OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

An Independent Voice for Families and Children

ANNUAL REPORT
2022

Patrick Dowd, Director
ofco.wa.gov

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To the Residents of Washington State:

I am pleased to submit the 2022 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, 2021, to August 31, 2022. We thank the parents, youth, relatives, foster parents, professionals, and others who brought their concerns to our attention. We take their trust and confidence in our office most seriously.

During this reporting period, OFCO received 836 complaints and completed 815 investigations regarding 1,209 children. As in past years, concerns about agency conduct and the separation and reunification of families were the most frequently identified issues in complaints. In addition to complaint investigations, OFCO monitors practices and procedures within the child welfare system and makes recommendations to better serve children and families. Systemic issues discussed in this report again include the use of hotels and temporary night-to-night foster care as emergency placements for children. The placement resource crisis has only worsened as our child welfare system has experienced a significant drop in foster homes and congregate care providers in the past two years. This reporting year, 281 children spent a combined total of 4,692 nights in hotels, night-to-night foster homes, or other placement exceptions. Children with complex behavioral and mental health needs, who are among the most vulnerable populations, also experience the most placement exceptions. Resolving the placement exceptions crisis will require expanding the array of placement resources and supports for families, as well as for children in foster, relative, and kinship care.

This reporting year OFCO also identified a disturbing increase in child fatalities and near fatalities from drug overdose. As of October 2022, OFCO has received 31 reports of child fatalities or near fatalities involving drug overdoses, compared to only five such reports in 2017. Of particular concern is the increase in incidents of young children accidentally ingesting controlled substances and, in particular, fentanyl. Substance abuse treatment resources, and prevention strategies and services, are essential to protect children from these sometimes fatal events.

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, 2021, through August 31, 2022.

CORE DUTIES

The following duties and responsibilities of the Ombuds are set forth in state laws:[1]

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

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

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

SYSTEM OVERSIGHT AND IMPROVEMENT:

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

[1] RCW 43.06A and RCW 26.44.030.

- Review child fatalities and near fatalities when the injury or death is suspected to be caused by child abuse or neglect and the family was involved with DCYF during the previous 12 months;
- Recommend changes in law, policy, and practice to improve state services for families and children; and
- Review notifications from DCYF regarding a third founded report of child abuse or neglect within a 12-month period involving the same child or family.

ANNUAL REPORTS:

- Submit an annual report to the DCYF Oversight Board and to the Governor analyzing the work of the office, including recommendations; and,
- Issue an annual report to the Legislature on the implementation status of child fatality review recommendations.[2]

WORKING TO MAKE A DIFFERENCE

Despite efforts to increase placement resources for children in state care, children continue to be housed in hotels and other temporary placements. This past year, OFCO received notice of 4,692 placement exceptions, an 85% increase from last year, involving 281 children. Most placement exceptions occurred in hotels (82.4%), as the Department largely succeeded in eliminating the practice of having children sleep in DCYF offices. In 2022, OFCO received reports of only two "office stays", compared to 751 in 2021. Additionally, DCYF opened two leased facilities in 2022, managed and staffed by DCYF employees, to provide greater stability for children in temporary placement. These facilities are located in Region 4 and Region 6, which experience the highest number of placement exceptions.

As identified in previous OFCO reports, a relatively small number of children continue to make up the majority of placement exceptions. This year, 59 children spent 20 or more nights in placement exceptions, accounting for 84% of all placement exceptions. Many of the children experiencing numerous placement exceptions have significant treatment, supervision, and placement needs, and, thus, are more challenging to appropriately place. One child with many of these needs experienced 275 nights in a placement exception.

In response to a class action lawsuit filed by Disabilities Rights Washington (DRW) on behalf of children in foster care who have behavioral health needs and/or developmental disabilities, the Department entered into a settlement agreement to end placement exceptions and provide appropriate placement and services for children in state care. The settlement agreement expands placement resources to include: an independent housing program for youth ages 16-21; professional therapeutic foster care; and a "Hub Home Model" program to support foster, relative, and kinship placements. The agreement also includes system and practice improvements that will be trauma-informed, culturally responsive, and LGBTQIA+-affirming. These enhanced programs and placement resources are essential to eliminate the practice of housing children in hotels and provide for the needs of all children in state care. In implementing this agreement, DCYF should prioritize expanding placement resources as these are essential to preventing short term emergency placements.

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

This year, OFCO has also noted an alarming increase in reports of children and teens involved with the state child welfare system overdosing on drugs, and in particular, fentanyl. Critical incident reports include youth intentionally overdosing, intentionally taking drugs, and accidentally overdosing, and toddlers and babies accidentally ingesting drugs and overdosing. Thus far in 2022, OFCO has received 31 critical incident reports of children overdosing on drugs; 16 of these fatalities or near fatalities were attributed to fentanyl, with seven of these incidents involved children ages 0-11 years accidentally ingesting fentanyl. Enhanced prevention strategies when engaging families and increased treatment resources are needed to protect children and preserve families.

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2021, and August 31, 2022, OFCO completed 815 complaint investigations regarding 1,209 children. This year, issues involving the conduct of DCYF staff and other agency services were the most frequently identified complaint issues. Issues involving the separation and reunification of families comprised the next highest category of issues identified in complaints.

OMBUDS IN ACTION

OFCO acts when necessary to avert or correct a harmful action, oversight, or avoidable mistake by DCYF. Forty-six complaints prompted intervention by OFCO in 2022. OFCO provided substantial assistance in an additional 63 complaints to resolve either the complaint issue or a concern identified by OFCO in the course of its investigation.

In 2022, OFCO made 20 formal adverse findings against DCYF. OFCO provides DCYF with written notice of adverse findings resulting from a complaint investigation. DCYF is invited to respond to the finding and may present additional information and request a revision of the finding. This process provides transparency for OFCO's work as well as accountability for DCYF.[3]

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

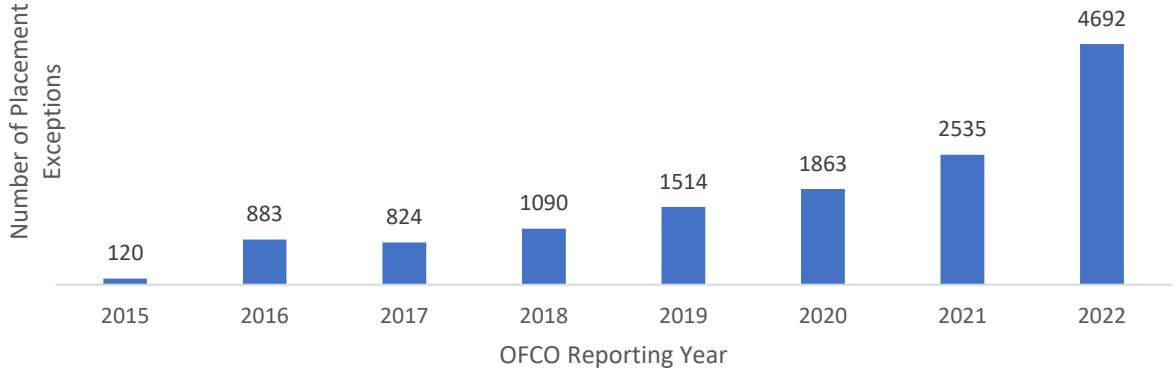
SECTION I: IMPROVING THE SYSTEM

- Placement Exceptions Data
- Agreed Settlement of Class Action Lawsuits Provides Plan to Reduce Placement Exceptions
- Accidental Ingestion of Drugs and Overdoses by Children: Fentanyl is a Growing Threat
- OFCO's Pro-Equity Anti-Racism Strategic Action Plan

PLACEMENT EXCEPTIONS DATA

Placement Exceptions for Foster Children

Figure 1: **Number of Placement Exceptions**



All children and youth in state care deserve safe, stable placements that meet their individual needs and support permanency goals, yet the number of placement exceptions has continued to rise over the past five years. From September 1, 2021, to August 31, 2022, OFCO received notice of 4,692 placement exceptions, an 85% increase from last year, involving 281 children.[4] Most placement exceptions occurred in hotels (82.4%). DCYF also reported placement exceptions in night-to-night placements (12.3%) and a leased facility in Region 4 (5.5%). DCYF nearly eliminated the practice of housing children in DCYF offices, reporting only two such occurrences this year. By comparison, in 2021 there were 751 reported "office stays."

This crisis is not unique to Washington State as child welfare systems across the country also struggle to meet the needs of children and provide services and appropriate placement. For example, in Texas, the number of children housed in offices, hotels, and unlicensed facilities increased 152% in the first half of last year, and in Georgia the number of children in temporary placements has more than doubled since before the pandemic.[5]

In Washington State, several factors have contributed to the increase in placement exceptions this year, including improved tracking, reduced placement resources, and youth entering care despite there being no allegations of child abuse or neglect. This past year, the Department included night-to-night foster care stays when reporting placement exceptions; in past years, the agency has not included this data

[4] OFCO receives notification of placement exceptions through DCYF's Administrative Incident Reporting System (AIRS).

[5] See, **New York City Aims to Reduce Children's Stays in Temporary Foster Care Facilities,** Imprint - October 13, 2022 New York City's Plan to Limit Temporary Foster Care Facility Stays - The Imprint (imprintnews.org); **High-needs foster kids sometimes have to sleep in hotels or offices. The pandemic made the problem worse ,**PBS.ORG News Hour -May 31, 2022 (https://www.pbs.org/newshour/nation/high-needs-foster-kids-sometimes-have-to-sleep-in-hotels-or-offices-the-pandemic-made-the-problem-worse); **Foster children housed in child welfare offices; officials work to end practice,** The Atlanta Journal-Constitution, June 20, 2022 (https://www.ajc.com/politics/foster-children-housed-in-child-welfare-offices-officials-work-to-end-practice/YCMAHV7YFFFFPDPTJEHQOYPFGI/); **Why Kids in Foster Care End up Sleeping in Offices,** Dallas Morning News, October 5, 2021 (https://www.aei.org/op-eds/why-kids-in-foster-care-end-up-sleeping-in-offices/); **With nowhere else to go, some Virginia foster children have been sleeping in government offices,** Virginia Mercury, April 1, 2022 (https://www.virginiamercury.com/2022/04/01/with-nowhere-else-to-go-some-va-foster-children-have-been-sleeping-in-government-offices/); and **Oregon foster system continues to house children in hotels, despite agreeing to stop,** The Oregonian, December 23, 2021 (https://www.oregonlive.com/politics/2021/12/oregon-foster-system-continues-to-house-children-in-hotels-despite-agreeing-to-stop.html).

when tracking placement exceptions. While technically these are not placement exceptions in the strictest sense, as the placement is a licensed foster home, the lack of stability and the transient nature of the placement results in a similar experience for the child. Children staying in leased facilities staffed and managed by DCYF are also included in the placement exception count. This year, the Department opened a leased facility in Region 4 that can accommodate 12 children and a facility in Region 6 for up to six children.[6] The child welfare system has also experienced a significant decrease in licensed placement resources, losing 14 group care facilities over the past two years. Additionally, approximately 1,000 foster homes have either given up their foster license or have decided not to accept additional placements. Health concerns related to the COVID pandemic have significantly contributed to the loss of licensed placements. Furthermore, children and families often find themselves involved with CPS not because of allegations of child abuse or neglect, but because the child's behavioral and/or mental health needs cannot be managed in the home, and the family is not able to access needed services and placement through Washington's health care system.

