OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

An Independent Voice for Families and Children

ANNUAL REPORT
2020

Patrick Dowd, Director
ofco.wa.gov

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To the Residents of Washington State:

I am pleased to submit the 2020 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, 2019 to August 31, 2020. 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 821 complaints and completed 830 investigations regarding 1,228 children. As in past years, the separation and reunification of families and concerns about agency conduct and services 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. Unfortunately, the placement resource crisis has only worsened and this reporting year, 220 children spent a combined total of 1,863 nights in hotels or offices. Children with complex behavioral and mental health needs, who are the most vulnerable, also experience the most placement exceptions. Until we are able to provide an adequate array of placement resources to meet the needs of all children in state care, the Department should take steps to normalize hotel and office stays for these children.

The COVID-19 pandemic has impacted every facet of our child welfare system, including the health and safety of our workforce; foster parents and caregivers; service providers; the court system; and most importantly, the children and families we serve. The pandemic has created financial hardship and stress on many families, creating an environment that may result in higher rates of child maltreatment. Children, however, are isolated from their communities and reports of abuse or neglect to Child Protective Services have fallen. The pandemic has also affected state revenue and the governor and legislature face the challenge of designing a budget that protects the health, safety, and welfare of our most vulnerable children and families.

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, 2019 through August 31, 2020, 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.

[1] RCW 43.06A and RCW 26.44.030.

System Oversight and Improvement:

- Monitor the procedures as established by the Department of Children, Youth, and Families (DCYF) to carry out its responsibilities in delivering family and children's services to preserve families when appropriate and ensure children's health and safety;
- Periodically review the facilities and procedures of state institutions serving children and state-licensed facilities or residences;
- Review child fatalities and near fatalities when the injury or death is suspected to be caused by child abuse or neglect and the family was involved with 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 COVID-19 pandemic has had a substantial impact on every facet of our child welfare system. Child Protective Services has experienced a decrease in reports of child maltreatment as children are not attending school and are generally isolated from mandated reporters. However, economic stress on families contributes to an increased risk of child abuse and neglect; thus, there is a distinct possibility that cases of child maltreatment are going unreported. The pandemic also increases pressure on foster parents, group care facilities and relative caregivers as they must ensure the health and welfare of children in their care as well as that of their staff, and families. Under these circumstances, many foster parents have declined to accept placements, straining an already overburdened system of care. Further, parents involved in the dependency court process may not be able to access reunification services, in-person visits with their children, or the courts to resolve contested issues. As a result, family reunification, as well permanency for children, may be delayed. Youth aging out of foster care at age eighteen, or twenty-one for those in the extended foster care program, face significant challenges under the best of circumstances. The pandemic's impact on employment and educational opportunities for youth only increases the risk of homelessness for youth exiting care.

Over the past five years, OFCO has reported on the growing number of children and youth placed temporarily in hotels or state offices because no other placement was available. Many of these children have serious mental health concerns, are involved with the juvenile justice system, and/or suffer from major developmental disabilities. The pandemic has made it even more difficult to provide an appropriate placement for children with complex needs, as many foster parents are unwilling to accept new placements out of concern for the health of themselves and their families.

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

The legislature and governor face the challenge of reduced revenue while establishing a biennium budget. However, it is essential that in response to the additional challenges wrought by the pandemic, adequate funding is allocated for services and programs to strengthen and preserve families and ensure the health, safety and welfare of children in state care.

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2019 and August 31, 2020, OFCO completed 830 complaint investigations regarding 1,228 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 categories of issues identified in complaints.

OMBUDS IN ACTION

OFCO takes action when necessary to avert or correct a harmful action or oversight, or an avoidable mistake by DCYF. Seventy-three complaints prompted intervention by OFCO in 2020. 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 57 complaints.

In 2020, OFCO made 67 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.

COVID 19 IMPACT ON CHILD WELFARE SYSTEM

The pandemic creates hardships for children, families, caregivers, and the workforce involved with our child welfare system. Children are not attending school in person and are isolated from professionals who have a duty to report suspected child maltreatment. Parents may face greater financial and housing uncertainty, and their ability to engage in reunification services may be compromised. In some cases, parent-child visits, as well as sibling visits, have been reduced to remote, electronic interactions to prevent the spread of COVID-19. Placement resources are also strained as foster parents deal with additional demands on caring for foster children and ensuring the health and safety of their biological family. Group care facilities face unique challenges as many children share close quarters and COVID-19 could more easily spread between residents and staff. Washington's child welfare system has never before faced a pandemic of this nature. Much remains unknown as an effective vaccine or treatment has not yet been developed and surges of the virus continue. The pandemic's impact on our child welfare system and the Department's responses to this crisis are summarized below.

CHILD WELFARE

CPS Intake

Due to the pandemic, Washington State experienced an immediate decline in reported cases of child maltreatment, as children and youth are kept away from their schools, regular medical appointments, extracurricular activities, and the professionals who have a legal duty to make a referral to CPS intake when they suspect child abuse or neglect. Following the closure of schools in March 2020, DCYF saw a 42% decrease in calls to the CPS hotline, and the number of weekly calls screened in for investigation dropped by 50%.[4] As school resumed this fall, CPS intake report from educators have increased but have not returned to pre-pandemic levels.[5] The pandemic may be contributing to conditions that increase the risk of abuse and neglect. Parenting stress, financial stress, mental illness, increased substance use, and social isolation are associated with an increased risk of child maltreatment and may be exacerbated during this pandemic. Child abuse and domestic violence increase significantly in post-disaster settings, such as the COVID-19 pandemic, and traumatic brain injuries (TBIs) are the most common form of injury due to child abuse after a disaster.[6] Nationally, while CPS reports of child abuse have plummeted, doctors report an increase in treating children with serious injuries.[7] Under similar economic and social stresses during the Great Recession, Seattle Children's Medical Center experienced a 120% increase in the rate of Abusive Head Trauma cases.[8]

CPS Investigations and CFWS Case Services

CPS intake workers screen for COVID-19 related concerns when taking reports of suspected child maltreatment. If a report to CPS is screened in for investigation or a Family Assessment Response, a caseworker is required to conduct an initial face-to-face visit.[9] In order to ensure the caseworker's safety and the safety of others, prior to conducting this visit, the caseworker asks if anyone in the household is

[4] DCYF Office of Innovation Alignment and Accountability.

[5] Child Welfare and Health Services Trends, https://www.dshs.wa.gov/sites/default/files/rda/reports/DCYFcovid.pdf.

[6] Washington State Department of Health, Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19, August 2020. https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHG-COVID19StatewideSummaryForecastofBHImpacts-Aug2020Update.pdf.

[7] https://www.washingtonpost.com/education/2020/04/30/child-abuse-reports-coronavirus/.

[8] Id. Fn 1.

[9] DCYF Practices and Procedures, Section 2310.

sick, has been in contact with anyone known to have COVID-19, and if anyone has underlying health conditions. Based on the responses to those questions, the circumstances of the case, and health department recommendations, the caseworker and supervisor determine an appropriate course of action for conducting the initial visit, which, given the circumstances, may or may not include a face-to-face assessment of the family and living area.

DCYF must also conduct in-person health and safety visits with children in state care or placed with a parent in an in-home dependency.[10] In March 2020, this requirement was suspended by the Washington State's Governor's Proclamations (20-33 and 20-05), except for cases assessed as high risk or where there was an active safety threat. Health and safety visits occurred through videoconferencing, or by speaking to/observing the child through a window or from a distance of at least six feet. In May 2020, procedures were modified to address the transition back to face-to-face contact with recommendations for scheduling, asking screening questions related to COVID-19, and practicing social distancing during the contact. DCYF has also been working to ensure Personal Protective Equipment (PPE) is available to staff.

FAMILY REUNIFICATION

When a child enters state care due to allegations of child maltreatment, the primary goal is to remedy parental deficiencies and reunite the family. The Department must offer services to the parent that will enable them to resume custody of the child and encourage the maximum amount of parent-child contact possible. Laws and policies, however, also recognize that children need permanency, and if family reunification is not possible within a reasonable time period, an alternative permanent plan, usually termination of parental rights and adoption or guardianship, should be established. Unless the court has identified an exception, the Department must file for termination of parental rights once a child has been in out-of-home care for fifteen of the most recent twenty-two months.[11] The most common complaint to OFCO concerns family preservation and reunification. These complaints often identify issues related to access to services, parent-child visits, or a decision by the Department to pursue termination of parental rights.

Parent-Child Visits

Quality parent-child visits are a core component of successful family reunification. Early, consistent, and frequent visitation is crucial for maintaining parent-child relationships and making it possible for parents and children to safely reunify. As a result of the pandemic and the resulting need to balance public health and the needs of foster parents, relative caregivers, children, and families, an Executive Order[12] allowed the Department to immediately waive requirements for in-person visits.[13] In March 2020, DCYF changed visitation policy and implemented remote parent-child visits. DCYF worked with contracted family time providers to distribute equipment to parents and caregivers to access remote visits. Additionally, the Department developed tip sheets for staff, providers, Behavior Rehabilitation Service facilities, caregivers, foster parents, parents, and Tribal partners to make virtual visits age appropriate and more meaningful. Despite these efforts, the pandemic has had an adverse impact on the quality and duration of parent-child visits. For example, young children who are able to actively engage with their parents for several hours during in-person visits do not have the attention span or language skills to

[10] DCYF Practices and Procedures, Section 4420.
[11] RCW 13.34.136.
[12] Washington Executive Order 20-33.
[13] RCW 13.34 and RCW 74.13.

actively participate with their parents in a remote audio/video visit. This impacts a significant number of families as 41 percent of children in state care are four years old and under.

Beginning in May 2020, DCYF has gradually resumed some in-person visits, or a combination of in-person and virtual visits, depending on the individual circumstances of the case and pandemic variances across the state. DCYF issued interim policy guidance for considerations, questions, safety protocols, transportation, and cleaning to determine whether sufficiently safe conditions exist to warrant in-person family time.

Remote visits are not a substitute for in-person family time. However, technology and virtual visits can be used to enhance parent-child contacts as we return to in person visits.

Reunification Services

The pandemic has also affected parents' abilities to engage in reunification services. Service providers may not be able to meet in person with families, which may compromise the effectiveness of services aimed at ensuring child safety and promoting the reunification of families. For example, DCYF directed Combined In-Home Services (which includes various programs designed to strengthen, preserve and reunite families, and include programs such as Family Preservation Services, Triple P, Parent Child Interaction Therapy, and Incredible Years) to stop in-person visits and offer video or telephone visits instead. Additionally, a parent may have limited access to services as a result of illness; Stay Home, Stay Healthy requirements; or lack of transportation. Furthermore, it is more challenging for the agency to accurately assess a parent's progress in services and the likelihood of family reunification. Because of these factors, the federal Children's Bureau recently urged agencies to carefully consider whether it is appropriate to terminate a parent's rights after a child has remained in out-of- home care for 15 out of the past 22 months. The Bureau suggests agencies institute protocols that provide an additional layer of review prior to filing for termination of parental rights during and after the pandemic.[14]

IMPACT ON CAREGIVERS

Amid the COVID-19 pandemic, foster parents and relative caregivers face numerous challenges while providing critical supports for children and youth currently in state care, including financial impact on the family, additional demands created by school and day care closure, remote learning and the lack of extracurricular activities for children, facilitating visits between children and parents, and accessing services for the child. Many licensed foster parents are unable to accept new placements because of risks related to the pandemic. In order meet the need for licensed placements, DCYF created an emergency foster care waiver and exception process to support programs and families. Changes to the background check process aim to decrease turnaround time and safely remove barriers in assessing individuals who may provide care to children.

COVID-19 poses a particular risk for congregate care facilities or group homes where many children share close quarters. Several group homes in Washington State were affected by the pandemic with either staff and/or residents testing positive for COVID-19. Providers were expected to quarantine children onsite and continue operations. While some group homes have been able to meet this requirement, it places exceptional demands on facilities. For example, when an employee tests positive

[14] Children's Bureau, J. Milner Associate Commissioner, letter to State and Tribal Child Welfare Leaders, June 23, 2020. https://www.acf.hhs.gov/sites/default/files/cb/parental_rights_adoption_assistance.pdf.

for the virus, a group home provider may not be able to adequately staff the facility to quarantine children and accept new placements. In June 2020, an 18 bed group home providing placements for children in state care experienced an outbreak of COVID-19 with both residents and staff testing positive for the virus. This facility was unable to quarantine residents onsite and children were quarantined for two weeks in a DCYF office space normally used for supervised visits. The Department equipped six individual rooms with cots, televisions, and DVD players, and provided staff supervision, personal protective equipment, showers, and kitchen facilities.

To address the additional demands created by the pandemic, DCYF is partnering with stakeholders to:

- Speed up the licensing process and establish additional Residential Facility capacity and have state-wide emergency placement options.
- Allow provisional hiring in group care facilities.
- Create a staffing pool to provide additional resources by recruiting individuals with skills, knowledge, expertise and experience to serve children residing in residential facilities.

DCYF should continue to collaborate with private agencies operating group home facilities and develop flexible plans for addressing the need to quarantine youth or staff and maintain placement resources. The plan should maintain stability of the child's placement when possible, ensure medical needs are met, protect the health of residents and staff, recognize staffing needs and demands placed on agencies, and prepare for relocating children when necessary.

EXTENDED FOSTER CARE

Youth aging out of foster care at age 18, or age 21 for those who participated in extended foster care, face daunting challenges. Under normal circumstances, these young adults must take on the full responsibility of meeting their own needs when they exit care, without the family support many in family care have. The pandemic has only exacerbated these challenges with higher unemployment and college and school closures, creating an environment for a greater risk of homelessness. In April 2020, the Department made it easier for foster youth to participate in the extended foster care program. DCYF amended rules to allow youth who want to enroll or re-enroll in extended foster care the ability to give verbal consent to the terms of the Voluntary Placement Agreement and the Participation Agreement. While a few states mandated a temporary moratorium for aging out of foster care, Washington State has not provided for this, and instead has provided some financial assistance to youth exiting the Extended Foster Care Program. The Washington State Office of Homeless Youth allocated $1 million in CARES Act funding to DCYF in order to provide stipends to young adults aging out, or who have aged out, of extended foster care. This funding is intended to help support housing stability for youth exiting the Extended Foster Care Program.

Particularly in light of the pandemic, DCYF should begin to track outcomes for youth exiting extended foster care. This will help the Department and stakeholders better understand the struggles these youth face, develop more effective strategies to ensure success, and avoid youth homelessness.

DEPENDENCY COURT PROCESS

In March 2020, the Washington State Supreme Court responded to the COVID-19 pandemic and suspended all trials. Dependency fact-finding hearings and termination of parental rights trials were

continued.[15] As court operations are deemed essential, in May 2020, courts were directed to conduct as much business as possible consistent with public health guidance in their community and use remote proceedings whenever appropriate.

In June, the Washington State Supreme Court issued guidelines for resuming dependency fact-finding and termination of parental rights trials.[16] These guidelines considered the importance of timely permanency for children and families, due process rights for parents, public health and safety recommendations, active executive and Supreme Court orders, and the diversity of resources available to meet the needs of dependency courts across the state. The guidelines recommend that dependency fact-finding trials may proceed by video or a combination of video and in-person appearances. For termination of parental rights trials, the guidelines recommend conducting these proceedings in-person once the court has the ability to conduct them safely. No default orders for dependency fact-findings, termination trials, or Title 13 guardianships may be entered until a reasonable time after courthouse-based operations resume.

Shelter care hearings are considered emergency matters. Courts and all parties in shelter care hearings were directed to make it possible for these matters related to a child's removal from their home to be heard by video or in-person, provided social distancing and other public health measures are strictly observed. Courts are encouraged to hear non-emergency matters, such as procedural or substantive motions by video, telephone, or other means that do not require in-person attendance, as long as parties are able to participate in the hearings. For termination of parental rights trials, the guidelines state a strong preference for in-person trials once the court is able to conduct them safely. The court should weigh the participants' due process rights and consider a continuance if an in-person trial cannot be safely conducted.

The guidelines further direct that courts should hear motions about parent-child visits. In ruling on motions about visitation, the court must take into consideration public health risks resulting from exposure to COVID-19, the child's age and developmental level, the feasibility of in-person and remote visitation, functional capacity of the parent and child, the child's best interests, and the child's health, safety, and welfare. Any court-ordered in-person visitation shall mandate the specific health, safety and welfare protocols that must be followed.

RECOMMENDATIONS

As a result of the pandemic, Washington State is preparing for a significant reduction in revenue and the governor and legislators will face challenges in establishing a biennium budget that meets the needs of all Washingtonians. Particular attention must be paid to protecting our most vulnerable children and families and when possible preventing children from entering state care.

Expand Financial, Concrete Goods, and Housing Support for Families. While homelessness and poverty in and of themselves are not child maltreatment, circumstances facing poor families often lead to involvement with the child welfare system. Housing instability, including eviction, doubling up and

[15] The Supreme Court of Washington, Amended Order No. 25700-B-607.

[16] Washington Courts, Resuming Dependency Fact Finding and Termination of Parental Rights Trials in Washington State-Guidelines for Operations during the COVID19 Pandemic, June 2020.

homelessness, are more common among families with children in out-of-home care.[17] Financial support and helping families to meet their housing needs can reduce the need for out-of-home placement of children and reunite families engaged with the child welfare system.

Provide Adequate Behavioral Health and Substance Abuse Treatment. Mental health treatment, including substance use disorder treatment for youth and families, is more essential than ever. Social isolation is associated with increased behavioral health problems, such as depression, anxiety, mood disorders, psychological distress, post-traumatic stress disorder, and lack of self-control. The Department of Health predicts these circumstances will also lead to an increase in problem substance use. More than one-third of adults with substance use disorders have a co-occurring mental illness. Both are risk factors associated with child maltreatment and often lead to the removal of a child from a parent's care.

