policy on relative searches at the meeting. The local office also set expectations requiring supervisors to complete monthly reviews in their units to ensure that relative searches are being utilized effectively and consistently with the Department's policy.

OFCO initially made a finding that the lack of transparency with the caregivers about a possible change in placement and permanent plan was clearly unreasonable. The children had been in out-of-home care for almost four years and were placed with the prospective adoptive family for over one year. The children were abruptly moved to their maternal aunt's home in August 2020 after approximately two visits. Although the prospective adoptive family was notified of the change in placement five days prior to the move as required by DCYF policy, they were given no advance warning that a relative was being considered as a placement option or how this would impact the permanent plan. In addition to the adverse impact on the caregivers, failing to inform the caregivers about a potential change in placement and case plan impacted the Department's ability to develop a transition plan to the maternal aunt's care. The children exhibited significant externalizing behaviors following the change in placement.

The Department disagreed with this finding and requested a withdrawal. The Department argued that the permanent plan for the children did not change while they were placed with the foster parents. The Department explained that the foster parents were made aware that a relative had come forward and were notified that the relative requested to visit and eventually be a placement resource for the children. The court ordered the change in placement after review of all available information. The Department was required to follow the court's order and provided the foster parents the required by policy 5 days' notice prior to the placement move. The Department is obligated to consider and prioritize relative placements according to laws and policies. The Department also explained that there were challenges collaborating with the foster parents, which made it difficult to plan for a smooth transition.

After reviewing the information provided by the Department, OFCO agreed that the Department's conduct was not clearly unreasonable under the circumstances and withdrew the finding regarding the lack of transparency with caregivers.

FAMILY SEPARATION AND REUNIFICATION

The Department did not provide court-ordered visitation.

In March 2018, the Department filed dependency petitions in relation to two siblings due to allegations of physical abuse and neglect. The children were placed into foster care; the father was incarcerated the following year. In September 2019, the father was granted one supervised weekly video visit and one supervised monthly in-person visit. Due to COVID-19 restrictions, the visits were changed to video visits in April 2020. In October 2020, one of the siblings was moved to a therapeutic foster home, and it was around this time that the father's visitations with both children stopped. The visits did not resume until March 2021.

OFCO contacted the CFWS supervisor about the lack of parent-child visits. The supervisor confirmed that the Department had not provided the father with court-ordered visits for approximately four months. The supervisor explained that a new caseworker was assigned in late 2020 and was having technological issues with the required video application. Additionally, the worker experienced delays in obtained approval from the Department of Corrections to supervise video visits. In March 2021, the worker began providing video visits between the father and his children using her cell phone. The Department confirmed that the father was owed approximately 40 hours of visitation, and it was in the process of providing them to him.

Violation:

- **DCYF did not provide court-ordered visitation between the father and children from approximately mid-October 2020 to March 2021.**

  OFCO recognized that many factors contributed to the delay in providing the father court-ordered visits. However, it should not have taken approximately four months to resolve these issues.

DCYF Response:

The Department agreed that a significant amount of time had passed where the father was not offered visits. The Department explained that the new caseworker was not familiar with the procedures to set up the application and did not understand how to resolve the issues. The supervisor coached the caseworker, asking her to involve supervisors when barriers to visitation arise. The area administrator reminded workers at an all-staff meeting about the importance of ongoing regular visits, including with incarcerated parents. The area administrator also outlined the mechanism to set up the video application, so staff would know how to access it.

FOSTER PARENT/RELATIVE CAREGIVER ISSUES

DCYF did not refer a relative placement for a home study or document placement changes timely.

In October 2018, two siblings were placed into protective custody by law enforcement due to allegations of physical abuse. Shortly thereafter, DCYF filed a dependency petition on both children, and the siblings were placed separately with two different relatives.

In early July 2019, one sibling moved to the home of their aunt, as the prior relative placement could no longer care for the child. The aunt and her partner completed background checks for emergent placement and were cleared. The other sibling later disrupted from their placement in October 2019 and moved in with the aunt as well.

Supervisory review notes from August and September 2019 indicated that the aunt completed the home study application, and the social worker submitted the application to the Department of Licensed Resources (DLR). Supervisory review notes from January, March, and April 2020 stated that the background checks and fingerprints for the relative caregivers had been approved and that the relative caregivers would be referred for a home study. A supervisory review note from May 2020 stated that the relative caregivers had been referred for the home study. However, at the time of OFCO's review in August 2020, the home study referral had not been made to DLR.

Violations:

- **DCYF Policies and Procedures Guide, 45274 requires DCYF 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.**

  One sibling had been placed with the aunt for over a year, and the other for nearly a year. DCYF did not conduct a home study within the required timeframes.