Figure 2: **Placement Exceptions by Month, 2022**

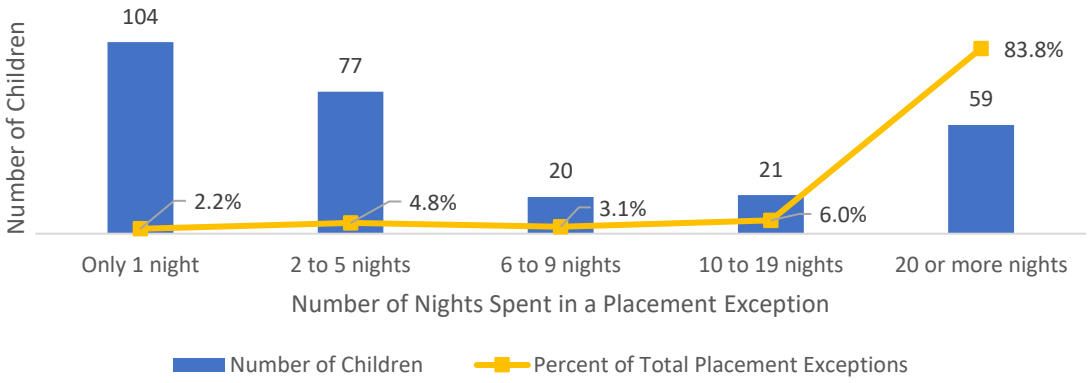
Table 1: **Location of Placement Exceptions, 2022**

DCYF Region	Hotel	Office	Night-to-Night	Leased Facility	Unknown	Placement Exceptions
Region 1	10	--	--	--	--	10
Region 2	5	--	--	--	--	5
Region 3	112	--	89	--	--	201
Region 4	1469	--	205	258	--	1932
Region 5	32	2	261	--	--	295
Region 6	2229	--	19	--	1	2249

[6] Lake Burien in Region 4 opened in July 2022, and Ryan's House in Region 6 opened in September 2022.

DCYF typically locates a placement within a few days for most children who experience placement exceptions. This year, DCYF identified a suitable placement for 64.4% of children within five days or less of a placement exception occurring; however, these children only accounted for 7% of all reported placement exceptions. Fifty-nine children (21%) were reported to have spent 20 or more nights in placement exceptions, and accounted for 83.8% of all placement exceptions, with a combined total of 3,933 nights. Of these, twenty youth accounted for half of all reported placement exceptions (2,342 nights).

Figure 3: **Number of Placement Exceptions per Child, 2022**



Who Are the 59 Youth Who Spent 20 or More Nights in Placement Exceptions?

- The highest number of nights in placement exceptions reported for a single child was 275 nights.
- Four of the five youth with the most placement exceptions identify as transgender.
- 41 youth (69.5%) were between ages 15-17.
- 38 youth (64.4%) were reported to have mental health needs, such as mental health disorders and/or past psychiatric stays.
- 27 youth (45.8%) were reported to have physically aggressive or violent behaviors.
- 24 youth (40.7%) have a history of running from placement. The five youth with the most placement exceptions were all reported to have run behaviors.
- 24 youth (40.7%) were reported to have suicidal ideation and/or self-harm behaviors.

Figure 4: **Characteristics and Behavior of Children Who Spent 20 or More Nights in Placement Exceptions, 2022**

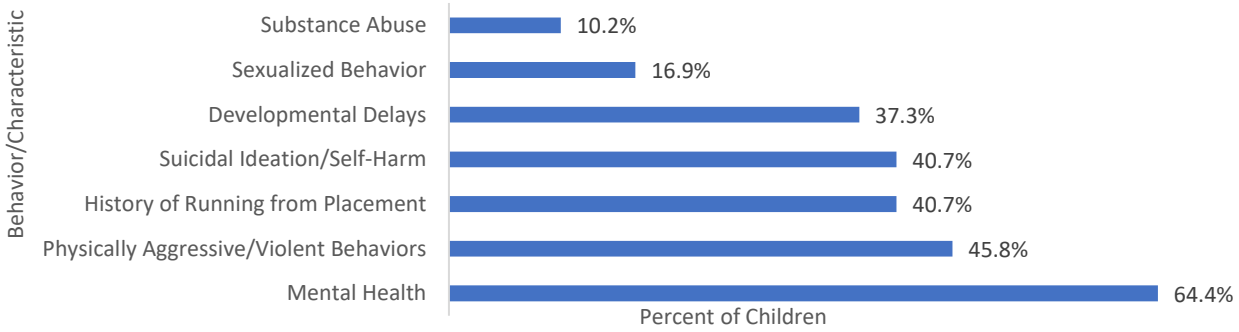


Table 2: **Age, Race, Gender of Children Who Spent 20 or More Nights in Placement Exceptions, 2022**

Age	Number of Children
0-4 years	--
5-9 years	1
10-14 years	17
15-17 years	41
Race	**Number of Children**
American Indian/Alaskan Native	2
Black/African American	13
Hawaiian/Other Pacific Islander	2
White/Caucasian	27
Multi-Racial *White/Caucasian & Black/African American (5)* *White/Caucasian, Black/African American & American Indian/Alaskan Native (1)* *White/Caucasian, Black/African American & Asian or Native Hawaiian/Other Pacific Islander (2)* *White/Caucasian & American Indian/Alaskan Native (3)* *White/Caucasian & Asian or Native Hawaiian/Other Pacific Islander (4)*	15
Gender	**Number of Children**
Female	15
Male	35
Transgender Female	3
Transgender Male	1
Other	5

Demographics of Children Experiencing Placement Exceptions

Of the 281 children who spent at least one night in a placement exception, approximately 56% were male and 37% were female. The remaining 7% identified as transgender or other gender.[7]

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

Although children ages 10 to 17 make up approximately 32% of the total out-of-home care population in Washington State,[8] they comprise over 83% of the children experiencing placement exceptions. As shown in Figure 6, and consistent with previous years, children who experience placement exceptions tend to be older than the total out-of-home care population.[9]

Figure 5: **Child Gender in Placement Exceptions, 2022**

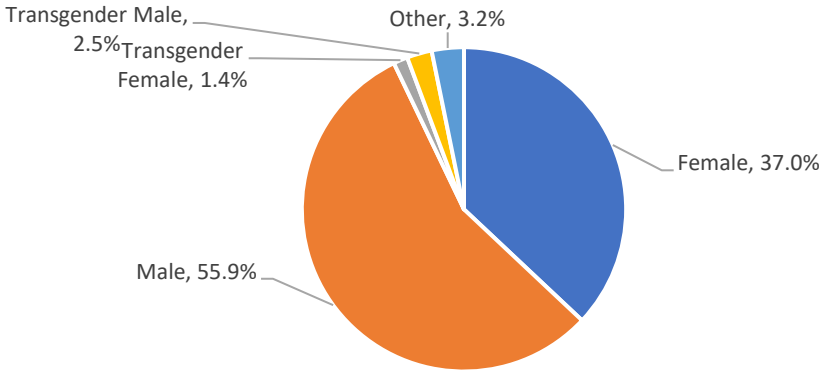
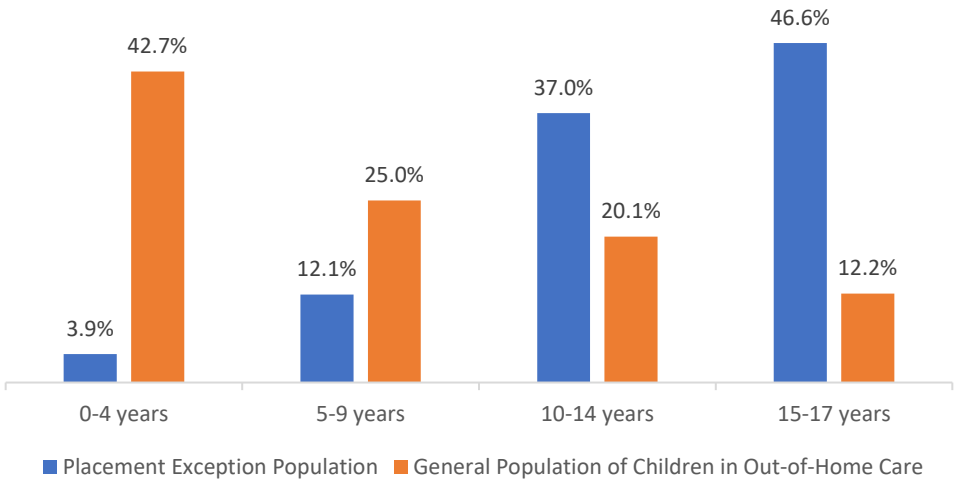


Figure 6: **Child Age in Placement Exceptions, 2022**



Children ages 10 to 17 spent the most nights in placement exceptions: Children ages 10 to 14 spent an average of 11.6 nights, and children ages 15 to 17 spent an average of 25.3 nights.

[8] Center for Social Sector Analytics & Technology (2022). [Graph representation of Washington state child welfare data 9/21/2022]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

[9] Center for Social Sector Analytics & Technology (2022). [Graph representation of Washington state child welfare data 9/21/2022]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

Figure 7: **Average Number of Placement Exceptions, 2022**

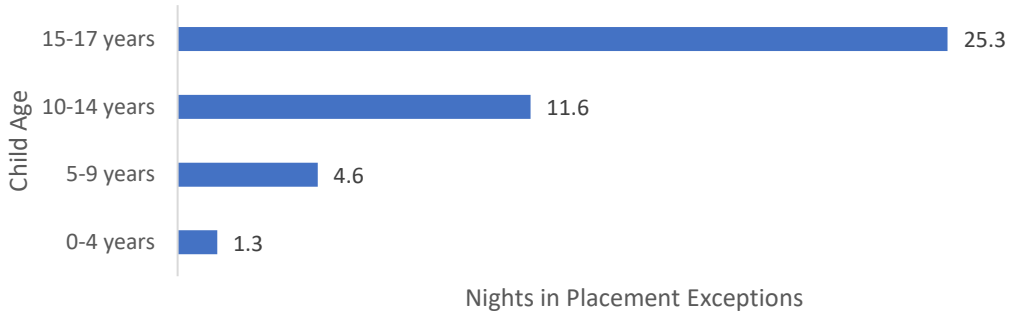


Table 3: **Child Race and Ethnicity**

Race/Ethnicity	Placement Exception Population	Region 4 & 6 Out-of-Home Care Population[10]	Washington State Out-of-Home Care Population[11]
2022			
African American/Black	13.9%	12.4%	9.0%
American Indian or Alaskan Native	2.8%	3.7%	4.5%
Asian or Pacific Islander	5.3%	2.7%	1.8%
Caucasian/White	55.5%	61.2%	62.9%
Multiracial	21.7%	19.9%	21.4%
Unknown	0.7%	--	--
Latino/Hispanic	11.0%	17.4%	20.6%
2021			
African American/Black	10.9%	12.6%	8.9%
American Indian or Alaskan Native	3.1%	3.9%	4.5%
Asian or Pacific Islander	0.8%	3.1%	1.9%
Caucasian/White	59.4%	60.9%	62.9%
Multiracial	25.4%	19.5%	21.4%
Unknown	0.4%	--	--
Latino/Hispanic	15.6%	17.2%	20.6%
2020			
African American/Black	16.4%	13.1%	9.5%
American Indian or Alaskan Native	1.8%	4.4%	4.5%
Asian or Pacific Islander	2.3%	3.4%	2.3%
Caucasian/White	57.7%	60.9%	62.9%
Multiracial	21.4%	19.1%	20.7%
Unknown	0.5%	--	--
Latino/Hispanic	11.4%	17.2%	20.3%

[10] Center for Social Sector Analytics & Technology (2022). [Graph representation of Washington state child welfare data 9/21/2022]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.
[11] Ibid.