Provide Adequate Support for Caregivers. Our child welfare system must enhance efforts to provide case aides to assist foster parents and caregivers and identify a system of support services for children in their care, including counseling, educational assistance and academic tutoring, transportation to appointments, respite care, and hands-on assistance for children with high risk behaviors. These supports are especially important as caregivers deal with additional pressures and the risks related to the pandemic and are essential to reducing placement disruption.

Create a Sufficient Array of Placement Resources for Children. In the 2019 supplemental budget, the legislature responded to the ongoing placement crisis of children temporarily placed in hotels and offices by providing additional funding for therapeutic placements to care for children with behavioral needs as well as to meet the needs of emergency placements. Unfortunately, due to the anticipated reduction in the 2021-2023 budget, the Department has not brought these additional placements on line. Dedicated funding is essential for the Department to establish an array of placement resources able to meet the needs of all children in state care.

[17] Families at the Nexus of Housing and Child Welfare, Dworsky, A., PhD. (2014) https://firstfocus.org/wp-content/uploads/2014/12/Families-at-the-Nexus-of-Housing-and-Child-Welfare.pdf.

SECTION I: IMPROVING THE SYSTEM

Placement Exceptions

PLACEMENT EXCEPTIONS

HOTELS AND DCYF OFFICES USED AS EMERGENT PLACEMENTS FOR FOSTER CHILDREN

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

Figure 1: **Number of Placement Exceptions**

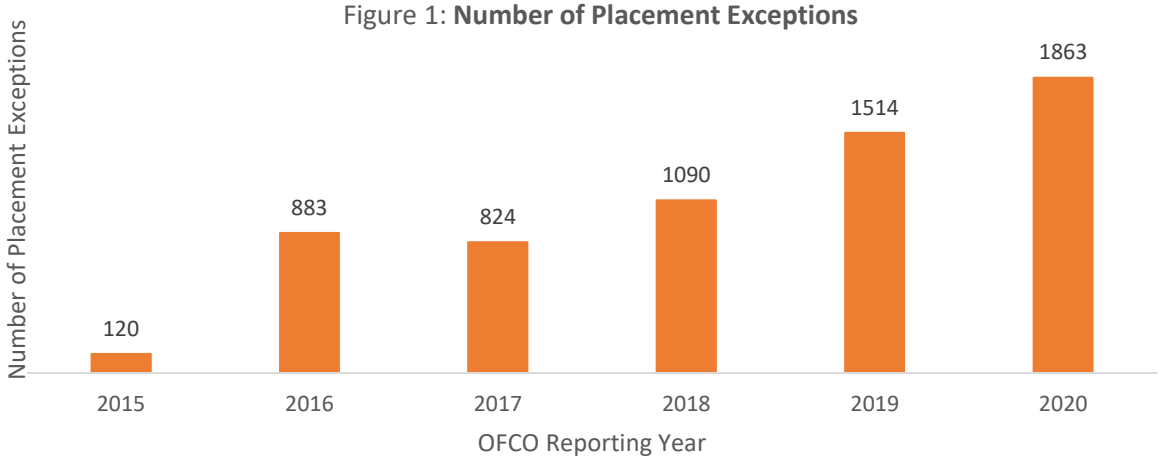
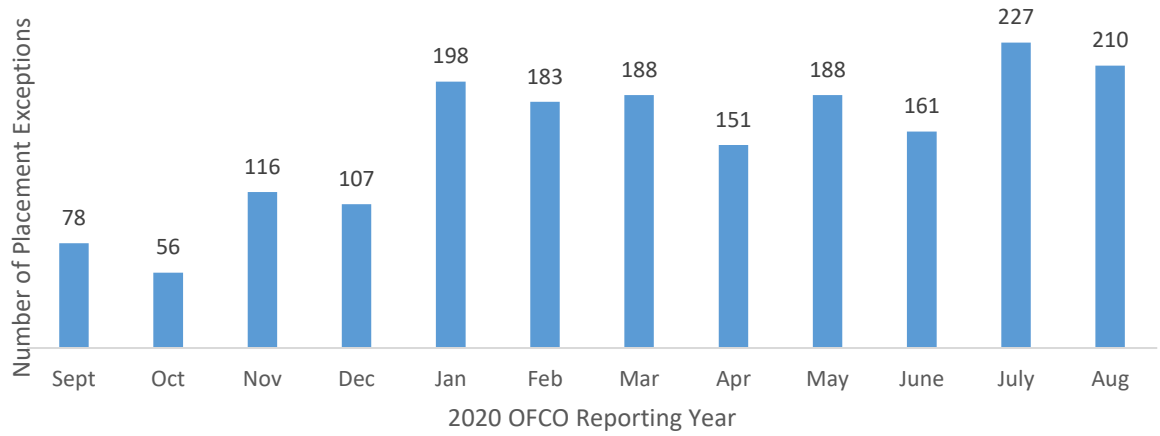


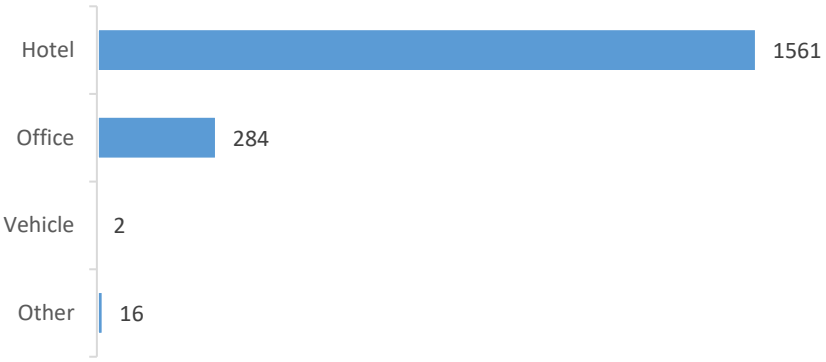
Figure 2: **Placement Exceptions by Month, 2020**



Since 2014, OFCO has tracked the Department's use of hotels and DCYF offices as emergency placements for children. These are referred to as "placement exceptions." Unfortunately, the placement of children in hotels continues at an alarming rate in Washington.

From September 1, 2019 to August 31, 2020, OFCO received notice of 1,863 placement exceptions involving 220 different children, an increase of 349 stays from 2019 and the most placement exceptions noted since OFCO began tracking placement exceptions. The vast majority of these placement exceptions (1,561) involved children spending the night in hotels supervised by caseworkers.

Figure 3: **Location of Placement Exceptions, 2020**



Of the 1,863 placement exceptions, 284 were reported to be office stays involving 43 children. The majority of the reported office stays involved children from Region 6.

Table 1: **DCYF Placement Exceptions that Occurred in a DCYF Office, 2020**

DCYF Region	Number of Placement Exceptions in a DCYF Office
Region 1	0
Region 2	0
Region 3	15
Region 4	25
Region 5	1
Region 6	243

COVID-19 STRAINS PLACEMENT RESOURCES RESULTING IN MORE HOTEL AND OFFICE STAYS

Placement exceptions have notably increased during the COVID-19 pandemic. Agency administrators attribute this to a multitude of factors, but one of the most impactful is the number of foster homes that are not accepting placements due to concerns for their health. For example, administrators in King County report that since the pandemic began, roughly 30% of foster homes in that area have stopped accepting placements due to concern about the virus. These losses have further strained an already inadequate array of placement resources. Regions are managing the growing placement crisis during a pandemic in a variety of ways.

In Region 4, an area that includes Seattle, early concerns led to the creation of a temporary facility to house children out of placement who were suspected of exposure to the virus. The visitation center of a local office was transformed into an overnight facility in coordination with the Department of Health. DCYF outfitted it with cots, televisions, gaming systems, and other amenities. The facility was staffed by employees who received specialized training.

Region 6, comprising the Olympic Peninsula and spanning the western portion of the state from Vancouver to Port Angeles, has experienced an increase in placement exceptions during the pandemic, and particularly in overnight office stays. The administration in that region is placing children in visitation rooms in local offices where they can be isolated from other youth and staff to minimize the risk of COVID-19 exposure or an outbreak, but still be properly supervised. The increase in office stays in this region, normally something that would be a concern due to the non-home like setting for the children staying there, instead represents a creative response to address the ongoing crisis of placement exceptions compounded by the global health crisis of a pandemic.

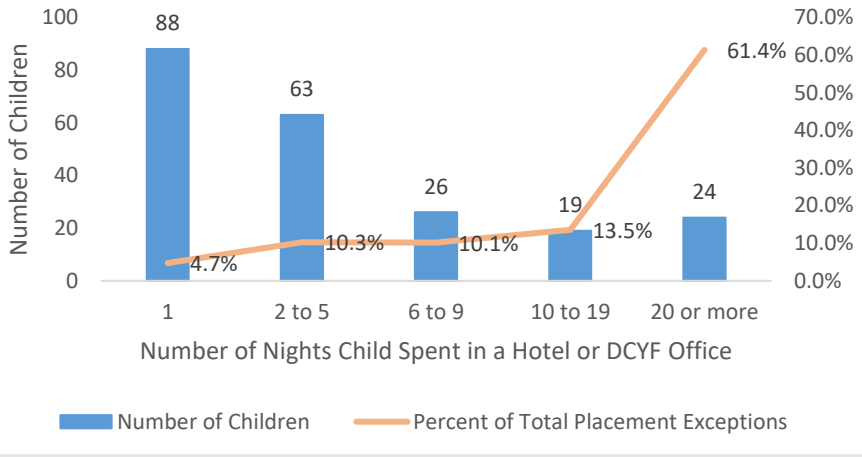
As in years past, many of the children experiencing placement exceptions are multi system involved and have complex care needs. As highlighted in OFCO's 2019 Annual Report, these are young people who are frequently also served, or should be served, by the Developmental Disabilities Administration, juvenile justice, and/or mental health care systems. Prior to the pandemic, DCYF was already struggling to meet their needs, as the child welfare system was not designed to address this multitude of concerns and other system failures. The addition of the COVID-19 pandemic has further strained the Department's already overburdened placement resources.

PLACEMENT EXCEPTIONS DATA

A Small Group of Children Account for the Majority of Placement Exceptions

For most children who experience them, a placement exception is limited to a few nights before a placement is located. A suitable placement was identified for 68 percent of children within 5 days or less of a placement exception: 88 children spent only a single night in a placement exception and 63 children spent 2 to 5 nights. However, 19 children spent 10 to 19 nights and 24 children spent 20 or more nights in placement exceptions. These 43 children spent a combined total of 1,395 nights in hotels or DCYF offices, making up approximately 75 percent of all placement exceptions. The highest number of nights spent in placement exceptions by a single child was 126 nights.

Figure 4: **Number of Placement Exceptions per Child, 2020**



Who are the Twenty-Four Children Who Spent Twenty or More Nights in Placement Exceptions?

Race and Gender

Figure 5: **Race of Children Who Spent 20 or More Nights in Placement Exceptions, 2020**

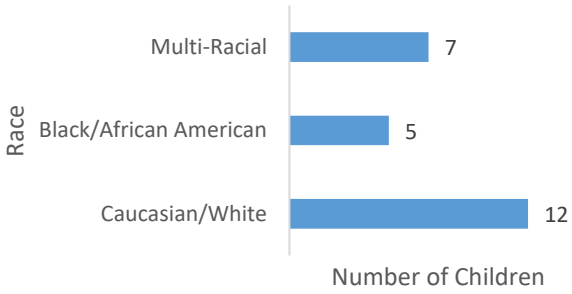
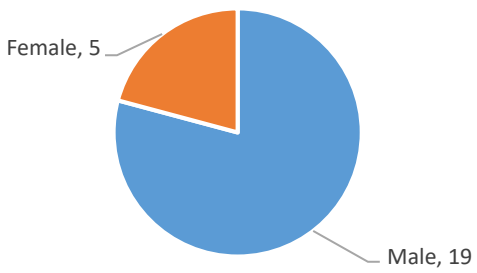
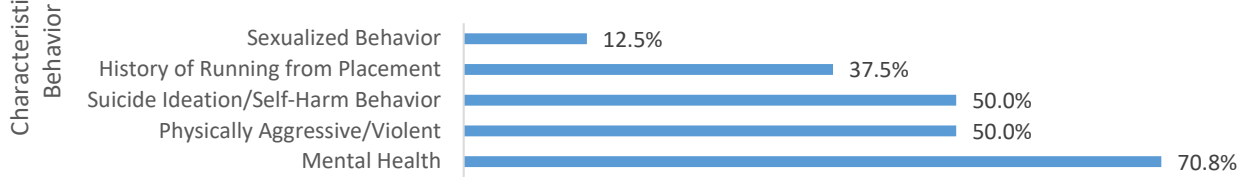


Figure 6: **Gender of Children Who Spent 20 or More Nights in Placement Exceptions, 2020**



Characteristics and Behavior

Figure 7: **Characteristics and Behavior of Children Who Spent 20 or More Nights in Placement Exceptions, 2020**



- Seventeen of the twenty-four children were reported to have unique mental health needs, such as mental disorders or past inpatient psychiatric stays.
- Half of the group was noted to have a history of physically aggressive behaviors towards caregivers, DCYF staff, and peers, which made finding a placement difficult.
- Half of the group was also reported to have suicidal ideation and self-harming behaviors, requiring closer supervision by staff.

Why are these children experiencing placement exceptions?

- Twenty-two of the twenty-four children were noted to have behavioral concerns, making it difficult to locate an appropriate placement. Many of the youth had high-risk behaviors and, due to the COVID-19 pandemic this year, foster homes were unwilling to have children placed in their homes who could pose a risk to others.
- Nine of the children were reported to have refused placements throughout the year, resulting in stays in hotels or DCYF offices after no other placement options were located.
- Five of the children were reported to have no appropriate placement while waiting for transport to an out-of-state placement or BRS home.

Where are these children placed now?

Table 2: **Current Placement of Children Who Spent 20 or More Nights in Placement Exceptions, 2020**

Current Placement[18]					
BRS placement or group home	11	Suitable other	1	Extended foster care, residing on own	1
Foster home	1	Relative placement	1	Aged out of foster care, residing in a homeless shelter	1
Children's psychiatric hospital	2	Placed with parent	1	Remain in placement exceptions	5

Five of the twenty-four children remain without placement. Four continue to spend nights in hotels and/or DCYF offices and one remains in a hospital on involuntary hold.

[18] Placement as of September 2020.

Demographics of Children Experiencing Placement Exceptions

Of the 220 children who spent at least one night in a placement exception, 62.3 percent were male and 37.7 percent were female.

Figure 9 shows that the children who experience placement exceptions tend to be older than the total out-of-home care population.[19]

Figure 8: **Child Gender in Placement Exceptions, 2020**

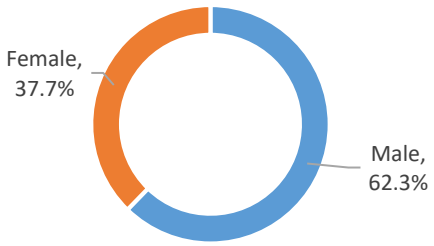
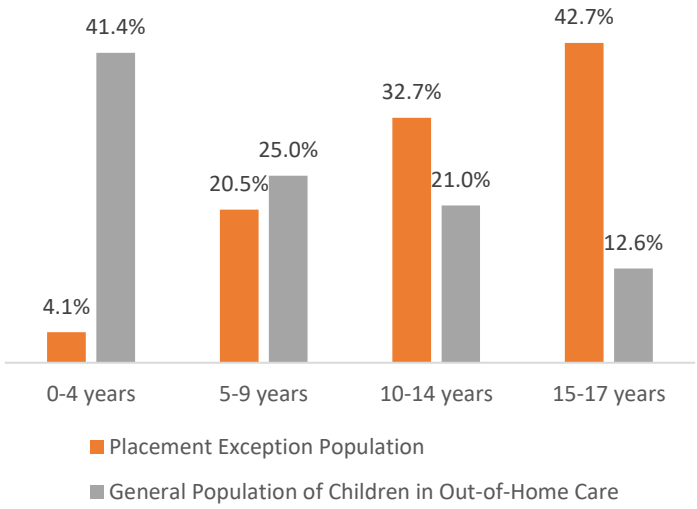
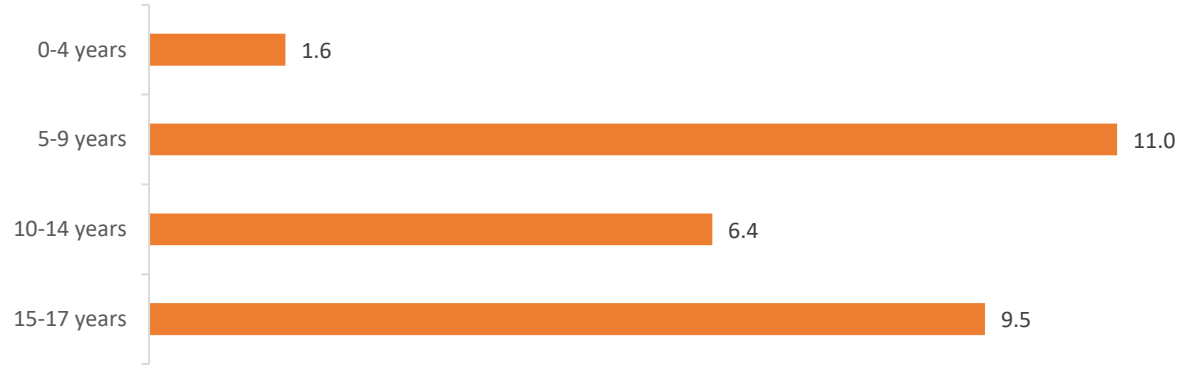


Figure 9: **Child Age in Placement Exceptions, 2020**



The average number of placement exceptions for the 220 children was eight nights. The average number of placement exceptions by age of the child is shown in Figure 10. Children age four and under spent the fewest nights on average in placement exceptions, averaging 1.6 nights. Children between ages five and nine had the highest average at eleven nights.