- **DCYF Policies and Procedures Guide, 4260(7)(a) requires that DCYF document in FamLink a child's move within three business days of a child moving.**

  DCYF did not document the placement changes of the children timely. At the time OFCO began investigating in 2020, DCYF's tracking system displayed each of the children as being placed in their separate relative placements where they had initially been placed in October 2018. Based on a review of the case notes and court orders, OFCO was able to confirm that the children had been placed with their aunt in July 2019 and October 2019. OFCO brought the issue to the Department's attention, and the placements for the children were updated in DCYF's tracking system in August 2020.

DCYF Response:
DCYF responded that the worker, who is no longer with the agency, erroneously reported to the supervisor that the family had been referred for a home study. This occurred at a time while the office was short of supervisors. The office has since hired more supervisors.

Additionally, the office initiated a tracking system to document the status of home study referrals for all relative placements, and the Licensing Division was scheduled to conduct a training on the home study process for the office staff. Plans were made for additional staff training on timely placement entry and the use of an application that would allow the worker to enter placement information from their phone.

DCYF did not assess the suitability of a relative caregiver prior to placement.

In February 2021, two children who were recently removed from the care of their parents were placed with a grandparent, following the completion of an emergent background check. The caseworker also had the grandparent complete fingerprints and did a walk-through of the home. Nearly two months later, the children were removed from this home following an incident of domestic violence in the home involving one of the parents and another relative. Additional allegations that one of the children was injured in the course of this event also arose. The caseworker received further information that the grandparent had been allowing the parents unsupervised access to the children, in violation of the court order. OFCO completed a search of the grandparent's history in DCYF's FamLink system and discovered that the grandparent had a home study denied in 2017 due to similar concerns as those that arose during this involvement: grandparent allowing unauthorized contact, domestic violence, and lack of boundaries. OFCO contact with the local office revealed that the caseworker was unaware of the denied home study.

DCYF Response and OFCO Withdrawal of Finding:
OFCO originally made a finding that DCYF did not conduct an adequate check of FamLink records to assess the suitability of the caregiver prior to placement as required by DCYF Policies and Procedures Guide, 45274 and Operations Manual, 6800.

The Department responded, requesting clarification about the specific policy requirements regarding this finding, as the caregiver successfully completed the background check. During a subsequent discussion with OFCO, DCYF noted that agency policies allow placement with a relative prior to completion of a home study when an unlicensed caregiver passes the background check and upon approval of the area administrator. Although the caregiver had a previously denied home study, this is not considered a negative action and would not disqualify this relative from placement.

OFCO determined that it was appropriate to withdraw the finding on this basis. However, in its response, it noted that an area administrator's decision to approve a placement prior to completion of a home study should be made in an objective and consistent manner. OFCO recommended that the Department develop and implement practice standards, which should include a review of the person's DCYF history, to guide the placement decision. OFCO noted that by reviewing FamLink history, the Department will be better able to identify any areas of concern and safety plan accordingly to protect children and support the placement if approved.

OTHER FINDINGS

DCYF did not follow DCYF Indian Child Welfare Policy and the terms of a Memorandum of Understanding.

In September 2020, an intake alleging sexual abuse of a child by their stepfather screened in for an emergent CPS investigation. The intake indicated that the family was associated with a tribe.

The intake was assigned that same day and the assigned CPS social worker went out to the address listed on the intake. After discovering the mother did not reside at that address, the assigned CPS social worker called the mother and obtained the mother's address, then met with the mother and the children at the mother's workplace. Case notes indicate the social worker was unaware that these locations were all on tribal lands.

The CPS social worker did not contact the tribe's ICW contact person to discuss the investigation until November 2020.

Violation:

- **DCYF Indian Child Welfare Policies and Procedures, Section 5 requires that the DCYF social worker contact the tribal social services program or the ICWA representative within 24 hours of being assigned the intake in order to coordinate activities and determine roles and responsibilities. DCYF Indian Child Welfare Policies and Procedures, Section 5 requires DCYF to follow the Tribe's Memorandum of Understanding (MOU), which involves coordination between the tribe ICW and DCYF of child abuse and neglect investigations of families living on the reservation. This MOU requires the Department to notify the Director of ICW prior to entering tribal lands when investigating referrals of child maltreatment within the reservation.**

  The case file documentation indicates the CPS social worker did not contact the tribal ICW representative within 24 hours as required. The social worker made initial contact with the tribal ICW representative approximately one month into the investigation. There were no efforts prior to that to coordinate the investigation and discuss who was taking the lead on the investigation.

DCYF Response:

The Department explained that the assigned CPS social worker was unaware that they were on tribal land. Although the tribe has parcels of land that are not on the reservation, the worker did not verify whether the address was considered tribal land or non-tribal land before going to conduct the initial face-to-face. The Department agreed with the finding that the MOU with the tribe was not followed.

The local office located and posted a map of the reservation with additional information regarding non-reservation land parcels addressed in the map. Coaching was also provided to the CPS social worker. ICW policy was reviewed with all workers and the CPS supervisor also reinforced that information. Staff were instructed to check the reservation map to determine whether the address for any field visit in that area is on tribal land.

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.