A Regional Issue

The placement crisis continues to be most prevalent in DCYF Region 4 (King County) and Region 6 (Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum Counties). Of the children experiencing placement exceptions this year, 89% were assigned to a DCYF office in Region 4 or 6. Approximately 45% of Washington households with children are located in these two regions, and approximately 39% of children in out-of-home care are placed in Region 4 or 6.[12]

Table 4: **Placement Exceptions by Region, 2022**

DCYF Region	Placement Exceptions	Percent of Total Placement Exceptions	Percent of Washington Households with Children[13]
Region 1	10	0.2%	12.4%
Region 2	5	0.1%	9.7%
Region 3	201	4.3%	16.9%
Region 4	1932	41.2%	28.6%
Region 5	295	6.3%	16.3%
Region 6	2249	48.0%	16.1%

[12] Center for Social Sector Analytics & Technology (2022). [Graph representation of Washington state child welfare data 9/21/2022]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

[13] Center for Social Sector Analytics & Technology (2022). [Graph representation of Washington state child welfare data 9/20/2022]. Count of All Households with Children. Retrieved from http://www.vis.pocdata.org/maps/hh-populationregions.

AGREED SETTLEMENT OF CLASS ACTION LAWSUITS PROVIDES PLAN TO REDUCE PLACEMENT EXCEPTIONS

In January 2021, Disabilities Rights Washington (DRW) filed a lawsuit on behalf of Washington children in foster care who have behavioral health needs and/or developmental disabilities. These children were separated from their families and sent to out-of-state institutions or spent significant periods of time in single night placements, Department offices, or hotels. A Settlement Agreement between DRW and DCYF was reached on June 6, 2022.

The Settlement Agreement requires DCYF to implement new statewide models for supporting youth and their families involved in foster care, and to collaborate with child welfare clients, alumni, and stakeholders to improve its policies and practices. Recognizing that foster children who experience hotel, one-night, and out-of-state placements are often survivors of complex trauma and disproportionately identify as Black, Indigenous, and people of color (BIPOC), and LGBTQIA+, the agreement includes system improvements that will be trauma-informed, culturally responsive, and LGBTQIA+-affirming. These improvements include the following alternatives to out-of-state, hotel/office, and one-night foster care placements:

> **Emerging Adulthood Housing Program:** DCYF will develop an array of supported housing programs for 16- to 21-year-old young people in foster care or extended foster care who prefer to live independently rather than in a family setting. Components of this program will include 24/7 staffing, intensive case management, and preparation for transition out of care.
>
> **Professional Therapeutic Foster Parenting:** DCYF will develop and implement a contract and licensing category for therapeutic foster parent professionals to care for children with developmental disabilities and/or behavioral health needs. Professional therapeutic foster parents must demonstrate the ability to provide therapeutic, culturally responsive, LGBTQIA+ affirming, and trauma-informed care. Additionally, these foster parents will work to maintain supportive relationships with each child's parents and includes them in making decisions for the child and facilitate active visitation and participation in the child's educational, extracurricular, medical, mental health, religious, cultural, and social activities.
>
> **Statewide Hub Home Model Program:** DCYF will develop and implement a statewide Hub Home Model program (at least one in each region) for foster, extended, and chosen families supporting foster children. A Hub Home is a licensed foster parent with experience caring for young people who qualified for Wraparound with Intensive Services (WISe) or Behavioral Rehabilitative Services (BRS) services and supports up to ten Satellite Homes. Hub Homes provide Satellite Homes with culturally responsive, LGBTQIA+ affirming, and trauma-informed support to young people and adults; training, mentoring, and coaching for satellite families; respite care, as well as planned crisis and placement stabilization respite; and support for permanency planning efforts and visitation for young people.

Additionally, DCYF will make practice improvements to help placements be more successful through the following activities:

Revising Licensing Standards: DCYF will amend licensing requirements for foster care placements to be more developmentally appropriate and flexible to meet the needs of individual youth. Changes to licensing standards will address developmentally appropriate access to mobile phones and other resources necessary to engage in normal social activities with peers; facilitate connections to

immediate, extended, and chosen family members, in accordance with the youth's case plan; maintain youth in their school of origin; provide culturally responsive, LGBTQIA+ affirming, and trauma-informed care; provide education, training, and coaching to families of origin and other potential long-term or permanent placements about how best to support the child; and ensure sufficient nutrition and satisfaction of dietary needs.

Stakeholder Engagement: DCYF will hire a facilitator to meet with stakeholders, listen to their experiences, gather information, and report on feedback and recommendations regarding the following improvement efforts:

> **Kinship Engagement Unit:** DCYF will establish a statewide Kinship Engagement Unit (KEU) that includes a family finding model to identify and engage extended family members and friends to support children and families in safely reunifying or staying together.
>
> **Referrals and Transitions:** DCYF will develop trauma-informed, culturally responsive, and LGBTQIA+ affirming referral and transition protocols. These protocols will coordinate with interested local hospitals and juvenile justice entities to refer youth and families for pre-placement and reconciliation services to prevent the need for out-of-home care; preserve relationships where possible, or address grief and loss post-transition; and facilitate pre-placement phone or video contacts and in-person visits and orientation for children and youth to meet potential foster or unfamiliar kinship families.
>
> **Family Group Planning:** DCYF will amend their Shared Planning Meeting (SPM) and Family Team Decision Meeting (FTDM) policies and practices to better support and encourage the relevant child and family's participation, inform participants of placement and service options, and empower and authorize Family Teams to make and revisit decisions about how and where to best support the child.
>
> **Group Care Placement:** DCYF will establish a more comprehensive evaluation process for determining whether it is appropriate and necessary to place a child in a group care facility. The evaluation will be conducted by a neutral and objective qualified professional and include interviews with youth, family, and any involved natural supports, and reviews of primary source documents, identify the strengths and needs of the child, as well as child-specific short and long-term mental and behavioral health goals, and criteria for the youth to be reunified with family or placed in the care of extended family, suitable other adult(s), or a foster home, and must find that family-based alternatives have been considered and deemed insufficient to meet the child's needs.

A monitor has been appointed to review DCYF's implementation plan, as well as performance and outcomes and compliance with this Settlement Agreement. The Monitor will submit annual public reports on DCYF's progress in implementing the terms of the Settlement Agreement. The DCYF's ability to reduce placement disruptions and eliminate hotel and one-night placements are significant factors the Court will consider in determining whether DCYF has met its settlement obligations.

OFCO RECOMMENDATIONS

- The governor and legislature should ensure adequate funding for DCYF to fully implement the Settlement Agreement and meet the needs of children in state care. DCYF is requesting $35,052,000 and 69.6 full time equivalents (FTEs) in the 2023-25 Biennial Budget to implement programs, services and system improvements required in this Settlement Agreement.[14] DCYF should prioritize expanding placement resources such as the independent living program, professional therapeutic foster care, and the Hub Model home in order to meet the needs of children who experience prolonged placement exceptions.
- DCYF should collaborate with the Developmental Disabilities Administration and the Health Care Authority (HCA) to coordinate services and increase capacity for placements and services for children with behavioral and/or mental health needs. Specifically, enhanced resources are needed to meet the needs of children who qualify for services from DDA, as well as those in need of psychiatric treatment and care provided by the HCA. Eligible children currently wait up to six months for a Children's Long Term Inpatient Program, despite their acute needs.
- In order to meet the behavioral and mental health needs of children requiring acute care, Washington State should provide structured, short-term therapeutic step-down services to stabilize youth and promote their successful transition to less restrictive placements following their discharge from a psychiatric hospital. In some cases, transitional therapeutic placements could also serve as an alternative to imminent psychiatric hospitalization.

[14] Dept of Children, Youth, & Families 2023-25 Regular Budget Session Policy Level DS D.S. Compliance https://ofm.wa.gov/about/news/2022/09/agency-budget-requests-and-decision-packages-now-available-online.

ACCIDENTAL INGESTION OF DRUGS AND OVERDOSES BY CHILDREN: FENTANYL IS A GROWING THREAT

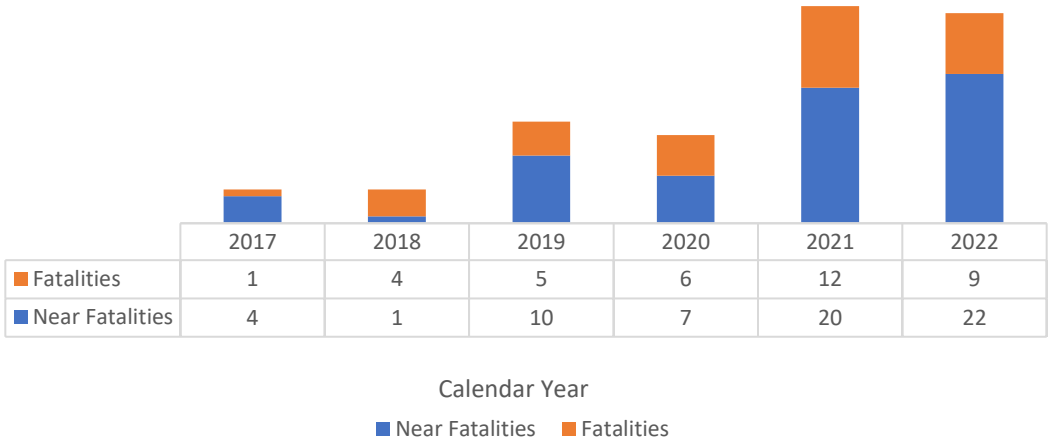
From calendar year 2017 to October 2022, OFCO received notice of 101 critical incidents involving accidental ingestion of drugs and overdoses by children, with a particularly sharp increase in incidents in 2021.[15] Thus far in 2022, OFCO has received 31 reports of child fatalities or near fatalities involving drug overdoses, compared to 5 reports in 2017.

All critical incidents involving children are tragic. Of particular concern, however, are the increase in incidents of young children accidentally ingesting a controlled substance. Of the 101 critical incidents OFCO reviewed, 45 involved accidental ingestion by children 0 to 11 years of age, 47 involved accidental overdoses by youth 11 to 22 years of age while using substances, and 9 involved intentional overdoses by youth 12 to 20 years of age.

TODDLER HOSPITALIZED AFTER INGESTING FENTANYL

Child Protective Services (CPS) became involved with a family after the mother relapsed on substances and was unable to safely care for her 2-month-old child. The child was placed with a relative and the mother was referred for substance abuse disorder treatment. After the relative obtained temporary guardianship of the child, CPS closed its case. Six months later, CPS received a report that the child had a near fatality event due to ingesting fentanyl while unattended in the mother's care. The mother reported finding the child chewing on foil with blue residue. When taken to the hospital, the child was lethargic, unresponsive, and barely breathing. Once medical staff administered Narcan, the child's condition improved.

Figure 8: **Number of Critical Incidents Involving Accidental Ingestion and Overdoses, 2017-2022**



[15] Critical incidents counted for 2022 are as of 10/6/2022.