Figure 10: **Average Number of Placement Exceptions, 2020**



[19] Partners for Our Children Data Portal Team. (2019). [Table representation of Washington state child welfare 10/04/2020]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

A Regional Issue

This year, the placement crisis 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 80 percent of nights spent in a placement exception during the 2020 OFCO reporting year involved children with cases assigned to a DCYF office in Region 4 or 6. Approximately 45 percent of Washington households with children are located in these two regions and 40 percent of children in out-of-home care have cases in Region 4 or 6. Other regions may instead use night-to-night foster care placements, which also lack stability and permanency.

Table 3: **Placement Exceptions by Region, 2020**

DCYF Region	Number of Placement Exceptions	Percent of Total Placement Exceptions	Percent of Washington Households with Children[20]
Region 1	146	7.8%	12.4%
Region 2	--	--	9.7%
Region 3	192	10.3%	16.9%
Region 4	900	48.3%	28.6%
Region 5	1	0.1%	16.3%
Region 6	624	33.5%	16.1%

Racial Disproportionality

Although the percentage of Black/African American children experiencing placement exceptions decreased by 4 percent this year, Black/African American children still continue to be disproportionately represented in the placement exception population. Of the children who experienced placement exceptions, 16.4 percent were Black/African American, while Black/African American children comprise 13 percent of the out-of-home care population in Regions 4 and 6 and 9.4 percent of the out-of-home care population statewide.

[20] Partners for Our Children Data Portal Team. (2019). [Table representation of Washington state child welfare data 11/10/2020]. Count of All Households with Children. Retrieved from http://www.vis.pocdata.org/maps/hh-population#regions.

Table 4: **Child Race and Ethnicity**

	Race/Ethnicity	Placement Exception Population	Region 4 & 6 Out-of-Home Care Population[21]	Washington State Out-of-Home Care Population[22]
2020	Black/African American	16.4%	13.1%	9.5%
	American Indian or Alaskan Native	1.8%	4.4%	4.5%
	Asian or Hawaiian/Pacific Islander	2.3%	3.4%	2.3%
	Caucasian/White	57.7%	60.9%	62.9%
	Multi-Racial	21.4%	19.1%	20.7%
	Unknown	0.5%	--	--
	Latino/Hispanic	11.4%	17.2%	20.3%
2019	Black/African American	20.7%	12.9%	9.2%
	American Indian or Alaskan Native	3.9%	4.6%	4.9%
	Asian or Hawaiian/Pacific Islander	3.6%	3.2%	2.3%
	Caucasian/White	57.1%	60.2%	62.9%
	Multi-Racial	14.6%	18.5%	20.4%
	Unknown	--	--	--
	Latino/Hispanic	11.8%	15.3%	19.7%
2018	Black/African American	20.0%	11.6%	8.9%
	American Indian or Alaskan Native	2.1%	4.6%	4.5%
	Asian or Hawaiian/Pacific Islander	2.1%	3.4%	2.4%
	Caucasian/White	54.4%	61.4%	65.5%
	Multi-Racial	19.0%	18.8%	18.7%
	Unknown	2.6%	--	--
	Latino/Hispanic	11.3%	15.9%	19.4%
2017	Black/African American	22.6%	12.5%	8.8%
	American Indian or Alaskan Native	4.6%	5.6%	5.1%
	Asian or Hawaiian/Pacific Islander	2.1%	3.1%	1.9%
	Caucasian/White	45.6%	61.7%	65.3%
	Multi-Racial	23.6%	18.3%	18.0%
	Unknown	1.5%	--	--
	Latino/Hispanic	10.3%	16.5%	19.0%

[21] Partners for Our Children Data Portal Team. (2020). [Table representation of Washington state child welfare data 11/10/2020]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

[22] Partners for Our Children Data Portal Team. (2020). [Table representation of Washington state child welfare 11/10/2020]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

	Race/Ethnicity	Placement Exception Population	Region 4 & 6 Out-of-Home Care Population[21]	Washington State Out-of-Home Care Population[22]
2016	Black/African American	19.9%	11.5%	8.7%
	American Indian or Alaskan Native	5.0%	5.9%	5.7%
	Asian or Hawaiian/Pacific Islander	3.2%	3.3%	1.2%
	Caucasian/White	52.0%	61.6%	66.1%
	Multi-Racial	16.7%	18.6%	16.8%
	Unknown	3.2%	--	--
	Latino/Hispanic	17.6%	16.8%	17.4%
2015	Black/African American	20.8%	12.5%	9.0%
	American Indian or Alaskan Native	11.1%	6.0%	6.2%
	Asian or Hawaiian/Pacific Islander	1.4%	2.4%	1.5%
	Caucasian/White	61.1%	60.9%	66.9%
	Multi-Racial	5.6%	18.8%	15.2%
	Unknown	--	--	--
	Latino/Hispanic	19.4%	16.7%	18.5%

Children with Significant Emotional and Behavioral Problems are at Higher Risk of Placement Exceptions

Research shows that behavior problems are commonly found among children who have experienced abuse and neglect, and that these behavior problems can have a significant negative impact on foster children's placement and permanency outcomes. Behavior problems contribute to risk for placement and adoption disruption, long-term foster care, and returning to care after reunification with parents.[23] Many of the children who experienced placement exceptions have significant treatment, supervision, and other special needs which pose barriers to locating and maintaining an appropriate placement. Foster families, relatives, or group homes may not feel equipped to care for children with significant needs. Most of these youth were noted to have challenging behaviors that made identifying a placement more difficult.

To gather information on youth's history, behaviors, and supervision needs, OFCO reviewed the AIRS email notification of the placement exception (which frequently documents the barriers encountered by the Department in trying to find an appropriate placement for the child); the most recent Child Information and Placement Referral (CHIPR)[24]; and if available, the most recent Comprehensive Family Evaluation.[25] This year, OFCO observed physical aggression, mental health needs, a history of running from placements, and suicidal ideation as the most common characteristics among the 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 a higher risk of COVID-19 exposure to the household or facility.

Figure 11: **Characteristics of Children in Placement Exceptions, 2020**

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

[24] 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.

[25] 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 RECOMMENDATIONS

DCYF Should Normalize Hotel Stays to Provide a More Stabilizing and Supportive Environment for Youth

Over the last five years, DCYF has hosted increasingly larger numbers of children in hotels and offices overnight. For some of these youth, the experience does not end with one overnight, but rather can extend for days, weeks, or even months. Despite the fact that the agency may not have any possibility of a placement, DCYF requires that each morning these children leave the hotel or office where they spent the previous night, taking all of their belongings with them, with the expectation they will not be returning to the same room, or perhaps even the same hotel. Frequently, due to staff shortages and logistics, these children also spend their evenings transporting other youth who are out of placement. Their meals are consequently improvised as well, and they frequently eat fast food or food from grocery or convenience stores. They also endure ever shifting arrangements of both the other children and the supervising staff that they spend the night with, a remarkable lack of continuity for the intimacy of these arrangements. A variety of community members report to OFCO that these young people are inadequately served in this environment. The concerns relate to gaps in education, inadequate access to nutritious food, emotional dysregulation, children losing their belongings in transit, and other issues.

OFCO has discussed these concerns with DCYF, and the agency's position has routinely been that hotel and office stays are not an appropriate placement for youth, and thus few resources will be expended on legitimizing or entrenching these placement exceptions. While OFCO agrees that DCYF should do everything in its power to eradicate the need for hotel and office stays, it must also now provide a more humane experience for the youth who continue to experience them, given the intractability of the problem.

OFCO recommends that, at a minimum, DCYF amend their current practice regarding placement exceptions and allow youth to stay in the same hotel room from night to night. Placement exceptions are extremely destabilizing for children, and they and their advocates have reported to OFCO that if these children at least knew they would be sleeping in the same room some of their anxiety would be curbed. This approach should not cost DCYF additional funds, as the agency is paying for these hotel nights already, and daytime staffing arrangements would not change. While it may not be possible to afford every youth this comfort (for instance if a placement arises and then falls through), youth and their advocates have stated that for those for whom this is possible it is meaningful and necessary. DCYF should adopt this practice immediately and begin considering other, more aggressive measures aimed at creating a more stable and home like experience for youth spending multiple nights out of placement, to address the additional concerns above. Strategies implemented by the Department should address the following:

- Ensure that children do not sleep in cars even when being transported for much of the night;
- Establish office kitchen facilities stocked with healthy foods for children experiencing hotel or office stays; and
- Create dedicated office space and adequate staffing for children out of placement to engage in school work and activities.

SECTION II: LISTENING TO FAMILIES AND CITIZENS

Inquiries and Complaints

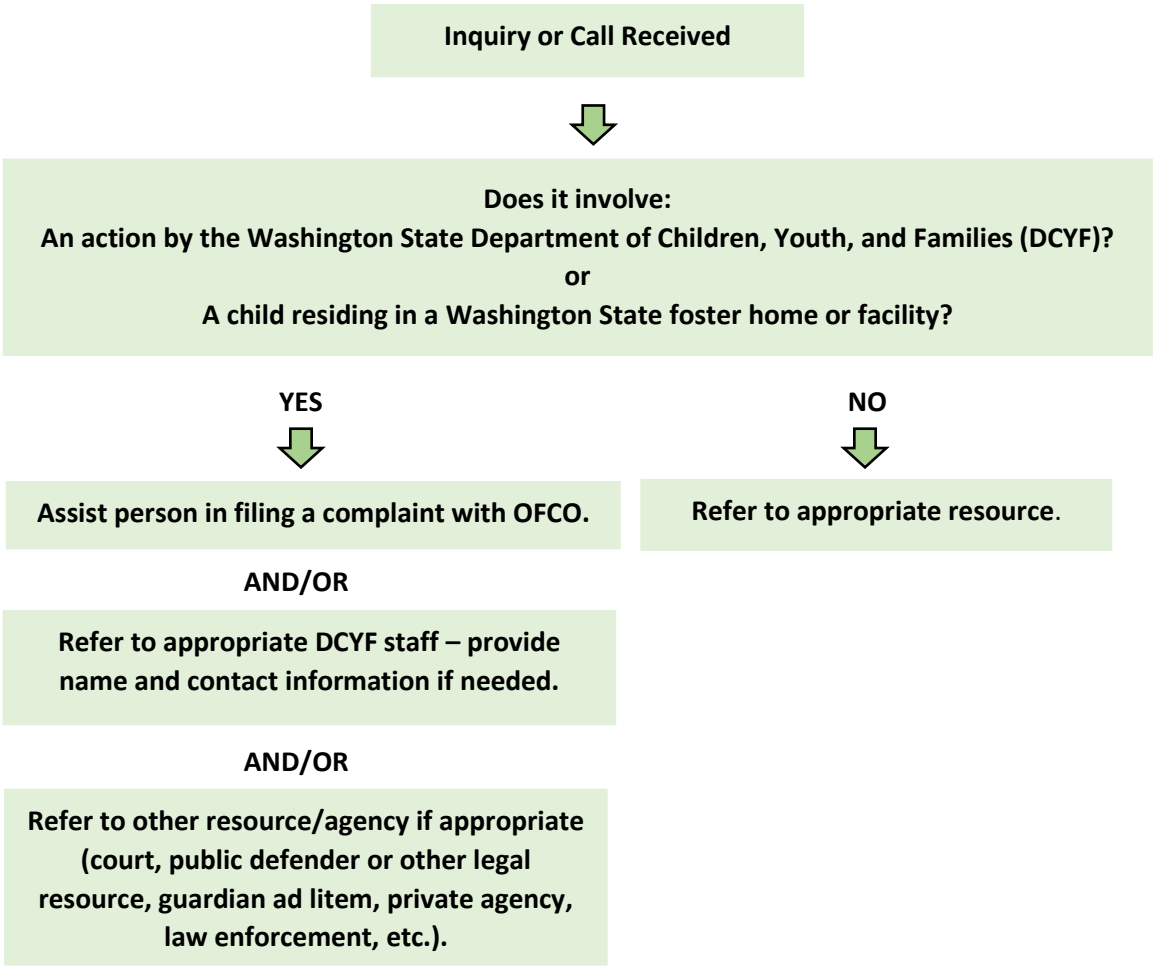
Complaint Profiles

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 help address a caller's concerns, we will refer them elsewhere for information or support.

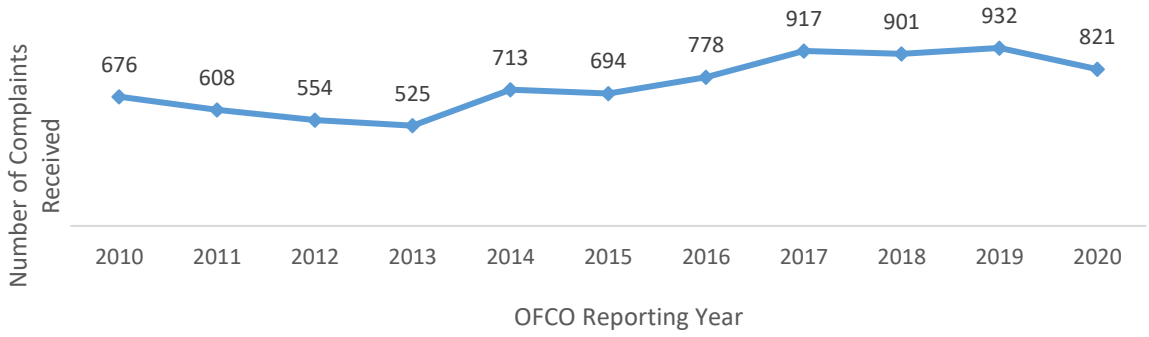
Figure 12: **What Happens When a Person Contacts OFCO?**



Complaints Received

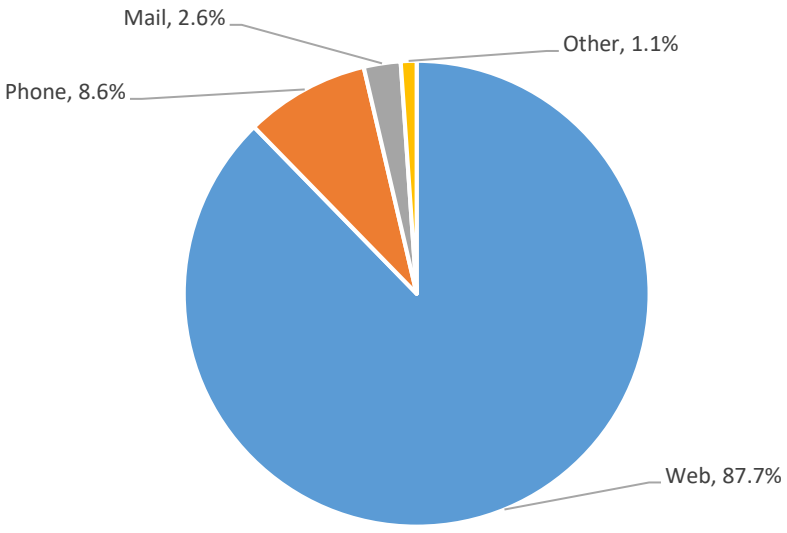
This section describes complaints filed during OFCO's 2020 reporting year – September 1, 2019 to August 31, 2020. OFCO received 821 complaints in 2020.[26]

Figure 13: **Complaints Received by Year**



87.7 percent of complaints were submitted via OFCO's website, 8.6 percent were taken over the phone, and 2.6 percent were submitted through the mail.

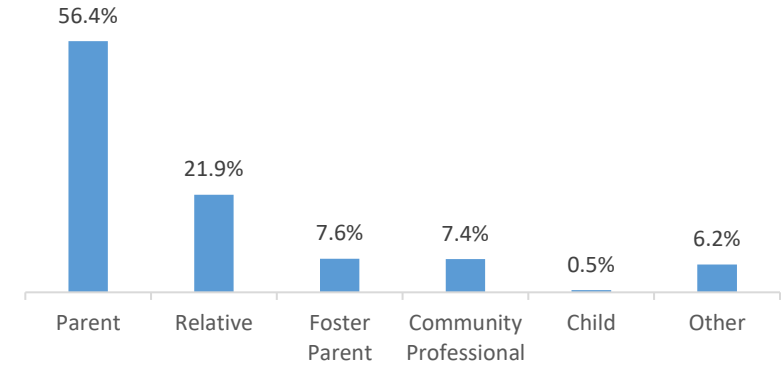
Figure 14: **How Complaints Were Received, 2020**



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

Persons Who Complained

Figure 15: **Complainant Relationship to Children, 2020**



As in previous years, parents, grandparents, and other relatives of the child whose family is involved with the Department of Children, Youth, and Families (DCYF) filed the majority of complaints investigated by OFCO (78.3 percent). Foster parents filed 7.6 percent and community professionals filed 7.4 percent. As in previous years, few children contacted OFCO on their own behalf.

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

Table 5: **Complainant Race and Ethnicity, 2020**

	OFCO Complainants	Washington State Population[27]	Children in Out-of-Home Care[28]
Caucasian/White	68.8%	78.7%	62.9%
African American/Black	9.3%	4.2%	9.5%
American Indian or Alaskan Native	1.9%	1.8%	4.5%
Asian or Pacific Islander	2.2%	10.0%	2.3%
Multiracial	5.6%	5.3%	20.7%
Other	--	--	
Declined to Answer	12.2%	--	
Latino/Hispanic	6.9%	13.3%	20.3%

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

[28] Partners for Our Children Data Portal Team. (2020). [Graph representation of Washington State Child Welfare Data 11/06/2020]. Children in Out-of-Home Care (Count). http://www.vis.pocdata.org/graphs/ooh-counts.