Table 5: **Number of Critical Incidents Involving Accidental Ingestion and Overdoses, 2017-2022**

	2017	2018	2019	2020	2021	2022
Accidental Ingestion by Child Ages 0-11	2	1	8	6	15	13
Accidental Overdose by Youth Ages 11 to 22	1	4	7	6	15	14
Intentional Overdose by Youth Ages 12 to 20	2	--	--	1	2	4

Figure 9: **Age of Children Involved in Accidental Ingestion and Overdoses, 2017-2022**

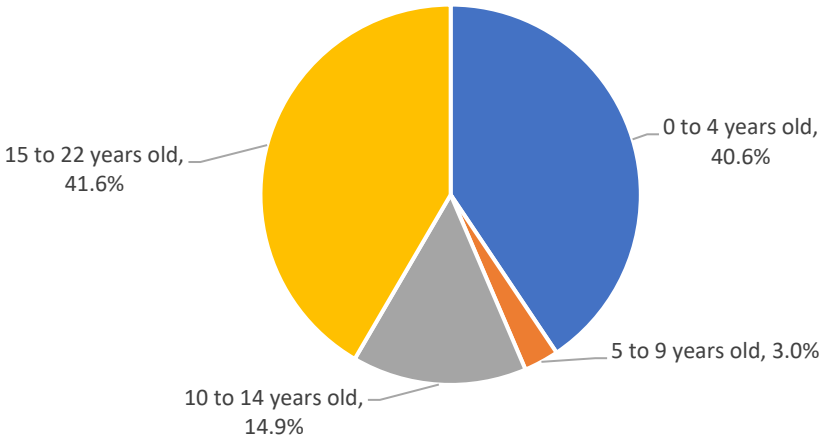
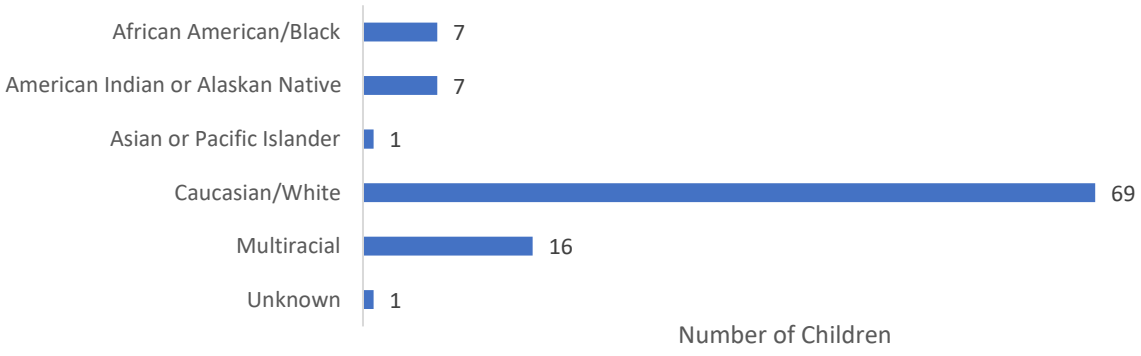


Figure 10: **Race of Children Involved in Accidental Ingestion and Overdoses, 2017-2022**



Fentanyl was the most common drug involved in these incidents. OFCO received notice of 40 critical incidents involving fentanyl: 15 involved accidental ingestion by children under five years of age and 24 involved accidental overdoses by youth ages 11 to 22. OFCO also received notice of seven additional critical incidents involving other opiates and opioids and 12 critical incidents with no information provided about the type of substance involved. It is unknown if these incidents also involved fentanyl.

Figure 11: **Critical Incidents Involving Fentanyl, 2017-2022**

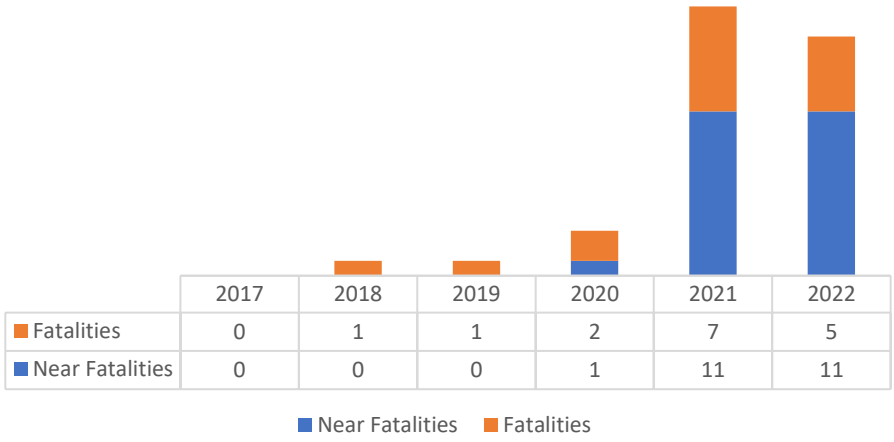


Table 6: **Critical Incidents Involving Accidental Ingestion of Fentanyl by Children Ages 0-11, 2017-2022**

	2017	2018	2019	2020	2021	2022
Number of Incidents	--	--	1	2	5	7

The fentanyl epidemic is a public health crisis. The toll on society is not limited to children involved with DCYF. Statewide, fentanyl deaths have skyrocketed, with experts noting that use of fentanyl has reached stunning levels across Washington.[16] As of July 2022, the number of people who died from fentanyl overdoses in King County alone had more than doubled since the year prior.[17] In 2021, the number of fentanyl involved overdose deaths in King County was 385. As of October 12, 2022, that number is already 447.[18] A recent University of Washington survey of drug use in 20 Washington counties resulted in a recommendation by its authors for an "immediate and substantial scale up of evidence-based public health interventions, community education, and substance use treatment to mitigate the impact of escalating fentanyl use and reverse the trend of fatal overdoses involving fentanyl."[19]

A 2020 report to DCYF's Office of Innovation, Alignment and Accountability (OIAA) found that child welfare involved families do not have adequate access to substance abuse treatment, including but not limited to opioid treatment. About one-quarter of parents and caregivers involved with DCYF had an

[16] https://mynorthwest.com/3384638/fentanyl-use-washington-stunning-levels-uw-survey/.
[17] https://www.king5.com/article/news/health/fentanyl-public-health-crisis-king-county/281-b3e45c5d-e835-4e70-bea4-945039fc9860.
[18] https://kingcounty.gov/depts/health/examiner/services/reports-data/overdose.aspx.
[19] Results from the 2021 WA State Syringe Service Program Health Survey (uw.edu), https://adai.uw.edu/wordpress/wp-content/uploads/ssp-health-survey-2021.pdf.

indication of substance use disorder (SUD), yet only 39% of those received any SUD treatment within 12 months of a CPS intake. For families with a child in out-of-home care, nearly 60% of parents or caregivers had an indication of SUD, and only 49% received any SUD treatment within 12 months of the child's removal. The report also found disparities across the state regarding access to treatment. Eastern Washington, along the Oregon border in central Washington, and the south Puget Sound region had the lowest rates of SUD treatment penetration. Areas with the highest numbers of caregivers with identified SUD who did not receive SUD treatment were located in the greater Spokane region, the South Puget Sound, and the Yakima region.[20]

OFCO RECOMMENDATIONS

OFCO makes the following recommendations to address the ongoing, growing fentanyl crisis among Washington families and children:

- OFCO endorses the recommendation in the 2020 report to OIAA that DCYF and the Health Care Authority (HCA), coordinate on referrals between child welfare and the SUD treatment system and on building treatment capacity for child welfare involved caregivers in targeted regions across the state. DCYF and HCA should also consider what supplementary services (e.g. onsite childcare, parenting skills supports) could be paired with SUD treatment to increase the likelihood that child welfare-involved caregivers are successful in reaching their recovery and parenting goals.
- DCYF should work with local chemical dependency providers and other facilities that provide urinalysis tests (UAs) for DCYF clients to ensure that the facility's testing process captures the use of fentanyl, as some are not currently doing so. Early detection of fentanyl use would allow DCYF to offer appropriate services and education, as well as harm reduction tools to families.
- DCYF should provide a lock box or bag for secure medication storage for every DCYF involved family, including those where drug use is not a documented concern. OFCO has determined that children have ingested fentanyl even in families who did not previously report drug use or abuse. Providing a lock box or bag to families regardless of self or community reporting of use will capture those families that are not willing or able to reveal their use, and could prevent accidental ingestion and even death, especially among young children who at times encounter the pills on the floor.

[20] **Substance Use Disorder Treatment Penetration among Child Welfare-Involved Caregivers,** (Deleena Patton, PhD, Qinghua Liu, PhD, Ellen Kersten, PhD, Barbara Lucenko, PhD, Barbara E.M. Felver, MES, MPA) December 2020. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-7-121.pdf

OFCO's PRO-EQUITY ANTI-RACISM STRATEGIC ACTION PLAN

In April 2020, the legislature and the governor created The Washington State Office of Equity[21] to:

- promote access to equitable opportunities and resources that reduce disparities and improve outcomes statewide across state government;
- support state agencies in our commitment to be an anti-racist government system;
- partner with state employees and communities to develop the state's comprehensive equity strategic plan and outcome measures designed to bridge opportunity gaps and reduce disparities; and
- report on the effectiveness of agency programs on reducing disparities using input from the communities served by those programs.

All state executive agencies are responsible for developing, implementing, and reporting on progress of their Pro-Equity, Anti-Racism (PEAR) Strategic Action Plan.

OFCO has developed and begun implementing its own PEAR Strategic Action Plan. OFCO staff met multiple times to develop our PEAR Strategic Plan, as well as establishing a designated intra-office PEAR team. OFCO is also actively participating with DCYF's PEAR Team to ensure access to the resources and accountability of the larger state agencies' PEAR teams. OFCO will continue to regularly hold small group and all-staff meetings to discuss ways to implement and refine the strategic plan into our work, policies, practices, and procedures. These efforts are grounded in the following key principles:

Washington is a state where all are welcomed and will have the opportunity to thrive regardless of race, ethnicity, creed, color, national origin, citizenship or immigration status, sex, honorably discharged veteran or military status, sexual orientation, or the presence of sensory, mental, or physical disability.[22]

> ***Diversity***
> *Describes the presence of differences within a given setting, collective, or group. An individual is not diverse – a person is unique. Diversity is about a collective or a group and exists in relationship to others. A team, an organization, a family, a neighborhood, and a community can be diverse. A person can bring diversity of thought, experience, and trait, (seen and unseen) to a team — and the person is still an individual.*[23]
>
> ***Equity***
> *The act of developing, strengthening, and supporting procedural and outcome fairness in systems, procedures, and resource distribution mechanisms to create equitable (not equal) opportunity for all people. Equity is distinct from equality which refers to everyone having the same treatment without accounting for differing needs or circumstances. Equity has a focus on eliminating barriers that have prevented the full participation of historically and currently oppressed groups*.[24]
>
> - *Equity is not equality. Equity requires developing, strengthening, and supporting policies and procedures that distribute and prioritize resources to people in identified groups who have historically been and currently are marginalized, including tribes;*

[21] ESSHB 1783, Chapter 332, Laws of 2022, https://app.leg.wa.gov/billsummary?BillNumber=1783&Year=2019.
[22] Executive Order 22-04 https://www.governor.wa.gov/sites/default/files/exe_order/22-04%20-%20Implementing%20PEAR%20%28tmp%29.pdf.
[23] "DEI Glossary of Equity-Related Terms". Washington State Office of Financial Management. https://ofm.wa.gov/sites/default/files/public/shr/Diversity/SubCommit/DEIGlossaryofEquityRelatedTerms.pdf.
[24] "DEI Glossary of Equity-Related Terms."

- *Equity requires the elimination of systemic barriers that have been deeply entrenched in systems of inequality and oppression; and*
- *Equity achieves procedural and outcome fairness, promoting dignity, honor, and respect for all people*.[25]

Inclusion
Intentionally designed, active, and ongoing engagement with people that ensures opportunities and pathways for participation in all aspects of group, organization, or community, including decision-making processes. Inclusion is not a natural consequence of diversity. There must be intentional and consistent efforts to create and sustain a participative environment. Inclusion refers to how groups show that people are valued as respected members of the group, team, organization, or community. Inclusion is often created through progressive, consistent actions to expand, include, and share.[26]

OFCO's PEAR STRATEGIC ACTION PLAN

- Incorporate pro-equity anti-racism in OFCO's mission and values statements.
- Apply a race equity lens to child welfare issues addressed in OFCO's annual, critical incident, and systemic reports.
- Apply a race equity lens to individual investigations and be aware of how racial bias and/or injustice may have negatively impacted the individual who submitted the complaint and the identified children and family involved with the child welfare system.
- Implement regular internal discussions and trainings on anti-racism strategies and racial justice topics in order to continue to reinforce DEI principles and concepts within the agency.
- Engage with the Washington State Office of Equity, DCYF, and the Office of Innovation, Alignment and Accountability (OAAI) to support DCYF's internal pro-equity, anti-racism work.
- Proactively seek external trainings from organizations involved in race equity, racial bias, and discrimination investigative work.
- Include in OFCO's annual report complaint allegations of bias and discrimination.
- Create a process to review complaint investigation outcomes for marginalized groups and determine if bias impacted the outcome; if it did, take steps to rectify the individual complaint and protect against a future outcome.
- Create space to directly hear from marginalized individuals who have historically faced bias and discrimination within the child welfare system.

[25] Washington State Office of Equity, https://equity.wa.gov/policy/about-policy.
[26] "DEI Glossary of Equity-Related Terms."

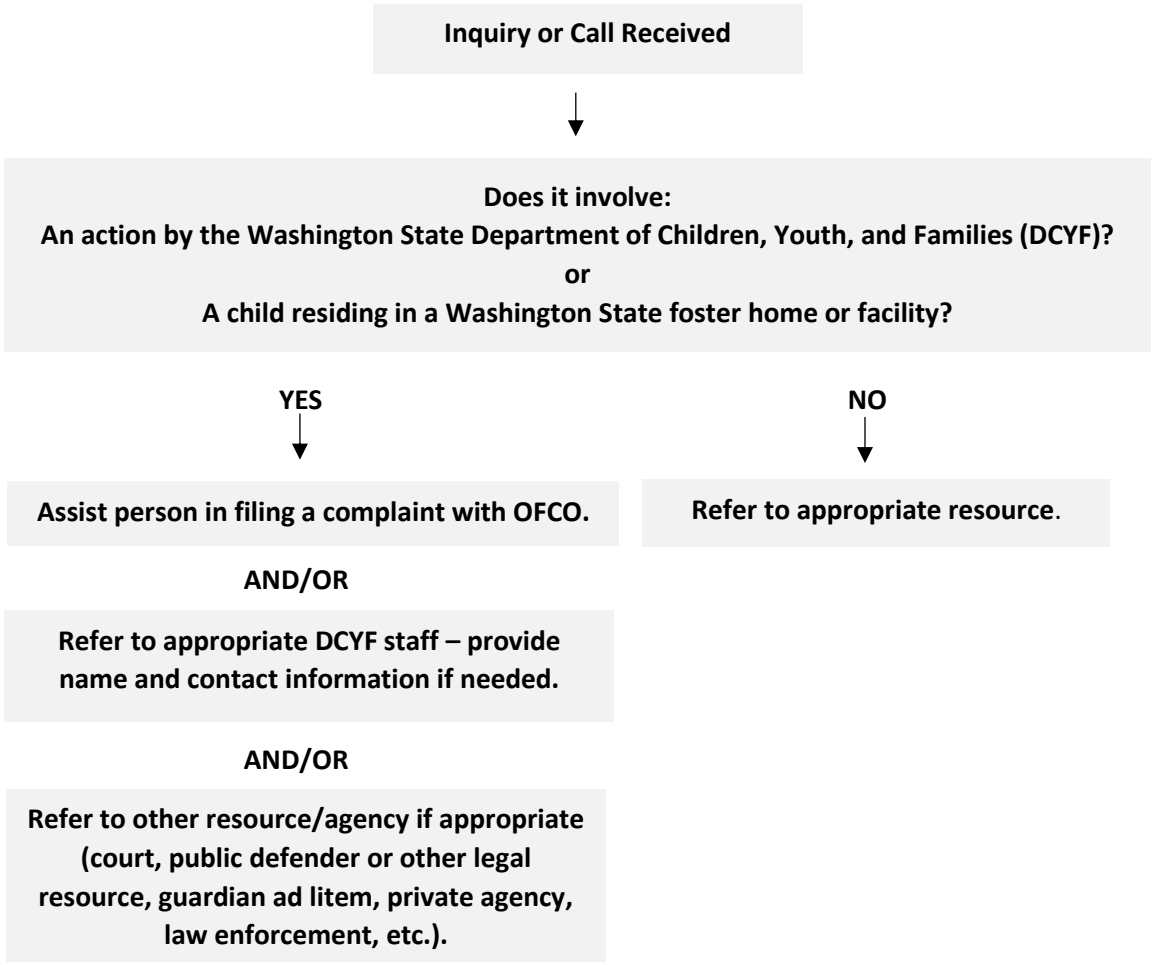
SECTION II: LISTENING TO FAMILIES AND CITIZENS

- Inquiries and Complaints
- Complaint Profiles
- Complaint Issues

INQUIRIES AND COMPLAINTS

OFCO listens and responds to people who contact the office with questions or concerns about services provided through the child welfare system. Callers may simply need information about the Department of Children, Youth, and Families' processes and/or services, or they may want to know how to file a complaint with OFCO. If OFCO cannot address a caller's concerns, the caller will be referred elsewhere for information or support.

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



COMPLAINT PROFILES

Complaints Received

This section describes complaints filed during OFCO's 2022 reporting year: September 1, 2021, to August 31, 2022. OFCO received 836 complaints during this reporting year. Most complaints received by OFCO were submitted via OFCO's website.

Figure 12: **Complaints Received by Year**

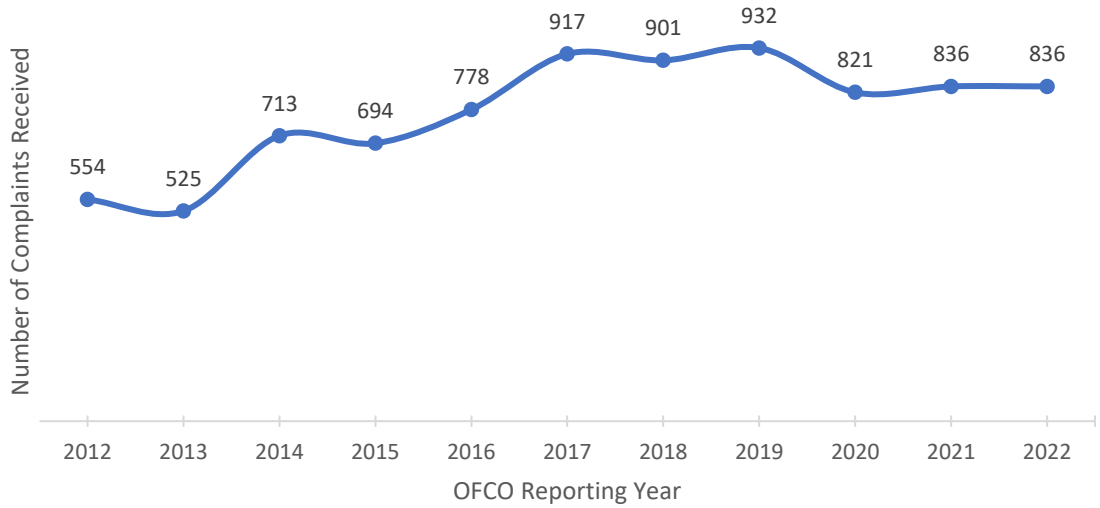
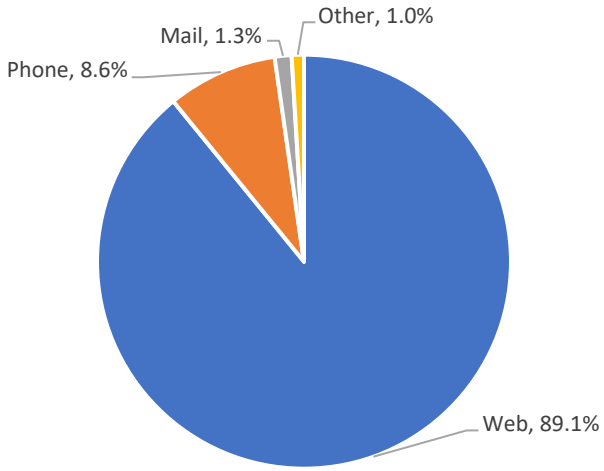


Figure 13: **How Complaints Were Received, 2022**



Persons Who Complained

Parents, grandparents, and other relatives of a child whose family is involved with DCYF filed the majority of complaints investigated by OFCO (78.5%). Consistent with previous years, few children contacted OFCO on their own behalf.

Table 7 displays the race and ethnicity of this year's complainants.

Figure 14: **Complainant Relationship to Children**

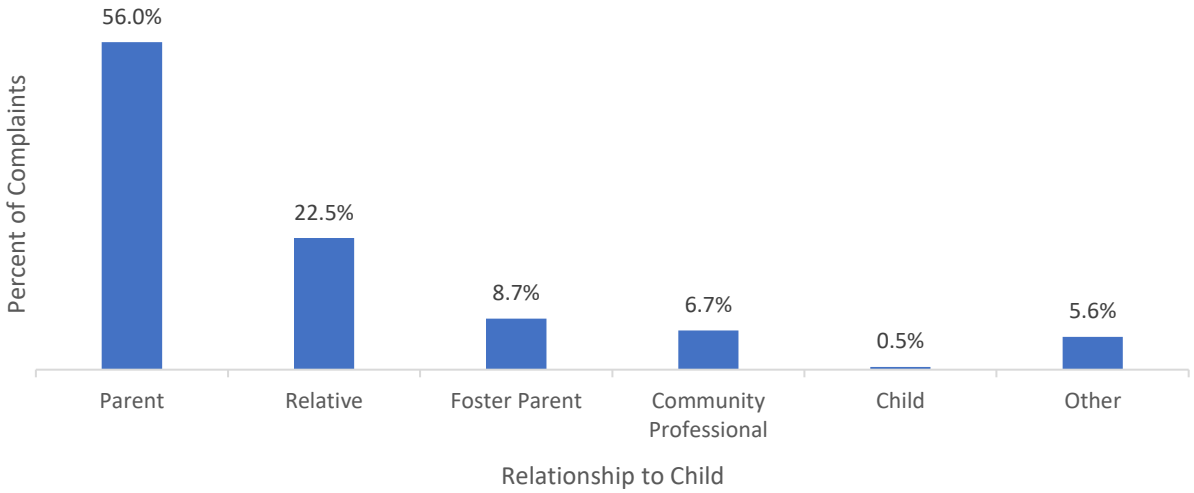


Table 7: **Complainant Race and Ethnicity, 2022**

Complainant Race and Ethnicity	OFCO Complainants	Washington State Population[27]	Children in Out-of-Home Care[28]
Caucasian/White	68.9%	78.3%	62.9%
African American/Black	7.2%	4.3%	9.0%
American Indian or Alaskan Native	3.6%	1.8%	4.5%
Asian or Pacific Islander	1.9%	10.4%	1.8%
Multiracial	5.7%	5.2%	21.4%
Other	0.1%	--	--
Declined to Answer/Unknown	12.6%	--	--
Latino/Hispanic	8.1%	13.4%	20.6%

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

[28] Center for Social Sector Analytics & Technology (2022). [Graph representation of Washington state child welfare data 9/21/2022]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

Children Identified in Complaints

Of the 1,209 children identified in complaints this year, approximately 68% were nine years of age or younger. Consistent with previous years, OFCO receives fewer complaints involving older children, with the number of complaints decreasing as the child's age increases. This closely mirrors the ages of children placed in out-of-home care through DCYF.