Children Identified in Complaints

Of the 1,228 children identified in complaints, 36.2 percent were four years of age or younger and 31.2 percent were between ages five and nine. OFCO receives fewer complaints involving older children, with the number of complaints decreasing as the child's age increases. This closely mirrors the ages of children in out-of-home care through DCYF.[29]

Table 6: **Age of Children in Complaints to OFCO and Out-of-Home Care through DCYF, 2020**

Age of Children	Percent of Children in Complaints to OFCO	Percent of Children in Out-of-Home Care through DCYF
0-4 years	36.2%	41.5%
5 to 9 years	31.2%	24.9%
10 to 14 years	23.2%	20.9%
15 to 17 years	8.3%	12.7%
18+ years	1.1%	--

Table 7 shows the race and ethnicity of the children identified in complaints, compared with children in out-of-home placement through DCYF and the general state population.

Table 7: **Race and Ethnicity of Children Identified in Complaints, 2020**

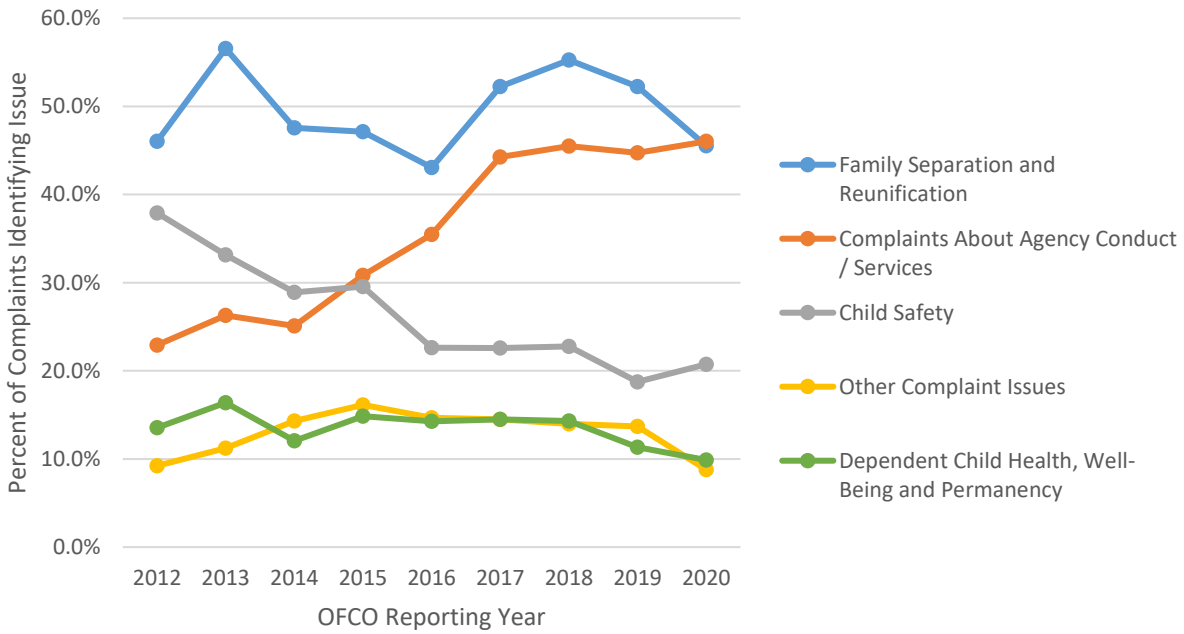
	OFCO Children	Children in Out-of-Home Care[30]	Washington State Children (ages 0-19)[31]
Caucasian/White	65.5%	62.9%	72.6%
African American/Black	10.0%	9.5%	5.0%
American Indian or Alaskan Native	2.4%	4.5%	2.4%
Asian or Pacific Islander	1.8%	2.3%	9.5%
Multiracial	18.9%	20.7%	10.5%
Other	0.2%	--	--
Declined to Answer	1.3%	--	--
Latino/Hispanic	13.4%	20.8%	22.0%

[29] Partners of Our Children Data Portal Team. (2020). [Graph representation of Washington state child welfare data 11/06/2020]. Children in Out-of-Home Care (Count). http://www.vis.pocdata.org/graphs/ooh-counts.
[30] Partners for Our Children Data Portal Team. (2020). [Graph representation of Washington State Child Welfare Data 11/06/2020]. Children in Out-of-Home Care (Count). http://www.vis.pocdata.org/graphs/ooh-counts.
[31] Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2019. http://www.ofm.wa.gov/pop/asr/default.asp.

COMPLAINT ISSUES

Figure 16 displays the categories of issues identified by complainants. Complaints can often be complex and complainants will identify multiple issues or concerns they would like investigated.

Figure 16: **Categories of Issues Identified by Complainants, 2020**



Historically, issues involving the separation and reunification of families have been the most frequently identified in complaints to OFCO. However, this year, issues involving the separation and reunification of families decreased and issues involving the conduct of DCYF staff and other agency services increased.

Table 8 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 8: **Issues Identified by Complainants**

	2020	2019	2018
Complaints About Agency Conduct	382	415	411
Unwarranted/unreasonable/inadequate CPS intervention	144	121	131
Unprofessional conduct, harassment, conflict of interest or bias/discrimination by agency staff	129	125	100
Communication failures	58	98	98
Breach of confidentiality by agency	26	21	34
Family Assessment Response	12	7	--
Poor case management, high caseworker turnover, other poor service	8	25	12
Inaccurate agency records	8	13	16
Unreasonable CPS findings	3	10	14
Retaliation by agency staff (does not include complaints of retaliation made by licensed foster parents)	3	2	6

	2020	2019	2018
Family Separation and Reunification	378	485	498
Unnecessary removal of child from parental care	123	111	131
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	78	117	116
Failure to reunite family	68	91	98
Failure to place child with relative	54	85	76
Unnecessary removal of child from relative placement	27	23	24
Other inappropriate placement of child	17	32	22
Inappropriate termination of parental rights	4	8	4
Other family separation concerns	3	4	5
Failure to provide sibling visits and contact	1	7	5
Failure to place child with siblings	1	7	13
Concerns regarding voluntary placement and/or service agreements	--	--	4

	2020	2019	2018
Child Safety	172	174	205
Failure to protect children from parental abuse or neglect	64	56	78
Suspected child neglect	41	26	40
Suspected child abuse	23	30	34
Other child safety issue	--	--	4
Failure to address safety concerns involving children in foster care or other non-institutional care	60	56	84
Failure to address safety concerns involving children being returned to parental care	29	26	24
Child safety during visits with parents	8	20	12
Children with no parent willing/capable of providing care	4	6	6
Failure by agency to conduct 30 day health and safety visits with child	3	6	2
Safety of children residing in institutions/facilities	1	2	1

	2020	2019	2018
Dependent Child Health, Well-Being and Permanency	73	105	129
Failure to provide child with adequate medical, mental health, educational or other services	24	31	52
Unreasonable delay in achieving permanency	18	14	7
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	12	21	23
Placement instability/multiple moves in foster care	8	7	1
Inadequate services to children in institutions	3	3	--
ICPC issues (placement of children out of state)	2	10	11
Inappropriate permanency plan/other permanency issues	2	9	25
Failure to provide appropriate adoption support services/other adoption issues	2	4	6
Extended foster care/independent living services	1	3	--
Placement not meeting child's unique needs	1	2	--

Other Complaint Issues	2020	2019	2018
Failure to provide parent with services/other parent issues	28	26	39
Lack of support/services and other issues related to unlicensed relative or fictive kin caregiver	17	31	23
Violation of parents' rights	16	20	30
Lack of support/services to foster parent/other foster parent issues	7	25	14
Foster care licensing issues	7	10	9
Violations of ICWA	4	8	3
Foster parent retaliation	2	2	5
Children's Legal issues	1	5	5

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:

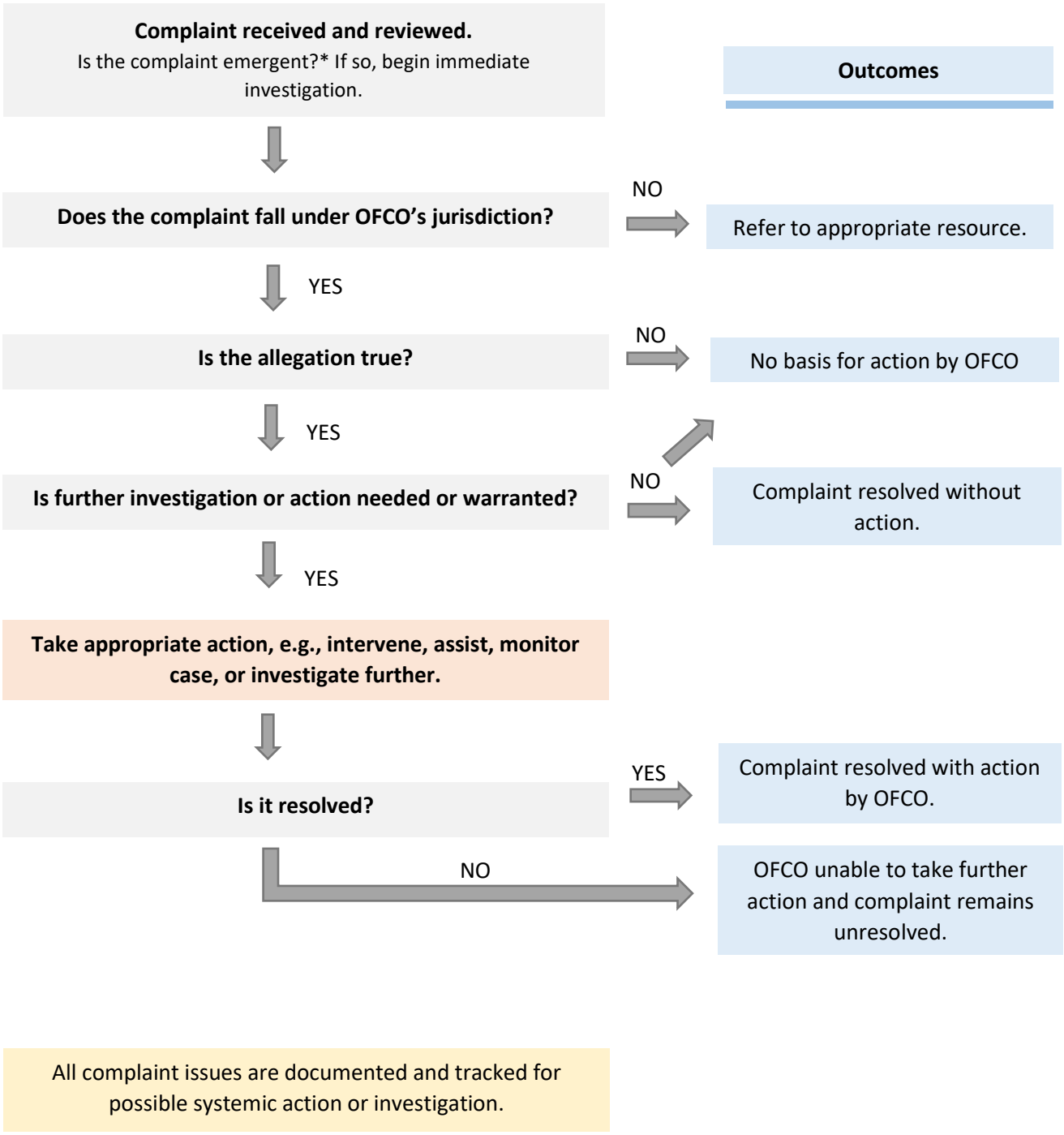
- Where OFCO finds that the agency is properly carrying out its duties, the Ombuds explains to the complainant why the complaint allegation does not meet the above criteria, and helps complainants better understand the role and responsibilities of child welfare agencies.
- Where OFCO makes an adverse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

OFCO completed 830 complaint investigations in 2020. As in previous years, the majority of investigations were standard, non-emergent investigations (80.6 percent); however, this year, 161 complaints met OFCO's criteria for initiating an emergent investigation, nearly twice as many as the previous year.

Over the years, OFCO consistently intervenes in emergent complaints at a higher rate than non-emergent complaints. In 2020, OFCO intervened or provided timely assistance to resolve concerns in 21.7 percent of emergent complaints, compared to 15.7 percent of non-emergent complaints.

OFCO's COMPLAINT INVESTIGATION PROCESS

Figure 17: **How Does OFCO Investigate Complaints?**



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

INVESTIGATION OUTCOMES

Complaint investigations result in one of the following actions:

OFCO Intervention

- OFCO substantiated the complaint issue and intervened to correct a violation of law or policy or to prevent harm to a child/family; OR
- During the course of the investigation, OFCO identified an agency error or other problematic issue, sometimes unrelated to the issue identified by the complainant, and intervened to address these concerns.

OFCO Assistance

- The complaint was substantiated, but OFCO did not find a clear violation or unreasonable action. OFCO provided substantial assistance to the complainant, the agency, or both, to resolve the complaint.

OFCO Monitor

- The complaint issue may or may not have been substantiated, and OFCO monitored the case closely for a period of time to ensure any issues were resolved. While monitoring, the Ombuds may have had repeated contact with the complainant, the agency, or both. The Ombuds also may have offered suggestions or informal recommendations to agency staff to facilitate a resolution. These complaints are closed when there is either no basis for further action by OFCO or the identified concerns have been resolved.

In most cases, the above actions result in the identified concern being resolved. A small number of complaints remain unresolved.

Resolved Without Action by OFCO

- The complaint issue may or may not have been substantiated, but was resolved by the complainant, the agency, or some other avenue. In the process, the Ombuds may have offered suggestions, referred complainants to community resources, made informal recommendations to agency staff, or provided other helpful information to the complainant.

No Basis for Action by OFCO

- The complaint issue was unsubstantiated and OFCO found no agency errors when reviewing the case. OFCO explained why and helped the complainant better understand the role and responsibilities of the child welfare agency; OR
- The complaint was substantiated and OFCO made a finding that the agency violated law or policy or acted unreasonably, but there was no opportunity for OFCO to intervene (e.g. complaint involved a past action, or the agency had already taken appropriate action to resolve the complaint).

Outside Jurisdiction

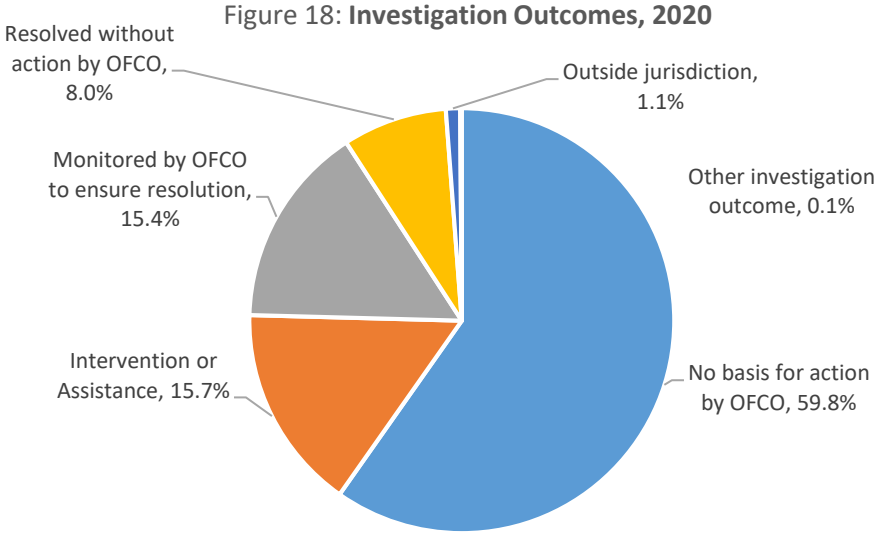
- The complaint involved agencies or actions outside of OFCO's jurisdiction. Where possible, OFCO refers complainants to another resource that may be able to assist them.

Other Investigation Outcomes

- The complaint was withdrawn, became moot, or further investigation or action by OFCO was unfeasible for other reasons (e.g. nature of complaint requires an internal personnel investigation by the agency – which is beyond OFCO's authority).

Investigation results have remained fairly consistent in recent years. OFCO assisted or intervened to try to resolve the issue in 15.7 percent of complaints in 2020 – this represents 130 complaints. OFCO monitored 128 complaints (15.4 percent) for a period of time until either the identified concerns were resolved, or OFCO determined that there was no basis for further action. OFCO found no basis for any action after investigating in more than half of complaints this year (59.8 percent).