Table 8: **Age of Children in Complaints to OFCO and Out-of-Home Care through DCYF, 2022**

Age of Child	Percent of Children in OFCO Complaints	Percent of Children in Out-of-Home Care through DCYF[29]
0-4 years	36.9%	42.7%
5 to 9 years	30.9%	25.0%
10 to 14 years	21.3%	20.1%
15 to 17 years	9.1%	12.2%
18+ years	1.9%	--

Table 9: **Race and Ethnicity of Children Identified in Complaints, 2022**

Child Race/Ethnicity	OFCO Children	Children in Out-of-Home Care[30]	Washington State Children[31]
Caucasian/White	64.6%	62.9%	72.2%
African American/Black	8.7%	9.0%	5.1%
American Indian or Alaskan Native	3.4%	4.5%	2.4%
Asian or Pacific Islander	1.7%	1.8%	9.9%
Multiracial	20.7%	21.4%	10.4%
Other	0.2%	--	--
Declined to Answer/Unknown	0.7%	--	--
Latino/Hispanic	13.1%	20.6%	21.9%

[29] Center for Social Sector Analytics & Technology (2022). [Graph representation of Washington state child welfare data 9/21/2022]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

[30] Ibid.

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

COMPLAINT ISSUES

Complaints can often be complex, and complainants may identify multiple issues or concerns they would like investigated. Figure 15 displays the categories of issues identified by complainants.

This year, issues involving the conduct of DCYF staff and other agency services were the most frequently identified in complaints made to OFCO. Over half of complainants (52%) expressed these concerns. The most frequently identified concerns include:

- Unwarranted, unreasonable, or inadequate CPS interventions (167 complaints);
- Unprofessional conduct by agency staff, such as harassment, discrimination, bias, dishonesty, or conflict of interest (111 complaints); and
- Communication failures, such as caseworkers not communicating with parents or relatives (72 complaints).

Issues involving family separation and reunification were the next most identified concerns. However, the number of complainants expressing these concerns decreased by 9% from last year. The most frequently identified concerns involving family separation and reunification include:

- Unnecessary removal of child from parental care (104 complaints);
- Failure to provide contact between child and parents or other family members (70 complaints);
- Failure to reunite family (55 complaints); and
- Failure to place child with a relative (32 complaints).

Figure 15: **Categories of Issues Identified by Complainants**

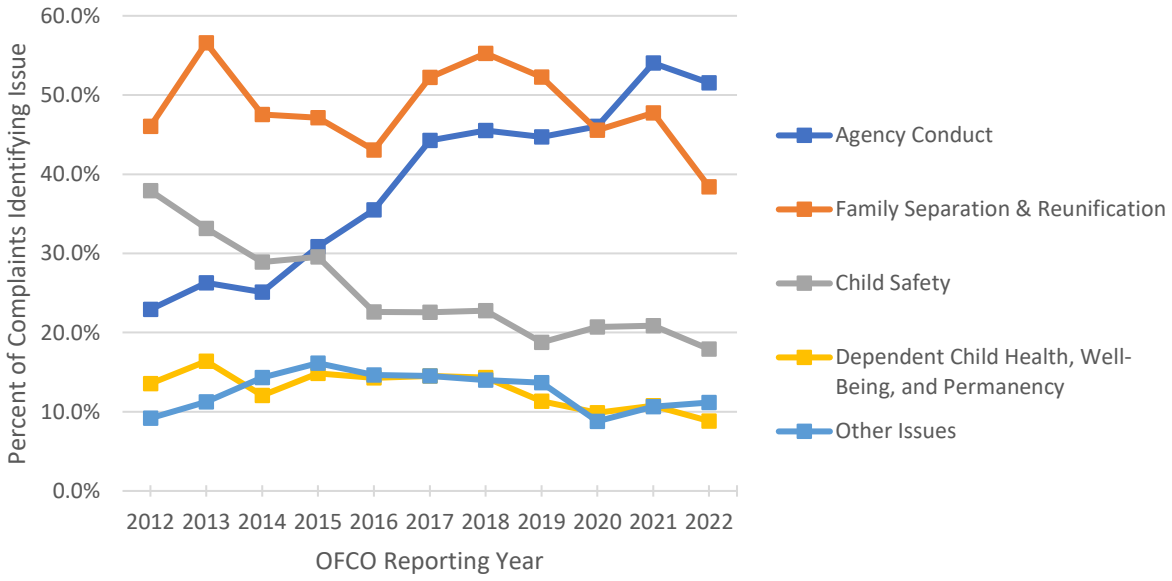


Table 10 on the following pages show the number of times specific issues within these categories were identified in complaints.

Table 10: **Issues Identified by Complainants**

Complaints about Agency Conduct	2022	2021	2020
	420	396	382
Unwarranted/unreasonable/inadequate CPS intervention	167	158	144
Unprofessional conduct, harassment, conflict of interest or bias/discrimination by agency staff	110	100	129
Communication failures	72	80	58
Breach of confidentiality by agency	23	24	26
Poor case management, high caseworker turnover, other poor service	21	10	8
Unreasonable CPS findings	17	10	3
Family Assessment Response	9	6	12
Inaccurate agency records	8	10	8
Retaliation by agency staff (does not include complaints of retaliation made by licensed foster parents)	1	4	3

Family Separation and Reunification	2022	2021	2020
	313	350	378
Unnecessary removal of child from parental care	104	81	123
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	70	89	78
Failure to reunite family	55	87	68
Failure to place child with relative	32	48	54
Other inappropriate placement of child	26	21	17
Unnecessary removal of child from relative placement	12	14	27
Failure to provide sibling visits and contact	8	4	1
Failure to place child with siblings	4	2	1
Inappropriate termination of parental rights	2	2	4

Child Safety	2022	2021	2020
	146	153	172
Failure to protect children from parental abuse or neglect	58	57	64
Suspected child neglect	*27*	*32*	*41*
Suspected child abuse	*31*	*25*	*23*
Failure to address safety concerns involving children in foster care or other non-institutional care	37	53	60
Failure to address safety concerns involving children being returned to parental care	22	23	29
Child safety during visits with parents	18	9	8
Failure by agency to conduct 30-day health and safety visits with child	1	1	3

Dependent Child Health, Well-Being, and Permanency	2022	2021	2020
	72	79	73
Unreasonable delay in achieving permanency	21	14	18
Failure to provide child with adequate medical, mental health, educational or other services	20	27	24
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	11	25	12
Placement instability/multiple moves in foster care	5	5	8
ICPC issues (placement of children out of state)	3	4	2
Failure to provide appropriate adoption support services/other adoption issues	3	1	2
Placement not meeting child's unique needs	2	2	1
Extended foster care/independent living services	2	1	1

Other Complaint Issues	2022	2021	2020
	91	78	82
Failure to provide parent with services/other parent issues	26	28	28
Violation of parents' rights	22	20	16
Lack of support/services and other issues related to unlicensed relative or fictive kin caregiver	14	11	17
Lack of support/services to foster parent/other foster parent issues	13	6	7
Violations of ICWA	11	3	4
Foster parent retaliation	3	5	2
Foster care licensing issues	2	5	7

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 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 nonetheless identifies legitimate concerns. In these cases, the Ombuds helps to resolve the concerns.

This reporting year, OFCO completed 815 complaint investigations. Consistent with previous years, the majority of investigations were standard, non-emergent investigations (83%). Approximately 17% met OFCO's criteria for initiating an emergent investigation. OFCO intervened or provided timely assistance to resolve concerns in 20% of emergent complaints, compared to 12% of non-emergent complaints.

Investigation Outcomes

Complaint investigations result in one of the following actions:

OFCO Intervention

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

OFCO Assistance

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

OFCO Monitor

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

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

Resolved Without Action by OFCO

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

No Basis for Action by OFCO

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

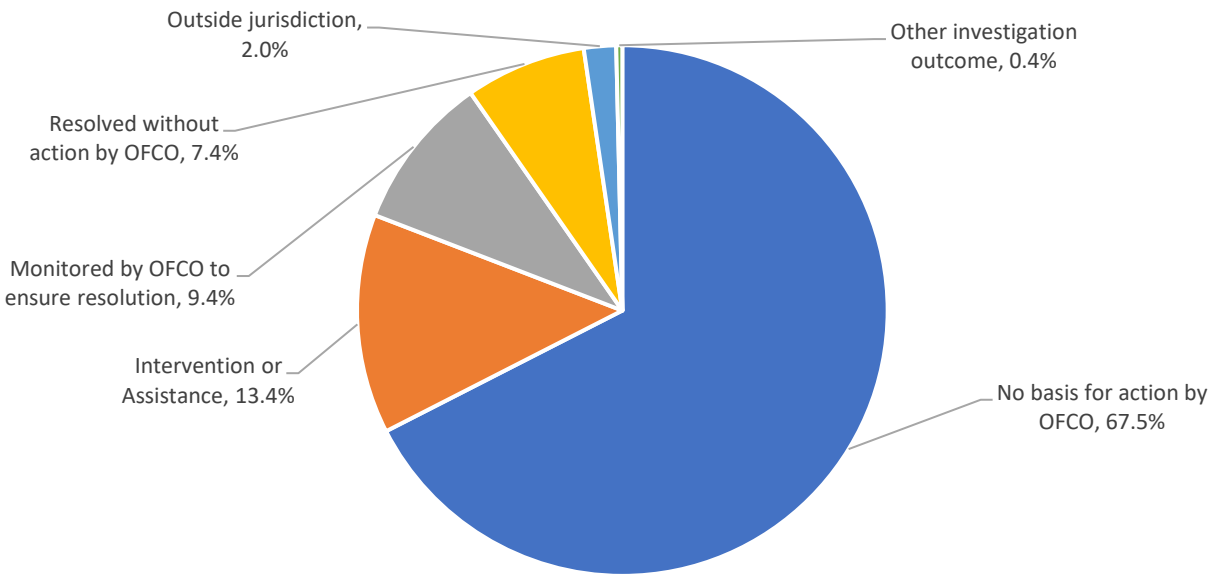
Outside Jurisdiction

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

Other Investigation Outcomes

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

Figure 16: **Investigation Outcomes, 2022**



Investigation results have remained consistent in recent years. In 2022, OFCO assisted or intervened to try to resolve an identified issue in 109 complaints (13.4%). OFCO monitored 77 complaints (9.4%) for a period until either the identified concerns were resolved or OFCO determined that there was no basis for further action. No basis for further action was found in the majority of complaints (67.5%).

OFCO's ADVERSE FINDINGS

OFCO takes action when necessary to avert or correct a harmful oversight or avoidable mistake by DCYF or another agency. If OFCO substantiates a significant complaint issue, OFCO may make a formal finding against the agency after an investigation. In some cases, the adverse finding involves a past action or inaction, leaving OFCO with no opportunity to intervene before the harm occurs; in these instances, OFCO intervenes to protect against future violations. However, in situations where the agency's action or inaction is ongoing and could cause foreseeable harm to a child or family, the Ombuds intervenes to persuade the agency to correct the problem.

CRITERIA FOR ADVERSE FINDINGS AGAINST THE AGENCY

- The agency violated a law, policy, 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 2022, OFCO made 20 adverse findings in a total of 10 complaint investigations. OFCO provides written notice to DCYF of any adverse finding(s) made on a complaint investigation. The agency is invited to formally respond to the finding and may present additional information and request a modification of the finding. This year, DCYF provided a response to all findings. In addition to the 20 adverse findings, OFCO made one other finding that was withdrawn after the Department provided more information to OFCO and requested its withdrawal. The number of adverse findings by region and office are broken down in Table 11.

Table 12 shows the various categories of issues in which adverse findings were made. Findings most often related to parents' rights and child safety.

Table 11: **Adverse Findings in Complaint Investigations by DCYF Region and Office, 2022**

Region	DCYF Office (Number of Findings)	Total Number of Findings	Percent of Findings
Region 1	Clarkston (3)	3	15.0%
Region 2	--	--	--
Region 3	--	--	--
Region 4	King East (2) Martin Luther King, Jr (6)	8	40.0%
Region 5	Lakewood (1) Puyallup (2)	3	15.0%
Region 6	Kelso (3) Shelton (1) Vancouver-Clark (1) Vancouver-Columbia (1)	6	30.0%

Table 12: **Adverse Finding by Issue**

	2022	2021	2020
PARENTS' RIGHTS	**7**	**6**	**19**
Delay in completing CPS investigation/CPS FAR or internal review of findings	5	4	15
Failures of notification/consent, public disclosure, or breach of confidentiality	2	1	3
CHILD SAFETY	**6**	**11**	**33**
Failure by DCYF to ensure/monitor child's safety:			
Failure to conduct required monthly health and safety visits	3	4	15
Inadequate CPS investigation or case management	2	3	6
Inappropriate CPS Finding (Unfounded)	1	2	--
POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY	**5**	**7**	**4**
Inadequate documentation of casework	3	5	--
Other poor practice	2	2	4
DEPENDENT CHILD WELL-BEING AND PERMANENCY	**1**	**1**	**2**
Delay in achieving permanency	1	--	--
ICWA VIOLATION	**1**	**--**	**--**

NUMBER OF FINDINGS	**20**	28	67
NUMBER OF CLOSED COMPLAINTS WITH ONE OR MORE FINDING	**10**	16	28

APPENDICES

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

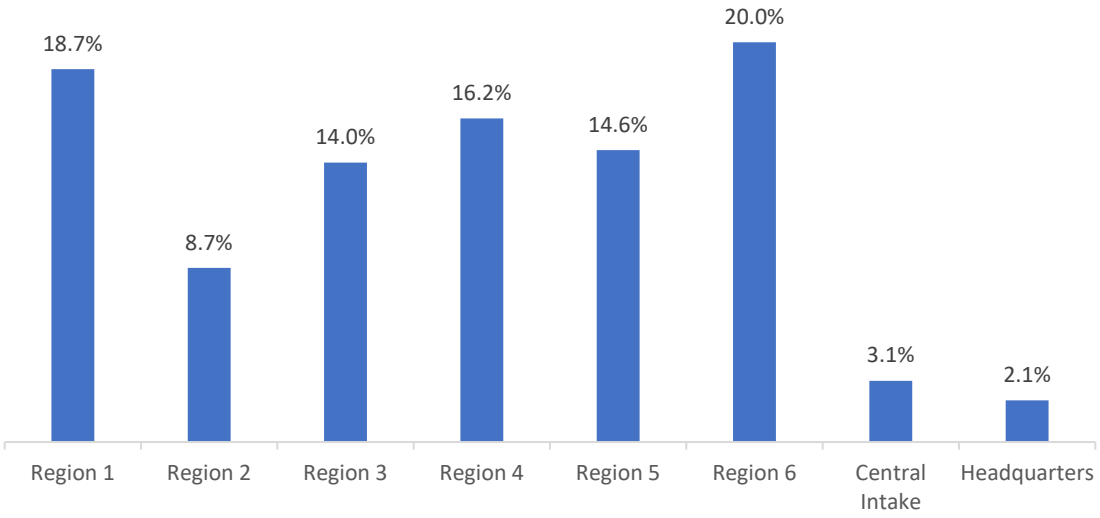
APPENDIX A: COMPLAINT INVESTIGATIONS BY REGION AND OFFICE

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

Table 13: **Populations by DCYF Region**[32]

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

Figure 17: **OFCO Complaint Investigation by DCYF Region, 2022**



[32] Center for Social Sector Analytics & Technology (2022). [Graph representation of Washington state child welfare data 9/23/2022]. Count of All Children. Retrieved from http://www.vis.pocdata.org/maps/child-populationregions.

Table 14: **Number of OFCO Complaint Investigations Completed by Office, 2022**

Region 1			
Clarkston	14	Region 1 - Adoptions	1
Colfax	4	Region 1 - Licensing Division	2
Colville	2	Region 1 - Regional Intake	1
Moses Lake	14		
Newport	1		
Omak	4		
Republic	1		
Spokane Central	31		
Spokane ICW	3		
Spokane North	23		
Spokane Valley	34		
Wenatchee	17		
Region 2			
Ellensburg	12	Region 2 - Licensing Division	1
Goldendale	0	Region 2 - Regional Intake	3
Richland (Tri-Cities)	19		
Sunnyside	3		
Toppenish	4		
Walla Walla	9		
White Salmon	0		
Yakima	20		
Region 3			
Bellingham	24	Region 3 - Adoptions	3
Everett	20	Region 3 - DLR/CPS Safety & Monitoring	2
Friday Harbor	2	Region 3 - Regional Intake	3
Lynnwood	11		
Mount Vernon	24		
Oak Harbor	3		
Sky Valley (Monroe)	10		
Smokey Point (Arlington)	12		
Region 4			
King East (Bellevue)	20	Region 4 - Adoptions	3
King South-East (Kent)	22		
King South-West (Kent)	14		
King West (Seattle)	29		
Martin Luther King Jr.	19		
Office of Indian Child Welfare	16		
West Seattle	9		

Region 5			
Bremerton	17	Region 5 - Centralized Services	1
Lakewood	21	Region 5 - DLR/CPS Safety & Monitoring	3
Parkland	24	Region 5 - Licensing Division	1
Puyallup	24	Region 5 - Regional Intake	3
Tacoma	25		
Region 6			
Aberdeen	20	Region 6 - Adoptions	2
Centralia	13	Region 6 - Centralized Services	1
Forks	0	Region 6 - DLR/CPS Safety & Monitoring	1
Kelso	22		
Long Beach	1		
Port Angeles	15		
Port Townsend	4		
Shelton	19		
South Bend	1		
Stevenson	4		
Tumwater	28		
Vancouver-Cascade	9		
Vancouver-Clark	10		
Vancouver-Columbia	13		
Other			
Central Intake	25		
Headquarters	17		
Non-DCYF/Other	26		

PARENT'S RIGHTS

DCYF CPS did not notify the subject of a pending investigation and the investigation was not completed in a timely manner.

In May 2021, DCYF received an intake alleging physical abuse and neglect of a two-year-old by the mother. The intake screened in for an emergent CPS investigation. The CPS worker went to the family home and completed the initial face-to-face interview with the child. During this visit, the CPS worker also spoke with the father but deferred to the father's wishes and made no contact with the mother, despite the mother being home. The CPS worker later obtained the mother's phone number and information on her whereabouts but did not attempt to contact the mother. A CPS status report was presented at a family court hearing the following month where the CPS worker reported that there were concerns regarding the mother's mental health. The concerns and recommendations CPS provided to family court were based solely on interviews with the father, as the CPS worker had not yet contacted the mother or collateral sources. The social worker did not contact the mother until early July 2021, at which time the mother provided the CPS worker with contact information for collateral contacts as well as a copy of a police report concerning threats from the father. The CPS investigation was closed in late August 2021.

Violations/Unreasonable Finding:

- **DCYF Policies and Procedures Guide, 2331 states that caseworkers must notify parents of any child maltreatment allegations made against them at the initial point of contact. The delay in contacting and notifying the mother of the allegations made against her was clearly unreasonable under the circumstances.**
  CPS chose not to notify the mother while conducting the initial face-to-face interview with the child and did not attempt to contact the mother after obtaining the mother's contact information. Additionally, CPS was aware that the mother was involved in a family court proceeding and that the mother was represented by an attorney but did not attempt to locate and contact the mother through her attorney. CPS' failure to contact the mother and notify her of the allegations had an adverse impact on the mother as CPS provided an incomplete report to family court based solely on information reported by the father and lacking information from the mother or from collateral sources she later provided.

- **DCYF Policies and Procedures Guide, 2331 (1)(a) and RCW 26.44.030 (13)(a) mandate that CPS investigations must be completed within 60 calendar days and 90 days respectively from the date CPS receives the intake.**
  The CPS intake was received early May 2021 and the investigation was closed late August 2021.

DCYF Response:
DCYF agreed that the mother was not notified in a timely manner and that the case was not closed within the 90 days required in statute. To ensure timely case closure, the local area administrator reviewed timeliness reports on Family Assessment Response (FAR) cases twice weekly for the following month and sent reminders to supervisors requesting the status of case closures. The Quality Assurance/Continuous Quality Improvement manager also reviewed FAR cases with no ongoing

services for the following month to identify cases that were appropriate for closure. Both the supervisor and caseworker on this case received additional coaching on managing closure of cases.

DCYF CPS did not complete an investigation in a timely manner and did not conduct required health and safety visits.

In July 2021, an intake screened in for a CPS Risk Only investigation due to concerns of ongoing domestic violence and suspected drug use in a home with three children. The initial face-to-face contact with the children occurred the following day. The worker also stopped by the home for another visit later that week.

In August 2021, CPS received another intake involving the family that identified the two younger children as the alleged victims. This intake screened in for CPS Family Assessment Response (FAR). The assigned worker learned that the oldest child was still in Washington, but the two younger children moved out of state to live with relatives. The worker completed the initial face-to-face interview with one of the two younger children by the end of August 2021 but was unable to complete the initial face-to-face with the other child until September 2021. There were no case activities documented in October 2021.

Between October 2021 and December 2021, OFCO contacted DCYF regarding the status of the CPS investigation and the closure of the FAR case. During the month of December 2021, the worker made attempts to arrange a final health and safety visit with the children. The worker met with the two younger children but learned that the oldest child moved out of state with his father in November 2021.

The CPS investigation and the FAR case closed in December 2021.

Violations:

- **DCYF Policies and Procedures Guide, 2331 (1) 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 investigation was closed approximately five months after the intake screened in.

- **DCYF Policies and Procedures Guide, 2332 (5)(a)(i) states that a FAR case must be closed within 45 calendar days from the date the intake was received unless the parent or guardian receiving services consents to the case remaining open for up to 120 calendar days per RCW 26.44.030.**
  The FAR case was open continuously for approximately four months. The parent was not receiving services in this case.

- **DCYF Policies and Procedures Guide, 2331 (2)(c) requires that DCYF conduct monthly health and safety visits for all children identified in a CPS case open longer than 60 days.**
  DCYF was unable to complete health and safety visits with the two younger children as they were residing out of state. However, the oldest child remained in Washington until November

2021. There was no documentation of face-to-face contact or efforts to contact the oldest child in October or November 2021.

DCYF Response:
The assigned worker identified that the mother and children were living out of state for a portion of the Department's involvement which made it difficult to complete the investigation and assess the family in a timely manner. The health and safety visits with the oldest child were not completed as the worker was focused on the risk and safety of the two younger children listed as victims. The area administrator met with the office supervisor and the assigned worker to discuss the importance of case closure and health and safety visits with all children. The area administrator planned to attend two monthly clinical supervision meetings and review FamLink reports weekly to monitor timely completion of CPS activity.

CPS did not notify the subject of a CPS finding in a timely manner.

In November 2021, an intake alleging physical abuse of an infant by the mother and the maternal grandmother screened in for a CPS investigation. At the time of the incident, the infant and the mother resided with the maternal grandmother. The Investigative Assessment was completed in December 2021 and a founded finding for physical abuse was made against the maternal grandmother. No findings were made against the mother.

DCYF's tracking database documented that a findings letter was mailed to the mother in December 2021 through certified mail. The letter notified the mother that she received a founded for physical abuse. OFCO reviewed the file and found that a findings letter was never sent to the maternal grandmother. The grandmother learned of the finding after losing her job as a result of the finding.

OFCO contacted DCYF regarding the findings. DCYF reported that there was a clerical error and that corrected findings letters were sent to the subjects. DCYF also contacted the maternal grandmother by phone regarding the finding.

Violation:

- **DCYF Policies and Procedures Guide, 2559 (B) requires DCYF to give notice to the subject of an investigation including "information regarding request for review of the founded finding."**
  DCYF did not give notice to the maternal grandmother of a finding made against her. As a result of the finding, the grandmother lost her job. Additionally, the clerical error resulted in undue harm to the child's mother who received an erroneous finding.