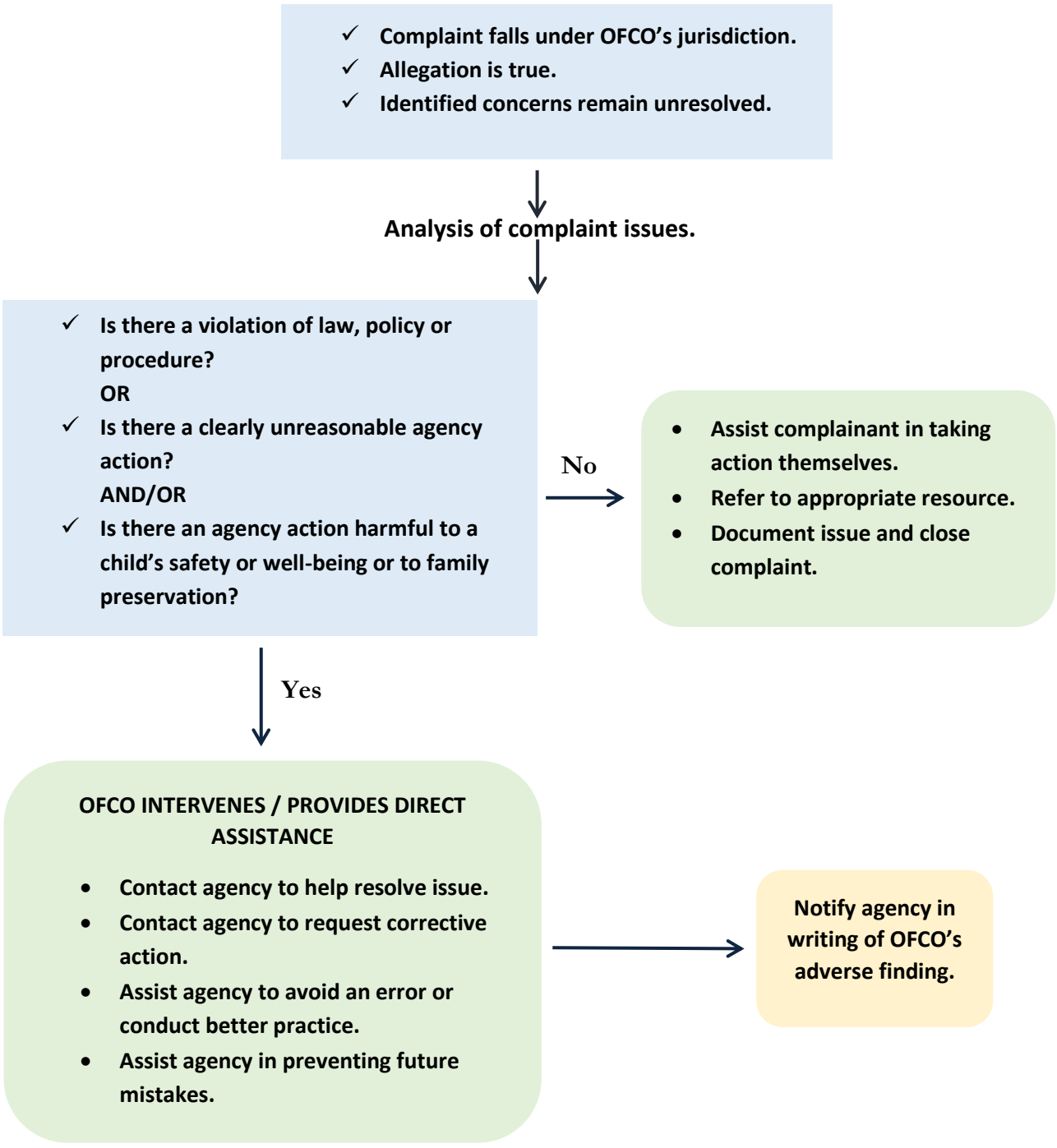
Figure 18: **Investigation Outcomes, 2020**



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 19: **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 2020, OFCO made 67 adverse findings in a total of 28 complaint investigations. Some complaint investigations resulted in more than one adverse finding. OFCO provides written notice to the DCYF of any adverse finding(s) made on a complaint investigation. The agency is invited to formally respond to the finding and may present additional information and request a modification of the finding. DCYF provided a written response to all findings but one. In addition to the 67 adverse findings, OFCO made two other findings that were withdrawn after the Department provided more information to OFCO and requested a withdrawal.

Table 9 shows the various categories of issues related to adverse findings. Approximately half of all adverse findings in 2020 related to the safety of children (33 findings). These findings include failures to conduct required monthly health and safety visits, failure to complete safety assessment, and inadequate CPS investigations or case management issues.

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

Table 9: **Adverse Findings by Issue**

	2020	2019	2018
Child Safety	33	25	18
Failure by DCYF to ensure/monitor child's safety			
Failure to conduct required monthly health and safety visits	15	12	4
Unsafe placement of dependent child	--	6	4
Failure to complete safety assessment	11	5	3
Inadequate CPS investigation or case management	6	2	5
Other child safety findings	1	--	2
Parents' Rights	19	12	9
Delay in completing CPS investigation/CPS FAR or internal review of findings	15	9	3
Failure to communicate with or provide services to parent	1	2	1
Failures of notification/consent, public disclosure, or breach of confidentiality	3	1	5
Family Separation and Reunification	4	4	3
Failure to place child with relative	3	3	--
Failure to provide appropriate contact / visitation between parent and child	--	1	2
Failure to provide contact with siblings	--	--	1
Other issues related to family separation and reunification	1	--	--
Dependent Child Well-being and Permanency	2	2	4
Other dependent child well-being and permanency finding	--	2	1
Delay in achieving permanency	2	--	1
Failure to provide medical, mental health, education or other services	--	--	2
Poor Casework Practice Resulting in Harm to Child or Family	4	1	0
Inadequate documentation of casework	--	1	--
Other poor practice	4	--	--
Foster Parent/Relative Caregiver Issues	2	3	3
Other foster parent / caregiver issues	2	2	3
Issues relating to child's removal from foster placement	--	1	--
Other Findings	3	0	3

Number of findings	67	47	40
Number of closed complaints with one or more finding	28	28	30

Adverse Findings by DCYF Region

Forty-six percent of adverse findings made by OFCO in 2020 involved DCYF Region 5. The number of adverse findings are further broken down in Table 13 in Appendix B.

Table 10: **Adverse Findings in Complaint Investigations by DCYF Region, 2020**

Region	Number of Findings	Percent of 2020 Findings
Region 1	0	0.0%
Region 2	9	13.4%
Region 3	7	10.4%
Region 4	14	20.9%
Region 5	31	46.3%
Region 6	5	7.5%
Headquarters	1	1.5%

SECTION IV: APPENDICES

Appendix A:

Complaints by Region and Office

Appendix B:

Adverse Findings by Office

Appendix C:

Summaries of OFCO's Adverse Findings

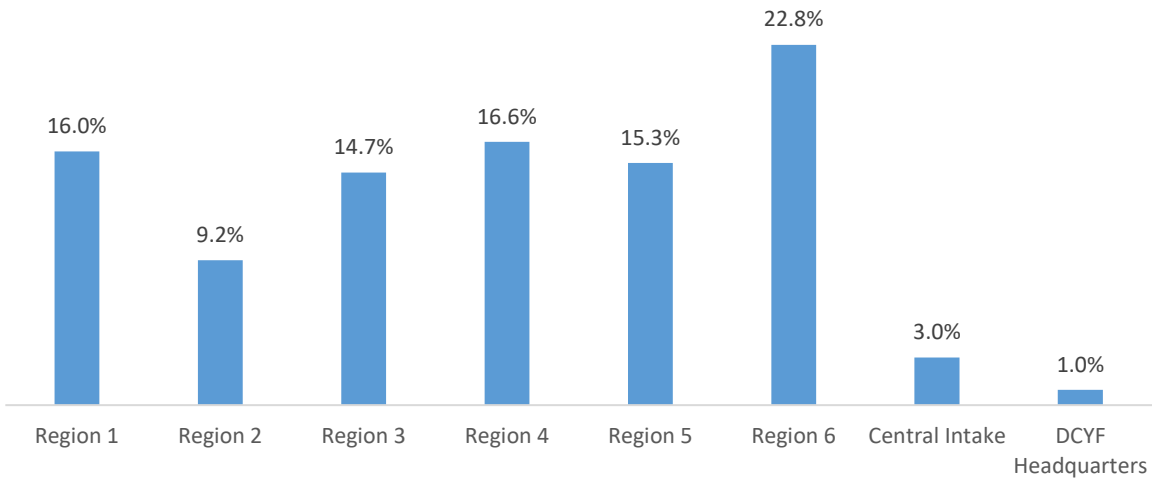
APPENDIX A: COMPLAINT INVESTIGATIONS BY REGION AND OFFICE

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

Table 11: **Populations by DCYF Region, 2020**[32]

DCYF 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 20: **OFCO Complaint Investigations Completed by DCYF Region, 2020**



[32] Partners for Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 11/09/2020]. Count of All Children. http://www.vis.pocdata.org/maps/child-population#regions.

Table 12: **OFCO Complaint Investigations Completed by Office, 2020**

Region	DCYF Office			
Region 1	Clarkston	4	Region 1 - Licensing Division	1
	Colfax	2	Region 1 - DLR/CPS SAM	1
	Colville	13		
	Moses Lake	19		
	Newport	2		
	Omak	8		
	Spokane Central	32		
	Spokane ICW	9		
	Spokane North	21		
	Spokane Valley	13		
	Wenatchee	8		
Region 2	Ellensburg	9	Region 2 - Licensing Division	1
	Goldendale	6	Region 2 - DLR/CPS SAM	2
	Richland (Tri-Cities)	25		
	Sunnyside	1		
	Toppenish	3		
	Walla Walla	10		
	White Salmon	3		
	Yakima	16		
Region 3	Bellingham	17	Region 3 DLR/CPS SAM	2
	Everett	21		
	Friday Harbor	2		
	Lynnwood	12		
	Mount Vernon	24		
	Oak Harbor	4		
	Sky Valley (Monroe)	21		
	Smokey Point (Arlington)	19		
Region 4	King East (Bellevue)	20	Region 4 - Licensing Division	3
	King South East (Kent)	15	Region 4 - DLR/CPS SAM	1
	King South West (Kent)	31		
	King West (Seattle)	27		
	Martin Luther King Jr.	28		
	Office of Indian Child Welfare	7		
	West Seattle	6		
Region 5	Bremerton	30	Region 5 - Licensing Division	5
	Lakewood	19		
	Parkland	16		
	Puyallup	26		
	Tacoma	31		

Region	DCYF Office			
Region 6	Aberdeen	29	Region 6 - Licensing Division	3
	Centralia	13	Region 6 - DLR/CPS SAM	2
	Forks	2	Region 6 - Regional Intake	2
	Kelso	27	Region 6 – Centralized Services	1
	Long Beach	1		
	Port Angeles	9		
	Port Townsend	4		
	Shelton	16		
	South Bend	3		
	Stevenson	1		
	Tumwater	29		
	Vancouver-Cascade	30		
	Vancouver-Columbia	17		
Other	Central Intake	25		
	Headquarters	8		
	Non-DCYF	9		
	Other	7		

APPENDIX B: ADVERSE FINDINGS BY OFFICE

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

Table 13: **Adverse Findings by Office, 2020**

Region	Office	Number of Findings
Region 1	--	--
Region 2	Richland	4
	Yakima	5
Region 3	Bellingham	1
	Everett	1
	Mount Vernon	1
	Smokey Point	4
Region 4	King East (Bellevue)	5
	King South-West	6
	King West	2
	MLK	1
Region 5	Bremerton	4
	Lakewood	5
	Parkland	3
	Puyallup	12
	Tacoma	7
Region 6	Aberdeen	1
	Centralia	1
	Kelso	1
	Port Townsend	1
	Centralized Services	1
Headquarters	Eligibility & Provider Supports	1

APPENDIX C: SUMMARIES OF OFCO'S ADVERSE FINDINGS

CHILD SAFETY

DCYF did not complete the safety assessment timely and did not complete required health and safety visits.

OFCO initiated an investigation after noting a lack of documentation of case activity following a child fatality.

CPS received an intake reporting the fatality of a 17-year-old youth. The referral alleged that the parent failed to seek immediate medical attention when the child was having difficulties breathing. The assigned caseworker completed the initial face-to-face interviews with both siblings, ages five and sixteen, on the same day at the family's home. CPS later received another intake alleging that the five-year-old found a gun in the home. An initial face-to-face was completed; however, the five-year-old was asleep and not interviewed. The 16-year-old was also not interviewed as he was living out-of-state with family.

There was no documentation of any health and safety visits over three months. During the course of the CPS investigation, there were three 90 day extensions approved due to a delayed medical examiner's report needed to complete the investigation.

Violations:

- **DCYF Practices and Procedures Guide, 2331(4)(d)(i) requires the Safety Assessment to be completed on all screened in CPS intakes no later than 30 calendar days from the date of the intake.**

  Both Safety Assessments were completed several months after the CPS intakes were received.

- **DCYF Practices 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.**

  Required health and safety visits did not occur over a three month period.

DCYF Response:

The Area Administrator noted that the office was challenged with numerous staff vacancies and the assigned caseworker is no longer working at DCYF. Regional staff are assisting with collateral contacts, and after-hours staff have been assigned responsibility for some intakes. The Area Administrator also said expectations for health and safety visits are sent to all staff on a monthly basis and are addressed by supervisors during one-on-one meetings with case workers. Work plans have also been developed regarding health and safety visits and structured two-hour protected time supports timely documentation of case activities.

A DCYF caseworker transported a two-year-old child without properly securing them into a car seat.

A two-year-old child was transported from a foster home to a visit with the mother in a car seat that was not properly installed. It was reported the car seat was not secured appropriately to the seat, that the child was not buckled into the car seat properly, and that the car seat was not rear facing as is required for the child's age and size.

Violation:

- **RCW 46.61.687 and DCYF Practices and Procedures 4254(1)(d)(ii) mandate that a child under eight years old must be properly secured in an appropriate child restraint system when being transported in a motor vehicle.**

  This child who was nearly two years old was transported in a car seat that was not properly installed or secured over a distance of approximately 50 miles.

DCYF Response:

DCYF responded that the caseworker was not educated on the proper way to install car seats as well as the appropriate use of child passenger restraint. As a result, the area administrator trained all of the caseworkers on proper child car seat safety and child passenger restraint. DCYF will also look for an opportunity to train new staff on car seat safety, as it is not a mandatory training.

DCYF did not complete required health and safety visits.

A five-year-old dependent child was placed with a suitable adult caregiver in July 2019 over DCYF's objections. The court approved this placement subject to various conditions including that the caregiver complete a background check, permit a walkthrough of her home, and allow DCYF to conduct regular health and safety visits including unannounced visits to the home.

Over the next six months, the assigned caseworker only visited the child for a health and safety visit at the caregiver's home on one occasion. The majority of the health and safety visits occurred at the child's therapeutic day care or the DCYF office before meetings.

After OFCO contacted DCYF about this issue, the caseworker conducted two health and safety visits with the dependent child at the caregiver's home. During each of the visits, the child alluded to being afraid of other adults and needing to hide from someone.

Violation:

- **DCYF Practices and Procedures Guide, 4420(3)(b) requires that the majority of health and safety visits must occur in the home where the child or youth resides.**

  Because health and safety visits did not occur in the home as required, DCYF missed opportunities to gather information to assess the child's safety and well-being. Specifically, observing the living situation; condition of the home; other adults in the home; and the interactions between the child and the caregiver on a more frequent basis.

DCYF Response:
DCYF confirmed that health and safety visits were not completed as per policy. Additionally, an email was sent to staff that the majority of health and safety visits should be completed within the home and if they cannot complete these, a plan will be developed and notes are to be documented regarding all attempts to visit in the home. Finally, DCYF advised that the internal continuous development team would begin reviewing cases.

PARENTS' RIGHTS

DCYF disclosed confidential case information.

In March 2019, CPS received an intake regarding concerns about the child's welfare in the father's care. The concerns included the child's accessibility to drug paraphernalia, inappropriate physical discipline, changes in the child's behavior, and domestic violence by the father. This intake was screened in to CPS FAR. The FAR caseworker conducted an initial face-to-face visit with the child at daycare and then a home visit to the father. The father denied the allegations.

In early April 2019, the mother returned to Washington State from deployment. Later that month, law enforcement responded to a domestic violence incident between the parents. The father was arrested and reportedly moved out of the residence.

The father informed the caseworker that the mother was filing for a restraining order to prevent all contact between him and the child. The FAR caseworker advised the father to oppose the domestic violence charges, get copies of law enforcement reports, and obtain an attorney. Additionally, the FAR caseworker offered to provide a letter for the court hearing, stating they did not find any evidence to substantiate allegations against the father in this case. The letter from the FAR caseworker revealed that the mother reported concerns to CPS intake and concluded that there was no evidence to substantiate the allegations in the intake. The caseworker's letter also referenced case activities during the family assessment and offered an opinion endorsing the father's competence.

Unreasonable Action:

- **RCW 13.50.100 allows a "juvenile justice or care agency" to release confidential information records to other participants in the juvenile justice or care system; however, the letter provided to the father did not conform with statutory requirements.**

  DCYF did not receive a request for information from a "juvenile justice or care agency" but rather produced a letter on its own initiative for use in a court proceeding. The letter not only disclosed confidential case information but also offered an opinion endorsing a parent's competence. Identifying the mother as the CPS referrer, as well as generating reports from other mandated reporters, could jeopardize the mother's personal safety, particularly when there are concerns for domestic violence and mental health.

DCYF Response and Request for Modification:
The Department requested modification of this finding asserting that releasing case information was not a violation of RCW 13.50.100. The Department accurately noted this statute also states in relevant part: "A juvenile, his or her parents, the juvenile's attorney, and the juvenile's parent's attorney, shall, upon request, be given access to all records and information collected or retained by a juvenile justice or care agency."
OFCO modified the finding to reflect the disclosure of confidential case information as clearly unreasonable in the circumstances rather than a violation of law or policy.

CHILD SAFETY	PARENTS' RIGHTS

DCYF FAR did not complete required monthly health and safety visits and the case remained open beyond required time frames.

In February 2019, CPS received an intake concerning child maltreatment related to the parents' alleged substance abuse and the unhygienic condition of the home. This report was screened in to CPS FAR. The parents were advised to clean the home. The FAR caseworker visited the home a week later and conditions had notably improved. However, the case remained open and there were no health and safety visits recorded for the months of March, April, and May 2019.

In June 2019, a newly assigned caseworker conducted a home visit. The caseworker determined conditions of the home were not safe for the children, the parents had not obtained medical care for one of the children, and there were concerns about inadequate supervision. The four children in the home were placed into protective custody by law enforcement. A CPS investigation was opened and the children were placed into foster care.

Violations:

- **DCYF Practices and Procedures Guide, 4420: Health and Safety Visits with Children and Youth and Monthly Visits with Parents and Caregivers requires face-to-face health and safety visits be conducted with children and parents who have an open case with DCYF.**

  There were no health and safety visits completed for the months of March, April, and May 2019.

- **DCYF Practices and Procedures Guide, 2332(4) states that, "A FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or caregiver receiving services consents to the case remaining open for up to 120 calendar days."**

  The FAR case was opened in February 2019 and remained open beyond 45 days.

DCYF Response:
DCYF responded that two caseworkers had been assigned to complete the health and safety visits; however, they left the agency before these could be completed. A thorough review of the case was conducted and the Area Administrator offered additional training to staff to ensure the fidelity of

their work, FAR assessments are completed in a timely manner, and health and safety visits occur regularly. Further, they reported that training of staff was occurring at quarterly meetings.

Case activities did not occur in a timely manner, required health and safety visits were not completed, and the case remained open beyond required time frames.

CPS received an intake reporting that a nine-year-old child disclosed that the mother punched him in the shoulder with a closed fist. The intake screened in for CPS FAR. An initial face-to-face interview with the child was conducted three days later. The child was not observed to have any bruises and made no disclosures. Over the next three months, there was no documentation of any case activities. CPS then received another intake after the child disclosed his mother pushed him, threw him in his room, sat on him, and tied his arms and legs with bungee cords. This intake screened in for CPS FAR.

The case remained open for two more months with limited documentation of case activities. Once the FAR case was reassigned to a new caseworker, various case activities occurred, including contact with both parents, an initial-face-face interview with the child, and completion of the Safety Assessments for both intakes. The FAR case was closed six months after the initial intake was opened for FAR.

Violations:

- **DCYF Practices and Procedures Guide, 2332(1) requires that DCYF make initial contact with the parent or caregivers to schedule an appointment to meet with the family to provide them with written information regarding FAR.**

  There was no documentation of contact with the mother regarding the intakes until five months after the initial intake.

- **DCYF Practices and Procedures Guide, 2332(2)(a) requires that all child victims in the home be assessed within 72 hours of the date and time the intake was received. DCYF Practices and Procedures Guide, 2310(1)(b) requires that DCYF meet in person with the victim or identified child within 72 hours for a non-emergent response.**

  There was no documentation that the alleged child victim was seen within the required non-emergent time frames.

- **DCYF Practices and Procedures Guide, 1120(1)(a) requires that a Safety Assessment be completed on all screened in CPS intakes no later than 30 calendar days from the date of the intake.**

  The Safety Assessments for both intakes were not completed in a timely manner.

- **DCYF Practices and Procedures Guide, 2332(4) states that a FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or caregiver receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030(13).**

  Neither intake was closed within the required time frames.

- **DCYF Practices and Procedures Guide, 2332(3)(e) requires that DCYF conduct monthly health and safety visits with children identified in a CPS FAR case open longer than 60 days.**

  In the six months the case was open, the alleged victim was seen for an initial face-to-face visit twice.

DCYF Response:
DCYF responded that they concurred there was no documentation to demonstrate that case activities occurred in a timely manner. The assigned caseworker was not able to complete activities prior to going on extended leave. The case was reassigned in July 2019 and a safety assessment was completed. The caseworker and supervisor both received guidance on required policy.

DCYF did not complete the Safety Assessment timely, did not complete required health and safety visits, and the case remained open beyond required time frames.

CPS received an intake reporting a fatality of a six-month-old child which screened in for an emergent CPS investigation as to the welfare of the two older children aged three and five years old in the home.

The CPS caseworker contacted the mother the same day the intake was received and completed the initial face-to-face with the three-year-old child. The next day, the CPS caseworker contacted the father of the two children. The father did not express any concerns about the mother's parenting. The CPS caseworker completed a visit at the relative's home where the mother and three-year-old were staying.

A few days after beginning this investigation, the CPS caseworker contacted the detective investigating the child's death. The detective reported that the cause was undetermined and, from law enforcement's perspective, there was no evidence of a crime of abuse or neglect.
There was no documentation of other investigative activities for five months. Monthly supervisory reviews identified areas for follow up, including separate interviews with the parents, follow up regarding the marijuana growing in the home, a referral for Early Childhood Education for the three-year-old, grief counseling for the mother, and to conduct a health and safety visit. This case remained open over 160 days.

Violations:

- **DCYF Practices and Procedures Guide, 2331(4)(d)(i) requires the Safety Assessment to be completed within 30 days of the date of the intake.**

  The Safety Assessment was not completed in a timely manner.

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

The CPS investigation was open for 166 days with no documentation of investigative activities occurring for 5 months.

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

  The three-year-old child was seen for an initial face-to-face. However, there was no documentation that further in-person contact occurred with the child after that date.

DCYF Response:
DCYF responded that there was staff turnover creating a greater number of intakes and investigations being assigned to remaining caseworkers, and this workload created lack of timeliness in this case. To manage this, the following was implemented:

- Two hours in the morning dedicated to document and close cases;
- Two after-hours caseworkers were assigned to help close cases;
- Regional program staff were designated to write summaries of cases and assist with case closure based on these write ups; and
- Supervisors to help staff who had been on leave prioritize cases for closure as well as sending weekly emails identifying cases for closure.

DCYF did not complete the safety assessment timely, did not complete required health and safety visits, and the case remained open beyond required time frames.

DCYF received two intakes regarding the mother physically abusing her children. Both intakes screened in for CPS FAR response. The initial face-to-face interviews were completed with the children. A month later, one of the children disclosed further and ongoing abuse by the mother. Despite this, neither this child nor the child's siblings were interviewed again by the caseworker to follow up on the allegations or for required health and safety visits, even though this FAR case remained open beyond 120 days.

Violations:

- **DCYF Practices and Procedures Guide, 1120(1)(a) requires that a Safety Assessment be completed on all screened in CPS intakes no later than 30 calendar days from the date of the intake.**

  The Safety Assessments for both intakes were not completed within 30 days.

- **DCYF Practices and Procedures Guide, 2332(3)(e) requires that DCYF conduct monthly health and safety visits with children identified in a CPS FAR case open longer than 60 days.**

  In this case, the children were seen for their initial face-to-face meetings and were not seen again, except for one child who was seen again two days later.

- **DCYF Practices and Procedures Guide, 2332(4), states that a FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or caregiver receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030(13).**

  The case remained open well past the allowed time frames.

DCYF Response:
The Area Administrator reported the originally assigned caseworker no longer works for DCYF and the case was reassigned. Subsequently, workload prevented the newly assigned caseworker from completing tasks in a timely manner. During this time, half of the caseworkers in the office were new and not able to be assigned primary responsibility for cases. In order to manage workload, the Area Administrator implemented the following:

- Created "paperwork days" and protected hour to allow staff the time to complete necessary documentation and close cases;
- Training on how and when to complete health and safety visits for new staff yet to be assigned as primary caseworker in cases;
- Supervisors to use interns to complete paperwork and assist in making collateral contacts;
- Assigned a supervisor to assist with casework and receive case assignments from caseworkers leaving DCYF to ensure smooth transition; and
- Worked with the assigned supervisor to review policy requirements with the assigned caseworker.

DCYF did not notify the subjects of an open FAR assessment in a timely manner and after the interview of the child, DCYF did not notify the parent at the earliest possible point in the investigation that would not jeopardize the safety or protection of the child or the course of the investigation.

In May 2019, an intake screened in to CPS FAR concerning allegations of physical abuse of a 15-year-old non-dependent child as well as psychological and sexual abuse of two non-dependent 13-year-old siblings by the stepfather. The 15-year-old was interviewed. The two siblings were not interviewed and the mother and stepfather were not notified of the FAR case or informed of the allegations in the referral.

In August 2019, an intake alleging physical and sexual abuse by the stepfather and negligent treatment including unsecured firearms screened in for CPS investigation. The caseworker conducted an initial face-to-face with the children and later met with the mother and stepfather outside of the home. The mother and stepfather denied the allegations. The CPS investigation outcome was unfounded and the case was closed. The FAR assessment was closed shortly after using the information obtained during the CPS investigation.

Violations:

- **DCYF Practices and Procedures Guide, 2332 states that the FAR caseworker must: Contact parents or caregivers by phone when possible to:**
  - **Inform a parent a FAR referral has been made regarding their child.**

- **Arrange an initial meeting. Unannounced home visits may occur when efforts to contact the parents have been unsuccessful or the safety of the child will be compromised.**
- **Provide the parents with the FAR Brochure DSHS 22-1534 and explain the FAR and investigation pathways to inform the parents or caregivers of:**
  - **their rights under FAR;**
  - **their options to participate or decline in FAR; and**
  - **CA options if they do not agree to participate in services offered in FAR.**
- **Ask if the parent or caregiver agrees or disagrees to participate in FAR.**
- **Discuss the IFF requirements with parents or caregivers and collaborate with them to conduct the IFF within 72 hours.**

  The parents were not advised about the open FAR case when the intake was made. This contact only occurred when another intake screened in for CPS investigation.

- **DCYF Practices and Procedures Guide, 2333(6)(a) states that the caseworker must notify the parent of the child's interview at the earliest possible point in the investigation that will not jeopardize the safety or protection of the child or the course of the investigation.**

  The parents were not notified of the interview of their child until a new intake was received which screened in for CPS investigation some three months later.

- **DCYF Practices and Procedures Guide, 2332(2)(b) states that all children in the home not identified as victims must be seen face-to-face prior to completion of the Safety Assessment.**

  The siblings of the identified victim were not seen face-to-face as part of the FAR Safety Assessment.

DCYF Response:

DCYF responded that the mother and stepfather were not notified of the open FAR assessment and that the assigned caseworker at the time no longer worked for the agency. The current assigned worker received coaching and a review was completed of requirements needed before closing a case. Further, training in FAR was held for all staff to ensure policies and time frames for FAR cases are met.

DCYF did not complete required health and safety visits and the case remained open beyond required timeframes.
CPS received an intake reporting that a five-year-old child described a recent incident where their father was angry and pushed a bookcase on top of them. The child reportedly had no marks or bruises. The intake screened in for CPS FAR. The initial face-to-face interview with the child occurred within required timeframes. The child denied that the incident occurred and said they felt safe in the home. The caseworker also met with the parents in a timely manner.

Over the next three months, there were no documented case activities with the exception of the completion of the Safety Assessment and monthly supervisory case notes. The FAR caseworker contacted collaterals and completed the FAR Family Assessment. There were no recommendations for any additional services and a supervisory review case note indicated that a health and safety visit was needed in order for the case to be closed. The case then remained open for approximately four months with no case activities other than monthly supervisory reviews indicating a health and safety visit was needed in order for the case to be closed.

Seven months after the CPS FAR case was opened, a different caseworker contacted the mother to arrange a health and safety visit with the two children. The mother expressed frustration regarding the timeliness and potential for the contact to negatively impact the child's well-being. The mother subsequently decided not to allow DCYF to conduct a health and safety visit with the children. This was documented and the case was closed a few days later.

Violations:

- **DCYF Practices and Procedures Guide, 2332(4) states that a FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or caregiver receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030(13).**

  The case was open continuously for approximately seven months from the date of the intake until the case was closed in December 2019.

- **DCYF Practices and Procedures Guide, 2332(3)(e) requires that DCYF conduct monthly health and safety visits with children identified in a CPS FAR case open longer than 60 days.**

  In this case, in the seven months the case was open, the alleged child victim and the younger sibling were seen one time. OFCO recognizes that an attempt was made to see the children prior to case closure but the family declined.

DCYF Response:

DCYF responded that there were many vacancies and high caseloads in this office, which contributed to the tasks not being completed timely. Further, supervisors will develop work plans with staff for CPS FAR case closures and the Area Administrator will monitor completion of CPS FAR cases, health and safety visits, and individual work plans. Additionally, the office dedicated two days per week for case documentation and case closures.

DCYF did not complete required health and safety visits and the case remained open beyond required timeframes.

In February 2019, an intake screened in to CPS FAR regarding neglect of a two-year-old child. Specifically, there were concerns about the great grandparent's ability to adequately care for the child. In March 2019, the FAR caseworker conducted an initial face-to-face visit with the child at the caregiver's home. The caregiver confirmed they did not have legal custody of the child and they were in the process of seeking non-parental custody. There was no further action taken until August 2019.

Throughout August 2019, the FAR caseworker was not able to complete a health and safety visit and the family did not attend a scheduled Family Team Decision Making (FTDM) meeting. Near the end of August 2019, the caseworker confirmed that the great grandparent had obtained non-parental custody of the child. The caseworker completed a health and safety visit prior to the case closing in September 2019. There was no documentation that health and safety visits occurred in May, June, or July 2019.

Violations:

- **DCYF Practices and Procedures Guide, 4420 and 2332(3)(e) mandate monthly health and safety visits with children identified in a CPS case investigation open longer than 60 days.**

  There were no health and safety visits completed in May, June, or July 2019.

- **DCYF Practices and Procedures Guide, 2332(4) and RCW 26.44. 030(14)(c) state that FAR assessments 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 days.**

  The FAR case was opened in February and closed in September, beyond required timeframes.

DCYF Response:

DCYF advised that staff turnover and staff being on extended leave resulted in a lack of timeliness on this case. The Area Administrator responded by:

- Allowing caseworkers two hours in the morning to documents case activities and to ensure cases are closed more efficiently;
- Assigned two After Hours caseworkers to assist with casework as well as directed regional staff to assist in closing cases by writing reports and closing them on this basis;
- Allowing supervisors to work with staff who had been on leave in prioritizing cases; and
- Directing supervisors to send weekly emails to staff identifying cases for closure.

DCYF did not complete a CPS "Risk Only" investigation timely; did not interview the subjects of the allegations; did not complete the safety assessment within required time frames; and did not complete required health and safety visits.

In October 2019, CPS received an intake reporting concerns about the safety of two children, ages three and four, as the mother's husband was convicted of communications with a minor for immoral purposes. Under the parenting plan, the children resided with the mother on the weekends. This intake was screened in as CPS Risk Only.

The following day, the CPS caseworker conducted an initial face-to-face with the children and spoke with the father and stepmother. There was no further documented case activity until the end of December 2019 when the CPS supervisor spoke with the father who requested CPS case documents for use in family court. The CPS supervisor informed the father that the family court could request this

information directly from the Department. In January 2020, the Safety Assessment was completed and approved.

Violations:

- **RCW 26.44.030 provides a CPS investigation shall be conducted within timeframes established by the Department and in no case shall the investigation extend longer than ninety days from the date the report is received.**

  This CPS case remained open beyond 90 days from the date of intake.

- **DCYF Practices and Procedures Guide, 2331 requires CPS to conduct in-person interviews with the child's parent and alleged perpetrator.**

  While CPS interviewed the father, CPS had not interviewed the children's mother or her husband.

- **DCYF Practices and Procedures Guide, 2331 states the safety assessment must be completed on all children no later than 30 calendar days from the date of the intake.**

  Here, the Safety Assessment was completed and approved three months after the intake.

- **DCYF Practices and Procedures Guide, 2331 requires the Department to conduct monthly health and safety visits with children and parents if the case is open longer than 60 calendar days.**

  The CPS caseworker conducted an initial face-to-face with the children and met with the father, but no health and safety visits occurred after this initial contact.

DCYF Response:

DCYF responded that when this intake was received, the Office of Indian Welfare (OICW) was experiencing a change in leadership at the area administrator and CPS supervisor level, and there was a vacancy rate of 50% in the CPS unit with an influx of 93 intakes that month. When the new leadership arrived in the office, OICW had a significant backlog.

The OICW Area Administrator and supervisors continue to meet as a team to address the backlog of CPS cases and stabilize the office. The Area Administrator has initiated "policy hour" with the supervisors, which is a time during which the managers focus on various policies. At the policy hour in February 2020, the supervisors reviewed the issues that resulted in adverse findings on the case. In addition, OICW leadership is authorizing overtime to close cases. The office has dedicated protected time each morning for caseworkers to enter case notes, submit service referrals and complete assessments. The office also held a "case closure push day" which focused on teamwork and support to close cases. The Area Administrator will continue to monitor the workload report and other data reports to assess progress, with a continued focus on CPS timeframes.

DCYF did not complete investigative activities timely; the CPS investigation remained open beyond required timeframes; required health and safety visits were not completed; interview of the non-victim child was not completed; and monthly case supervisor reviews were not documented.

OFCO initiated an investigation in response to a notification of a child fatality. OFCO's concern stemmed from a lack of documentation of case activity following the fatality.

Child Protective Services (CPS) received an intake regarding a child drowning and alleging that the mother left her five-year-old child in the pool, knowing the child could not swim. The child was intubated at the hospital but passed away. The intake was screened in for an emergent CPS investigation. Thirty-five days later, the caseworker completed an interview with the parents and two of their three children, ages two and four years old. The third sibling, age nine, was reportedly staying with a relative. The Safety Assessment was completed but did not include the nine-year-old.

The relative caring for the nine-year-old later contacted the caseworker and reported that the child had disclosed that the mother hit her with a stick when she got mad, there was little food in the home, and they sometimes did not get dinner until after 11 pm. The caseworker told the caregiver that she would be making arrangements for a caseworker to come and see the child at her home. However, over the next four months, there was no documentation of a caseworker interview with this child, monthly case supervision, or of any other case activities.

Violations:

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

  Required health and safety visits did not occur. There were no documented health and safety visits for over seven months.

- **DCYF Practices 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.**

  This CPS investigation remained open for more than 219 days.

- **DCYF Practice and Procedures Guide, 2331(4)(b)(iii) requires DCYF to assess each child's safety in the home. The caseworker is to complete face-to-face contact with each child who is not the identified victim prior to completing the safety assessment.**

  The caseworker only met with two of the three children prior to completing the Safety Assessment. The caseworker documented that the child in the care of a relative would be seen; however, there was no documentation that this occurred.

- **DCYF Practices and Procedures Guide, 46100 requires the supervisor to conduct monthly case reviews with each assigned worker and document each case review.**

  There is no documentation that monthly supervisory case reviews occurred.

DCYF Response:
The Area Administrator reviewed the case and concurred there was no documentation that the case activities occurred in a timely manner. The assigned caseworker was on extended leave and anticipated being able to complete work while on leave; however, this did not occur. There was also another caseworker on leave at the time.

The supervisor developed a plan to ensure monthly supervisory case reviews occur including scheduling these earlier in the month to allow time to be rescheduled in the event of an emergency. The office was also challenged with a large number of intakes. To address this and extended leave of staff, a staff member from FRS with CPS experience was asked to assist, as well as another CPS caseworker and another staff member from a different office.

DCYF did not complete the safety assessment and required health and safety visit. Additionally, the cases remained open beyond required timeframes. DCYF's actions were clearly unreasonable when it did not interview the subjects of a CPS intake in required timeframes.

These complaint findings stem from two CPS cases involving the same family.

In August 2019, a CPS intake screened in for CPS FAR based on the father's report that the mother stabbed him while the two-year-old child was nearby. The father also stated the mother drove while intoxicated with the child in the car. Supervisory review case notes from December 2019, January 2020, and February 2020, indicate that the caseworker needed to enter case notes before closing the FAR intervention and one specifically indicated that a health and safety visit occurred. However, there was no supporting documentation of this visit.

In October 2019, a CPS intake screened in for emergent investigation, reporting the child suffered burns on two separate occasions while in the paternal grandparents' home. The child sustained a second-degree burn on her leg caused by hot water. The grandparents reportedly were bathing the child and did not know how hot the water was. The child also sustained two circular burns on the right side of her chest when the grandparents put hot milk into the child's bottle and the child reportedly grabbed the bottle and spilled it on herself. A supervisory review case note entered in November 2019 states that law enforcement was not taking further action regarding the burn to the child and that the caseworker would interview the paternal grandparents. As of March 2020, CPS had not interviewed the father or grandparents regarding this intake.

Another intake screened in for emergent CPS investigation in October 2019 for possible physical abuse by the mother, as marks were observed on the child's back following a visit with her. The following day the caseworker conducted an initial face-to-face with the child at the paternal grandparents' home. The caseworker did not observe any marks on the child. From October 2019 to March 2020, there was only one case note entered by the caseworker documenting that the father emailed the caseworker in January 2020 to follow up on his ongoing concerns and share documentation that he had completed for family court.

Violations/Unreasonable Action:

- **DCYF Practices and Procedures Guide, 1120(1)(a) requires that a Safety Assessment be completed on all screened in CPS intakes no later than 30 calendar days from the date of the intake.**

  There was no documentation of the completion a Safety Assessment from any of the three intakes received, one in August 2019 and two in October 2019.

- **DCYF Practices and Procedures Guide, 2332(4) states that a FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or caregiver receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030(13).**

  The CPS FAR intake screened in in August 2019 and was still open in March 2020.

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

  The CPS intakes from October 2019 were open for investigation beyond the required timelines.

- **DCYF Practices and Procedures Guide, 4420 and 2331(4)(b)(viii) and 2332(3)(e) mandate monthly health and safety visits with children identified in a CPS investigation or CPS FAR case open longer than 60 days.**

  This case was opened in August 2019. While in person contact was made with the child during the first few months, there was no documentation of contact with the child for over four months.

- **DCYF's actions were clearly unreasonable.** The interviews of the subjects (father and paternal grandparents) for an intake made in October 2019 had not occurred by March 2020.

DCYF Response:

DCYF responded that some of these issues were a result of lack of documentation rather than a lack of attention to safety tasks. Health and safety visits were completed in October 2019, November 2019, and January 2020; however, November 2019 and January 2020 health and safety visits were not documented. The visit for December 2019 was missed as the caseworker was on leave and did not make arrangements to cover this visit. Additionally, the subjects were interviewed in October 2019; however, this was not in-person and not documented. The Safety Assessment was completed but not entered into DCYF's tracking system and it was confirmed that the FAR and CPS investigations were not completed in a timely manner.

In October 2019, CPS screened in for emergent CPS investigation a report that a father did not seek medical care for a two-year-old child's burn on the forearm. The father said he had been mowing the lawn and the child had burned their arm on the hot lawn mower. The child's mother later took the child to the hospital as the burn looked infected.

The following day, CPS conducted an initial face-to-face interview with the child. The child did not make any disclosures. The CPS caseworker also obtained the medical records from the child's visit to the emergency room. The records indicate that the child had a first- and second-degree burns on the right forearm after the child reportedly touched a hot lawn mower. There were no concerns documented in the records.

CPS completed interviews with both the mother and the father, but did not close this investigation in a timely manner, and there was no documentation of health and safety visits as this investigation remained open beyond 60 days.

Violations:

- **DCYF Practices and Procedures Guide, 1120(1)(a) and 2331(4)(d)(i) requires that a Safety Assessment be completed on all screened in CPS intakes no later than 30 calendar days from the date of the intake.**

  The Safety Assessment was not completed within 30 calendar days from the date of the intake. The intake screened in for investigation in October 2019 and the Safety Assessment was not initiated until January 2020.

- **DCYF Practices 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 beyond these timelines and reassigned to a new caseworker in February 2020.

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

  Required health and safety visits did not occur. The case was opened in October 2019 and the child was not seen after the initial face-to-face visit for more than four months.

DCYF Response:

DCYF responded that the caseworker received 42 new intakes between October 2019 and December 2019 and fell behind in health and safety visits and documentation. The Safety Assessment was completed within 30 days; however, they were unable to enter documentation timely. The caseworker updated their documentation.

The Area Administrator reported they intended on reviewing the policies for safety assessments, health and safety visits, and FAR one-on-one with supervisors. Further, the CPS supervisors were asked to review these policies in the next CPS section meeting. The region has also enlisted regional or rapid response teams to take over case assignments or close overdue cases with the goal of having all overdue cases completed within two months after the notice of the adverse finding.

DCYF did not complete the safety assessment and child victim interview timely, did not complete required health and safety visits, and the case remained open beyond required timeframes.

In July 2019, CPS received an intake alleging that a 15-year-old reported sexual abuse by the father and that the mother knew of the abuse but left the youth alone with him. The intake screened in for CPS investigation. CPS after-hours and law enforcement completed the initial face-to-face with the child two days later. The child did not report feeling unsafe; however, the child was not comprehensively interviewed about the allegations at that time.

For the following five months, the case remained open with limited documentation of investigative activities beyond three phone calls with law enforcement that occurred in November 2019 and two in December 2019. The assigned caseworker contacted the mother at the end of December 2019, which was the first contact with the family, and saw the youth for the first time one week later. The caseworker completed an interview at that time; however, a law enforcement report indicated that the detective attempted to involve the caseworker when conducting interviews but was told by the caseworker that was not possible due to workload.

Violations:

- **DCYF Practices and Procedures Guide, 1120(1)(a) and 2331(4)(d)(1) require that a Safety Assessment be completed on all screened in CPS intakes no later than 30 calendar days from the date of the intake.**

  The Safety Assessment was not completed until six months after the intake was received.

- **DCYF Practices 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.**

  This case was opened in July 2019 and the Investigative Assessment was not completed until January 2020.

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

  There is no record the caseworker completed the interview with the child during the initial face-to-face. Documentation indicates the child was interviewed in January 2020.

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

  This child was seen in July 2019 and not again until January 2020.

DCYF Response:

The Area Administrator responded that there were several vacancies in the CPS unit. The assigned caseworker was assigned 21 intakes per month with the average statewide being 8-10 per month. The caseworker was carrying an average of 48.36 cases during the six-month period and because of this workload was not compliant with policy requirements on this case. The supervisor did not monitor the completion of tasks as required.

In 2020, all CPS units received additional training by Alliance Coaches and the Quality Practice Specialist on Structured Decision-Making, Safety Assessment and the Safety Framework with emphasis on quality and timeliness. CPS also received training on health and safety visits and tracking and managing new intakes. The CPS unit received data from Quality Assurance staff including incomplete Safety Assessments and CPS cases over 60 days requiring health and safety visits. The region's roving unit and staff from another office assisted with workload and helped investigate new intakes in December 2019 and January 2020.

The Area Administrator also met with the assigned caseworker and supervisor to emphasize the expectation of coordinating and collaborating with law enforcement.

DCYF did not conduct the Safety Assessment nor interview the subjects of the CPS investigation timely; did not conduct required health and safety visits; and the case remained open beyond required timeframes.

In October 2019, CPS received an intake alleging two children, ages seven and thirteen, had access to firearms at their father's home. The assigned caseworker completed the initial face-to-face interview with the children the following day, but neither child made any disclosures. There was no documentation of other investigative activities after this interview and no documentation that health and safety visits were completed in January 2020 and February 2020. After OFCO contacted DCYF, a health and safety visit was completed in March 2020.

Violations:

- **DCYF Practices 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.**

  Required health and safety visits did not occur. This case was opened in October 2019 and a health and safety was completed several months later in March 2019. There was no documentation that health and safety visits were completed in January 2020 or February 2020.

- **DCYF Practices and Procedures Guide, 2331(4)(c)(i) requires that 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.**

  There was no documentation that either subject was contacted during the investigation.

- **DCYF Practices and Procedures Guide, 2331(4)(d)(i) requires the Safety Assessment to be completed within 30 days of the date of the intake.**

  The intake was received in October 2019 and the Safety Assessment was still pending as of March 2020.

- **DCYF Practices 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.**

  This investigation was open for over 150 days.

DCYF Response:
The Area Administrator reviewed this case and reported that intakes have been high for this office and there were several caseworker vacancies. The caseworker was behind in documentation and at the time of the review, had not entered notes reflecting attempts to interview the subjects In November 2019 and December 2019. The caseworker also had phone contact with the father attempting to arrange for a home visit four times in December 2019; however, it was difficult to schedule this visit with the father. Subsequently, the caseworker went on annual leave for the holidays then became ill, which extended their leave. The case was then reassigned to regional program staff to complete.

An email was sent to CPS supervisors in April 2020 with expectations for setting up tracking systems for Safety Assessments and health and safety visits to ensure policy compliance. The Area Administrator also established expectations for supervisors to spot check documentation in the first 30 days of a case being opened and monitor the case when they find missing documentation. CPS supervisors will participate in a video meeting and the policies identified in the adverse finding will be discussed during that meeting. When the office has resumed normal operations in light of the COVID-19 crisis, the Area Administrator will also attend a section meeting to discuss the policies and answer questions.

CHILD SAFETY	PARENTS' RIGHTS	FOSTER PARENT/RELATIVE CAREGIVER ISSUES

Investigative activities were not completed in a timely manner following the fatality of a child.

OFCO initiated an investigation in response to a notification of a child fatality. OFCO's concern stemmed from a lack of documentation of case activity following the fatality.

CPS received an intake reporting the fatality of a 23-month-old child while in the care of a relative and concerns for an 8-month-old sibling. The intake was screened in for an emergent CPS investigation. The after-hours caseworker completed the initial face-to-face with the younger sibling and relatives reported that the child resides with their mother at a local clean and sober housing.
Over the next three months, there was limited documentation of case activities other than an attempt to reach the mother by phone and a phone call with relatives. After contact from OFCO, the

caseworker completed a health and safety visit and the Safety Assessment, and the investigation was then closed.

Violations:

- **DCYF Practices and Procedures Guide, 2331(4)(d)(i) requires the Safety Assessment to be completed within 30 days of the date of the intake.**

  The Safety Assessment for this intake was not completed until three months after the intake was received.

- **DCYF Practices 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.**

  A required health and safety visit did not occur until three months after the intake was received.

- **DCYF Practices and Procedures Guide, 2331(4)(c)(i) requires parents and alleged subjects 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. In addition, DCYF Practices and Procedure Guide, 2334(1)(a) and (2) requires the investigator to "conduct individual and face-to-face interviews with the subject" and for the supervisor to confirm and document that "all alleged subjects" were interviewed. If the subject was not interviewed, "the reason why the interview did not occur" will be documented.**

  There was no documentation that the subject was notified of the investigation or interviewed. There is no documentation of why CPS did not interview the subject.

- **DCYF Practices 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 closed 134 days after the intake screened in.

DCYF Response:

The Area Administrator reviewed this case and reported that the eight-month-old sibling was not listed as a victim and the caseworker overlooked the requirement to complete health and safety visits for this child, as well as the requirement for a safety assessment. The caseworker had difficulty engaging the family as the subject of the investigation was in crisis and relatives also asked that the caseworker not interview the subject as she was experiencing trauma. The caseworker believed that the law enforcement interview of the subject satisfied the requirement for the subject interview.

Supervisors are now tracking all cases during case conferences and unit meetings for closure time frames and collaborating with caseworkers to develop action plans in order to complete required work consistent with the timelines in policy. The office will provide protected time for caseworkers to close cases and supervisors have reiterated to their staff the importance and expectation that subject interviews, as well as health and safety visits for children who are not identified as victims, are

completed. The QPS program manager is providing assistance and one-on-one coaching regarding safety assessments and Structured Decision-Making.

DEPENDENT CHILD WELL-BEING AND PERMANENCY

DCYF did not conduct a relative search for a dependent two-year-old child until after the child had been in the foster adoptive home for over two years and was legally free.

In 2017, a CPS intake was received regarding a newborn baby girl. While the mother and baby tested negative at the time of the birth, the mother reported using methamphetamine at the beginning of the pregnancy. The mother also had a legally free 22-month-old child placed in foster care. This intake screened in for CPS Risk Only. CPS located the mother and child in a homeless encampment and the child was placed in non-relative foster care. The mother was minimally involved in the dependency after 2017.

For approximately two years, there was no documented efforts to conduct a comprehensive relative search following the child's placement in foster care. From March 2018 through August 2019, monthly supervisory case notes stated there was "no relative available to be a placement or support" and a search should be initiated through the Native American Inquiry Referral Unit (NAIR).

In November 2019, the NAIR relative search unit contacted the supervisor and informed the supervisor that during an internal Continuous Quality Improvement (CQI) process, this case was identified as not having had a relative search completed. The NAIR unit conducted a relative search and identified at least three maternal relatives who expressed interest in being a placement. The child's case transferred to the adoptions unit to further assess the relatives.

Violation:

- **DCYF Practices & Procedures 4527 – Failure to conduct a relative search at the time the child was placed in out-of-home care, or on an ongoing basis during the life of the case. DCYF must search for relatives when the child is initially placed in out-of-home care; document relative search activities during the case and conduct an ongoing search for relatives when a child is not placed with a relative. Additionally, relative search activities are only discontinued when a permanent plan for a child has been completed.**

  In this case, a relative search was not initiated until the child had been in out-of-home care for approximately two years. As a result, the timely consideration of potential relative placements did not occur, which adversely impacted permanency for this child.

DCYF Response:

DCYF responded that several factors contributed to relative searches not being completed according to policy. The case was transferred to different caseworkers multiple times and although the supervisor documented the need for a relative search, this did not occur. DCYF sent an office wide email addressing expectations for relative searches and FTDM facilitators were advised to address the issue of relative searches during meetings. DCYF stated it would also be holding a refresher training on the relative search policy at a unit meeting.

FAMILY SEPARATION AND REUNIFICATION

DCYF improperly managed permanency planning for three dependent children, following the termination of parental rights but before the parent's appeal had been heard.

OFCO partially substantiated this complaint by finding that DCYF improperly allowed these children to be adopted while their parent's appeal of termination of parental rights was pending.

The three children became legally free in March 2018 with orders terminating parental rights of both parents. Their mother appealed. In November 2018, all three children were adopted by their foster parent and DCYF dismissed the dependency, though the mother's appeal was still pending. The AAG then informed the caseworker that the termination was on appeal and that the adoption should not have been completed. The AAG vacated the adoption and reinstated the dependency in December 2018. The caseworker and foster parents chose not to inform the children their adoption had been vacated, believing it would be detrimental to them, and in hopes that the appeal would be denied. In January 2019, the Washington State Court of Appeals reversed the order terminating the mother's parental rights and remanded the dependency case to superior court for further proceedings. The children started visiting with the mother and DCYF planned to file for termination of parental rights again.

Unreasonable Action:

- **DCYF's actions were clearly unreasonable to allow the adoption of the three children to move forward and dismiss the dependency when their parent's appeal of termination of parental rights was pending.**

  OFCO finds that this was harmful as the children were informed they had been adopted by their permanent placement, only to find out that this was not the case and they would be reentering dependency status. The reinstated dependency had been ongoing for the past year and has included parent-child visits, adding to the children's confusion. Additionally, the mother could understandably conclude that the DCYF's actions demonstrate bias against her and interfere with efforts to engage this parent to make reasonable efforts towards reunification.

DCYF Response:

DCYF did not provide a response to the finding.

DCYF did not make efforts to pursue a relative placement option for five children in foster care.

Five siblings were removed from their parents' care in October 2016 as a result of physical abuse and neglect. One of the children was placed separately from the other children. In January 2017, the CFWS caseworker sent home study paperwork to the maternal aunt and maternal grandmother who were seeking placement of the children. In May 2017, the maternal aunt responded and asked if the children still needed placement. There was no further contact with her until September 2019.

The child who had been placed separate from the others disrupted from placement in August 2019. In September 2019, the maternal aunt completed background checks. DCYF conducted a walk-through of the maternal aunt's home. In October 2019, the child was placed with the maternal aunt and her partner who were being considered as a permanent placement option. Despite making contact with DCYF about placement of all of the children in May 2017, the maternal aunt was not pursued as a placement option until September 2019.

Violation:

- **DCYF Practices and Procedures Guide, 4527 requires DCYF to make efforts to locate relatives when a child is placed in out of home care, notify known relatives when a child is placed in out of home care, and prioritize kinship placements when there are no safety concerns.**

  The maternal relative made contact with DCYF in 2017 and was not pursued as an option for placement until September 2019.

DCYF Response:

DCYF stated that had the aunt responded to the relative search request sooner than May 2017, a home study would have been initiated. However, DCYF also confirmed they did not follow through with the maternal aunt's interest in placement of all five children. As a result, the social and health program consultant staff in the office implemented a spreadsheet to track relative searches. Additionally, the Area Administrator sent an email to all staff with reminders about the appropriate policies and practices and directed supervisors to hold meetings with staff to go over appropriate policies and procedures relevant to relative placements.

DEPENDENT CHILD WELL-BEING AND PERMANENCY	FAMILY SEPARATION AND REUNIFICATION

DCYF did not conduct a background check or refer a relative for a home study in a timely manner.

In August 2019, DCYF filed for dependency and placed two children with their great-grandparent. Although this relative placement appeared stable, it was unclear if the great-grandparent was a long-term option for the children and DCYF assigned a relative search specialist to identify other potential relative placement options. In September 2019, the relative search specialist notified the caseworker that a grandparent expressed interest in caring for these children and provided the caseworker with the grandparent's contact information. By December 2019, it was clear that the great-grandparent was not able to care for these children and in January 2020, DCYF placed the children with a non-relative caregiver. In April 2020, the grandparent contacted DCYF and again expressed interest in placement of these children. DCYF then began assessing her for placement, seven months after she was identified as a potential placement resource and three months after the children were moved from the great grandparents' home. OFCO found that the Department did not conduct a background

check or refer the grandparent for a home study in a timely manner, and did not assess this relative for placement when the children's placement with the great-grandparent ended.

Violations/Unreasonable Action:

- **DCYF Practices and Procedures, 45274 and 6800 require DCYF to assess unlicensed relative caregivers through the completion of required background checks and a home study.**

  OFCO found the six month delay in initiating an assessment of the paternal grandmother to be unreasonable.

- **DCYF Practices and Procedures, 4527, Kinship Care: Searching for, Placing with, and Supporting Relatives and Suitable Other Persons requires DCYF to continue to search for relatives when a child disrupts from placement, and "to prioritize kinship placements as long as there are no safety concerns".**

  There was no documentation that the paternal grandmother, who came forward in September 2019, was contacted when it became clear that the maternal great grandmother was not a long term placement for the children and that the children were going to be moved.

DCYF Response:

DCYF noted that when the relative search specialist notified the caseworker about the grandparent's interest in placement, the supervisor was on leave which contributed to this delay. DCYF also confirmed it was working with this relative and the home study process was pending.

This finding was modified. After further review, a third finding was withdrawn.

FOSTER PARENT/RELATIVE CAREGIVER ISSUES

DCYF's delay in processing the background check of a proposed relative placement for a dependent child was clearly unreasonable.

In June 2018, a 12-year-old and two younger half siblings, ages two and seven, were removed from their parents' care and placed with a relative. In early 2019, the relative informed the agency that she was not a long-term placement for the children and other relatives were identified. In early July 2019, the three children were moved to another relative placement; however, the 12-year-old child disrupted from the placement and was placed back with the original relative caregiver until a different relative could be identified.

DCYF initiated background checks and an Interstate Compact on the Placement of Children (ICPC) home study for other relatives, one of which resided in Alaska. A background check was sent to the Administrative Review Unit (ARU) in late August 2019 for the local relative. After the relatives in Alaska withdrew, the DCYF supervisor repeatedly asked the ARU to prioritize and expedite this review, as the child's placement was disrupting. The ARU advised that the review could not be expedited and would be processed in the order received. Additionally, due to increased workload,

there was no clear timeframe for the completion of the review. The ARU was contacted again and the Area Administrator was told that they still needed to gather relevant records in order to clarify a conviction. The child was moved to a foster home in January 2020 and approximately two weeks later, the prospective relative placement's administrative review was approved. The 12-year-old child was then placed with the relative three days later.

Unreasonable Action:

- **DCYF's actions were clearly unreasonable** in that there was an unreasonable delay caused by DCYF in processing the background check of a proposed relative placement for a dependent 12-year-old child. It took approximately five months for an administrative review to be completed on a prospective relative placement. As a result, there was adverse impact to the child with an unnecessary placement disruption and placement in a foster home for approximately three weeks before the administrative review was approved.

DCYF Response:

DCYF responded that although there is no capacity to complete suitability assessments more timely, the assessment unit should have expedited this assessment after numerous requests by Department staff. Furthermore, expediting assessments would be considered on a case by case basis.

The DCYF caseworker impermissibly disclosed the name and phone number of the child's foster parent to the child's biological parent.

The caseworker sent a text message to the biological parent of a five-year-old dependent child as well as the current foster placement. In the ensuing text chain, the caseworker revealed to the biological parent that the other participant on the text chain was the foster parent and also revealed her full name. The biological parent expressed not being pleased with the foster parent or DCYF. The caseworker appropriately apologized to the foster parent. The foster parent had previously requested confidentiality due to the parent's history of violence and aggression and mental health issues. The foster parent stated that the biological parent made attempts to locate and harass her following the disclosure of her information.

Violations:

- **RCW 42.56 and CR 26-37, and "Foster Parent Rights and Responsibilities" (https://www.dcyf.wa.gov/sites/default/files/pubs/LIC_0001.pdf) explains that foster parents have the right to have their personal information be kept confidential, to the extent allowed by law.**

  This foster parent indicated they requested confidentiality due to the biological parent's concerning history and that following the disclosure of information the biological parent used it in an attempt to harass her.

DCYF Response:

DCYF responded that the caseworker indicated that in haste, they forwarded a text chain and identified the foster parent without thinking about the breach in confidentiality. The caseworker was immediately aware that they made an inadvertent mistake, contacted the foster parent to inform them, and apologized for the error. The caseworker has reviewed the "Foster Parent Rights and

Responsibilities" document and has had a discussion with their supervisor and the Area Administrator about the importance of maintaining foster parent confidentiality.

POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY

DCYF did not communicate with hospital staff timely regarding placement of a fourteen-year-old child who was medically cleared for discharge.

CPS intake was contacted about a Child In Need of Services (CHINS) petition for a fourteen-year-old child in the care of the father. The child had been admitted to three psychiatric facilities within six months due to significant mental health issues. The intake screened in for Family Reconciliation Services (FRS).

At the time the intake was received, the child was on an Involuntary Treatment Act (ITA) 72-hour hold due to suicidal ideations. The father filed a CHINS petition. Following a court hearing, the child was placed in a Behavioral Rehabilitative Services (BRS) group home. A few days later the child ran from placement. Law enforcement located the child and notified the FRS caseworker. The child was then placed in a temporary hotel stay for three nights. Before an appropriate placement was located, the child was transported by paramedics to a local hospital emergency room due to escalating behaviors and concerns for self-harm. The child was evaluated by a crisis counselor and an emergency room physician, and was then medically cleared for discharge from the hospital. An after-hours caseworker went to the emergency room and told the staff they were instructed to retrieve the child's medications from the child's prior placement and that they would return to take placement of the child. However, the caseworker did not return that night or inform anyone at the hospital about placement for the child.

The following day, CPS intake received a report that the child had been ready for discharge since the prior evening.

Unreasonable Action:

- **DCYF's actions were clearly unreasonable in the lack of timely communication between DCYF and hospital staff**. While OFCO does not fault DCYF's decision for the child to remain at the hospital overnight, there was a lack of communication by after-hours caseworkers to apprise hospital staff of their decision to not return for the child.

DCYF Response

DCYF responded that there was a miscommunication between after-hours staff, which resulted in a failure to communicate with the hospital about not picking up the child. The Area Administrator addressed this with the individual caseworker involved and directed after-hours staff to ensure they communicate with hospitals regarding child placements including timeframes as available.

DCYF provided a letter describing an ongoing CPS investigation to a parent, which was used in a child custodial proceeding.

DCYF received an intake alleging neglect and lack of supervision by the father of his two children, ages two and three. The intake screened in for a CPS FAR intervention. DCYF also received two CPS intakes with allegations relating to the mother; however, these intakes were screened out. During the course of the open investigation, collateral contacts reported concerns with the mother's parenting as well.

While this FAR case was open, the assigned caseworker provided a letter to the father stating DCYF received an intake with concerns regarding his children in their mother's care. These concerns included neglect due to substance abuse, criminal activity, and/or domestic violence. The father reportedly filed this letter in Superior Court in an ongoing custodial dispute with the mother.

OFCO determined that the letter included inappropriate and inaccurate information as CPS did not have an open investigation identifying the mother as the subject. Instead, there was an open intake alleging domestic violence identifying the mother as the victim. DCYF agreed that this letter appeared to provide inaccurate and misleading information and that the details shared in this letter were not appropriate.

Unreasonable Action:

- **DCYF's actions were clearly unreasonable** as the assigned worker provided a letter to a parent involved in an ongoing CPS investigation stating that the other parent was the subject of an open CPS intake, when that parent was not named as the subject. Furthermore, it was clearly unreasonable to include the level of detail regarding the allegations involved in the case. OFCO received information from a concerned party that this letter was filed in Superior Court and this misleading information is now a part of that court record.

DCYF Response:

DCYF responded that the caseworker identified that there was an open intake on the mother in error. While there was not an intake identifying the mother as the subject, there was concern about the mother's ability to safely parent. The caseworker did not intend to provide misleading information but was seeking input on the child. The supervisor and caseworker were instructed that any letters provided to a parent during an open investigation should be neutral and only speak to child safety concerns. The entire CPS unit was provided with a template letter that all new staff are given from the regional QPS team and they were reminded that DCYF does not write letters regarding family court matters.

DCYF monthly supervisor case reviews were not documented.

The specific issue raised in this OFCO complaint related to delay in permanency of a three-year-old child. However, OFCO found that monthly supervisor reviews were not documented.

CPS received an intake alleging the mother of a newborn was using drugs and unable to care for her child. The intake screened in for CPS-Risk Only. Given the mother's CPS history and recent relinquishment of an older child, DCYF filed a dependency petition. The child had five foster care

placements over two years. From April 2018 until March 2020, there were six documented monthly supervisor reviews.

OFCO finds that the lack of monthly supervision over a prolonged period resulted in little to no direction for the assigned caseworker and may have contributed to delays in permanency for the child.

Violation:

- **DCYF Practices and Procedures Guide, 46100 states that the casework supervisor must conduct monthly supervisor case reviews with each assigned caseworker and document each case review. Specifically, case review discussions are to include discussion regarding child safety as well as "steps the family and/or children need to achieve permanency including concurrent planning, relative search and community supports."**

  There was no documentation that monthly supervisor case reviews occurred for several months.

DCYF Response:

DCYF responded that the local office has a new area administrator who recognized the need to improve practices in this area and brought Quality Practice Specialists into the office to observe supervisory practice, train to the supervisory review tool, and make recommendations for scheduling the supervisor reviews. The Area Administrator also established written expectations that have been signed by all supervisors to complete case reviews in accordance with policy. The local office has improved their supervisory case reviews to 90% completion of all cases in the office, up from 30% completion of this task when the area administrator first began their new role. Statewide Field Operations leadership has also been involved by reviewing a sample of supervisor case reviews and sending a memo to all supervisors reminding them of the importance of monthly supervisor reviews and identifying the qualities in these reviews in order to provide needed direction to staff.

A DCYF caseworker provided a letter to a parent for use in a family court proceeding.

Complaint alleged DCYF caseworker provided a letter to a parent for use in a family court proceeding. The letter referenced a Child Protective Services (CPS) Family Assessment Response and stated there was no basis for the allegation and CPS involvement resulted from a false report. The caseworker had specifically been instructed by the CPS supervisor not to send the letter as written. OFCO notified DCYF administration that it substantiated this complaint and found that the caseworker's conduct was clearly unreasonable.

DCYF Response:

The Department requested that OFCO withdraw this finding as it falls outside OFCO's authority. DCYF correctly noted OFCO has the duty to investigate 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. Here, the assigned caseworker's actions that were the basis of OFCO's finding were not an administrative act as the DCYF supervisor expressly instructed the

caseworker not to send the letter. When the assigned caseworker did, she acted without agency authority to do so, and this conduct therefore did not constitute an "administrative act."

OFCO agreed with the Department's analysis and withdrew this finding.

PARENTS' RIGHTS AND OTHER FINDINGS

DCYF did not properly inquire, identify, and act on a family's Native American status, and the case remained open beyond required timeframes.

In December 2019, CPS received an intake alleging domestic violence in the children's presence. The intake screened in for CPS FAR. A caseworker completed the initial face-to-face meeting with the family and children four days later. This caseworker did not document any inquiry into the family's Native American status at that time and the family reported they were not asked.

In February 2020, the assigned caseworker interviewed the mother over the phone and the mother stated the father and children had Native American ancestry. In March 2020, the assigned caseworker interviewed the father by phone and obtained his tribal identification number as well as information that the children are registered with their tribe and the contact information for their tribal representative. However, there is no record that the Indian Identity Request form (DCYF 09-761) was completed nor was there information that a Native American Inquiry Referral (NAIR) was completed, nor any other attempt to contact the tribe. The case closed in March 2020. At the time of the OFCO findings, the children and father were still currently listed in the agency's online system as not having tribal involvement or affiliation.

Violations:

- **Indian Child Welfare Policies and Procedures, 3 requires that caseworkers must complete the Indian Identity Request form (DCYF 09-761) at the initial visit on all screened in cases for each child, including those who have not been identified as victims.**

  The initial visit with the family occurred in December 2019; however, the first inquiry into Indian Status was completed in February 2020.

- **Indian Child Welfare Policies and Procedures, 3 states that when a child may have Indian ancestry and be affiliated with a federally recognized tribe, the caseworker will complete a Family Ancestry Chart and send a Native American Inquiry Referral (NAIR) to the Native American Inquiry Unit. Additionally, the caseworker must use "due diligence" to "identify and work with all of the tribes of which there is reason to know the child may be a member (or eligible for membership), to verify whether the child is in fact a member or eligible for membership.**

  The mother informed the caseworker in February 2020 that the father and children identified as Native American. The father again informed the caseworker of this fact, as well as the tribal identification number and contact information for the tribe. However, there is no

indication that the caseworker took any steps to complete the Family Ancestry Chart or the NAIR, and thus no efforts were made to contact the tribe.

- **DCYF CA Practices and Procedures Guide, 2332(4) states that a FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or caregiver receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030(13).**

  DCYF received the intake regarding this matter in December 2019 and the case closed in March 2020. No services were offered to or obtained by the family during this time.

DCYF Response:
The Area Administrator responded that the case was not closed due to backlog. Although the caseworker recalls inquiring about Indian identity during the first visit with the family, this information was not documented as required. The caseworker did not follow up on the information by completing ICW requirements in policy.

A Rapid Response Team has been assigned to assist offices in the region to close CPS cases which has been very helpful in addressing backlog. Due to the COVID-19 crisis, the Area Administrator has been unable to immediately address the issues involving compliance with ICW policies. The agency reported that a supervisors' meeting was to be held and the Area Administrator would review supervisory responsibilities to monitor timely closure of cases, as well as ICW policies. The agency also reported that supervisors would be expected to perform quality assurance activities to review compliance with ICW policy. The CPS staff meeting was cancelled due to the pandemic, so in lieu of addressing these issues during a meeting, the Area Administrator committed to send out an email to all their CPS staff addressing expectations to follow ICW policy.

OTHER FINDINGS

DCYF did not promptly notify a dependent child's CASA/GAL of a report of alleged abuse or neglect and of the disposition of such report.

In 2016, two-year-old twins were removed from their mother due to concerns of neglect and were placed with relatives. In May 2017, the relative caregivers informed DCYF that they could no longer care for the children. The children were then placed with their grandmother who was referred for a home study. The maternal grandmother's home study was denied in 2018 and DCYF requested a change of the children's placement, which was denied.

In July 2019, CPS received an intake reporting that the grandmother was dating or married to a Level 3 registered sex offender (RSO) who reportedly spent time at the grandmother's home and was around the children. The grandmother reported that she was aware of his criminal history but they did not live in the same home. The grandmother denied he was ever at her home with the children alone. All of the children were interviewed and made no disclosures.

In August 2019, CPS received another intake that the maternal grandmother married this man. He reported to his corrections officer that he does not live in the home but that he visits. This intake

screened in for a CPS Risk Only investigation. The grandmother reported her husband visits about once per week and denied leaving any of her grandchildren alone with him.

A Shared Planning meeting was held in September 2019 during which DCYF raised serious concerns about the husband and maternal grandmother's ability to protect the two dependent children. This was the first time the CASA was informed of the CPS intakes and related investigations.

Violation:

- **RCW 26.44.030 (21) states, "upon receiving a report of alleged abuse or neglect involving a child under the court's jurisdiction under chapter 13.34 RCW, the department shall promptly notify the child's guardian ad litem of the report's contents. The department shall also notify the guardian ad litem of the disposition of the report." Additionally, RCW 13.34.105(3) states, "the guardian ad litem shall have access to all information available to the state or agency on the case."**

  DCYF did not promptly notify the CASA of the screened in CPS intakes from July 2019 and August 2019, and did not inform the CASA of the outcome of the CPS investigations.

DCYF Response:

DCYF responded that the caseworker was new and not aware of the obligation to notify the CASA as per statute. The Area Administrator held a meeting with the CASA supervisor. The requirement to notify CASAs was discussed with all supervisors to be reinforced at unit meetings and during supervision. The issue was discussed with all of this office's staff at a meeting.

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.