DCYF Response:
The Department reported that the finding was changed in the tracking database and the clerical staff responsible for sending out findings letters was not alerted of the change. Once the error was brought to the attention of the supervisor, the corrected findings letter was sent out, and the supervisor contacted the maternal grandmother to advise her of the finding and apologize for the error.

CHILD SAFETY

CPS did not conduct an adequate investigation.

In August 2021, an intake alleging that a child appeared to be withdrawing from methamphetamine screened in for a CPS investigation. Two days after the intake was received, the worker completed the initial face-to-face with the child but noted that they were unable to speak with the other child in the home due to the mother refusing to cooperate.

Two monthly supervisor review case notes were completed at the end of August and September 2021 stating that collaterals would be completed and that the case worker would attempt another walkthrough of the home. There was no documentation of any other investigative activities until another intake screened into CPS in October 2021.

Law enforcement accompanied the worker to the family home. The worker spoke with the children through the window as the mother refused to allow the worker in the home. It was documented that the worker requested a child welfare check on the home but there was no documentation that law enforcement completed the welfare check. The worker returned to the home the following day to interview the child but again was not allowed in the home to assess safety. Again, there were no documented investigative activities until another intake screened in for investigation in January 2022.

In February 2022, OFCO contacted the supervisor regarding the status of the August and October 2021 investigations. The supervisor reported that the worker left the agency and the cases had been reassigned.

Violations:

- **DCYF Policies and Procedures Guide, Section 2331 (2)(e) (i)(C) 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 investigations remained pending in FamLink.

- **DCYF Policies and Procedures Guide, 2331 (2)(c) requires that DCYF conduct monthly health and safety visits with children identified in a CPS case open longer than 60 days.**
  There was no documentation of face-to-face contact or efforts to contact the children in November or December 2021 as to the August CPS investigation. Additionally, the Department did not attempt to see the children in December 2021 for the October CPS investigation.

- **DCYF Policies and Procedures Guide, 2331, 2 (e)(i)(A) indicates that the Safety Assessment must be completed within 30 days from the date of the intake.**
  The Safety Assessment had not been completed for the October 2021 intake.

- **DCYF Policies and Procedures Guide, 2331 (2)(i)(iv) requires that the worker contact the non-custodial parents and collaterals.**
  Neither investigation documented following up with the children's father or additional collaterals, such as other relatives.

CHILD SAFETY

DCYF Response:

The local office was experiencing significant vacancies, particularly in the CPS investigation and FAR programs. Staffing shortages caused tasks to be missed and expected timelines were not met. The worker and supervisor on this case unexpectedly went on leave after assignment. DCYF reported that they were working to onboard new staff in the local office and that the area administrator would continue to monitor caseloads and ensure that collateral contacts were made before the investigations in this case closed.

CPS FAR was not completed in a timely manner and health and safety visits were not conducted.

In August 2021, an intake alleging that the mother was suffering from Munchausen By Proxy syndrome, and that, as a result, her child had received multiple unnecessary surgeries, screened in to CPS FAR. A few days later, the worker completed the initial face-to-face with the child and the subject interview with the mother. Only monthly supervisor reviews were entered in DCYF's tracking database, with the exception of one case note. The monthly supervisor reviews noted the need to follow up with a Medical Consult (MedCon); however, there were no other documented investigative activities until March 2022.

OFCO contacted the Department in March 2022 regarding the status of the August 2021 CPS FAR case. The Department reported that the social worker unexpectedly passed away in February 2022 and that the case was being staffed with the region's Quality Practice Specialist.

Violations:

- **DCYF Policies and Procedures Guide, 2332 (5)(a)(i) (A) mandate that CPS FAR assessments must be closed within 45 calendar days unless the parents or guardians consent to the case remaining open.**
  The CPS FAR that screened in in August 2021 remained pending in FamLink as of April 2022.

- **DCYF Policies and Procedures Guide, 2332 (3)(d) requires that DCYF conduct monthly health and safety visits with children identified in a CPS case open longer than 60 days.**
  There was no documentation of face-to-face contact or efforts to contact the child in November and December 2021. Additionally, the Department did not attempt to see the child in January or February 2022.

- **DCYF Policies and Procedures Guide, 2332 (1)(c)(x) requires the worker to see all the children or youth in the home who are not identified as victims prior to completing the safety assessment. Policy 2332 (1)(c)(xi) also requires the worker to identify and verify all individuals living in the home.**
  The safety assessment was completed September 2021. The other youth in the home was not seen until March 2022. Additionally, there was no documentation of the worker speaking to the child's father who was also reported to be living in the home.

DCYF Response:

The Department reported that the assigned caseworker unexpectedly passed away, making it difficult to determine what case activities were completed and not documented. The Department

acknowledged that the case was not closed in the required timeframe. The worker made a request for a MedCon in September 2021. However, the MedCon team was awaiting approximately 600 pages of medical documentation. The case was reassigned and was awaiting medical opinion as this was a complex case. The Department also acknowledged that health and safety visits were missed. The area administrator sent an email to the office detailing lessons learned from critical incidents, including reminders to interview all children in the home. Emails were also sent to remind staff about the importance of fully documenting health and safety visits. The area administrator was working with the Quality Practice Specialists to provide training to the office on health and safety visits and timely input of case notes.

POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY

No documentation of Family Reconciliation Services (FRS) case activities.

In April 2022, a 16-year-old youth contacted DCYF CPS Intake requesting assistance with finding placement. The intake screened in for Family Reconciliation Services (FRS) and was closed by the end of April 2022. During the time the case was open for FRS, there were no case notes entered documenting contact with the youth or the youth's father.

OFCO contacted the FRS supervisor regarding the case and the lack of documented case activities. The supervisor reported that the assigned worker resigned while the case was open. The supervisor believed that the worker contacted the youth and the father; however, the supervisor was unaware that the worker had not documented any case activities prior to approving the case for closure.

Violations:

- **DCYF Policies and Procedures Guide, 3100 (1) mandates that DCYF FRS must contact the family within 24 hours of being assigned the case, excluding weekends and holidays, to schedule an interview and assessment.**
  While the supervisor reported that the social worker did have contact with the family, there was no documentation of that contact.

- **DCYF Policies and Procedures Guide, 6600 provides guidance for documenting case activities and requires that DCYF workers document communication, events, and activities related to cases in FamLink.**
  There was no documentation of FRS case activities beyond a supervisory case note.

DCYF Response:

DCYF reported that the local office had significant staff turnover during this time. The area administrator developed a plan to ensure compliance with the identified policies. The FRS supervisor will review documentation during monthly supervision to ensure case notes are entered timely and prior to case closure. Staff are now expected to schedule dedicated time for documentation. The supervisor will meet with the FRS worker within 48 hours of assignment to discuss contact with the family and develop a case plan, including documentation.

POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY

A DCYF CPS social worker inappropiately provided case information to a parent and their attorney.

In May 2022, an intake alleging inappropriate contact between two children, ages 4 and 12, screened in for a CPS Risk Only investigation. It was reported that the father of the 12-year-old was not taking the concerns seriously and had not addressed the concerns nor shared the concerns with the child's mother.
During the investigation, the worker was contacted by both parents of the 12-year-old child regarding the investigation. The worker encouraged the mother to pursue legal assistance and request a new parenting plan. The mother later informed the worker that she filed an emergency restraining order on behalf of the children against the father. The mother provided contact information for her attorney and requested a letter from the social worker. Following this request, the worker sent an email to the mother's attorney indicating that the mother was the safe parent and that there were concerns for the children in the father's care. The worker also provided information about the status of the CPS investigation. The mother then used the email in family court proceedings.

OFCO contacted the area administrator regarding the letter and the information that the worker provided to the mother and her attorney. The area administrator indicated that it was common practice for a worker to provide a letter detailing DCYF involvement with the family and briefly outlining the case without mentioning the other parent. However, the area administrator agreed that the email sent to the mother's attorney was inappropriate. It was reported that the worker had briefly spoken with the supervisor about the request, but the worker had not understood the parameters and the supervisor was unaware of the full content of the email.

Unreasonable Finding:

- OFCO found that it was clearly unreasonable for the assigned worker to provide an email to the attorney representing the mother in a family law action and offering an opinion endorsing the mother's competence and belief that she was the safe parent while identifying concerns for the children in the father's care, particularly as the CPS investigation had not been completed.

DCYF Response:

DCYF reported that the worker had recently returned to the CPS program. The supervisor was unaware of the content of the letter and the Department agreed that the content was not appropriate. The supervisor spoke with the worker and educated the entire unit on the practice of sharing information with parents and their attorneys.

DCYF CPS unreasonably closed an Investigative Assessment with no finding and erroneously mailed a findings letter to the subject with an inaccurate finding.

In November 2021, an intake alleging sexual abuse of a 15-year-old youth by their stepfather screened in for an emergent CPS investigation and was sent to local law enforcement. There was a related intake that screened in for a CPS Risk Only investigation involving the stepfather's own two children.

POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY

The CPS social worker conducted an initial face-to-face interview with the 15-year-old youth the following day at the family's home. There was no documentation of coordination with law enforcement around the interview. The worker later spoke to a detective assigned to the criminal investigation who reported that they would not be doing a forensic interview as disclosures had already been made on tape during a Sexual Assault Nurse Examiner (SANE) exam at the hospital.

In January 2022, the case was reassigned to another CPS social worker. The mother reported that her 19-year-old daughter also disclosed similar allegations against the subject. The worker spoke with the 15- and 19-year-old youth and both provided additional details on the sexual abuse by the subject. The worker contacted the subject who answered general questions about his own two children but declined to answer questions regarding the sexual abuse allegations on the advice of his attorney. The worker also interviewed the subject's two children who made no disclosures of abuse by their father.

The CPS investigation into the allegations of sexual abuse of the 15-year-old by the subject was closed in February 2022 as "unable to complete investigation – no finding" due to lack of evidence and ongoing pending criminal investigation.

A findings letter sent to the subject in March 2022 indicated that the allegations were determined to be unfounded. The subject's attorney reportedly submitted the letter at a court hearing regarding a protection order.

Unreasonable Findings:

- **DCYF acted unreasonably under the circumstances by closing the Investigative Assessment with an "unable to complete investigation – no finding" when there are credible disclosures from the alleged victim and corroborated by others. While a finding that abuse or neglect occurred must be based on a preponderance of the evidence, the DCYF Investigative Assessment Guide states a finding may be based on one factor when it is significant and specifically notes that a child's statement alone may be compelling. A pending criminal investigation should not be a basis to close an investigation with no finding.**

- **A CPS investigative findings letter mailed to the subject stated that the allegations of child sexual abuse were unfounded when in fact the investigation was closed with no finding.** The 15-year-old youth reportedly disclosed sexual abuse to multiple people. The disclosure was also supported by the older sibling's description of sexual abuse, establishing a pattern of conduct by the stepfather. Although law enforcement appeared to be relying on the information from the SANE exam/interview, it was unclear from the documentation whether the child's SANE exam was obtained during the investigation. DCYF had gathered enough information to conclude the investigation with a finding and there was adequate evidence to support a founded finding of sexual abuse. OFCO recommended that DCYF contact the alleged subject to inform him that the unfounded CPS findings letter he received was an error and that a new CAPTA letter informing him that the investigation was closed as "unable to complete investigation - no finding" along with an explanation as to why.

DCYF Response:

DCYF reported that the assigned worker has resigned along with two of the three CPS supervisors for the office. The case was assigned to an FRS worker with some CPS experience, reporting to a

POOR CASEWORK PRACTICE RESULTING IN HARM TO CHILD OR FAMILY

supervisor with no CPS experience. The worker mistakenly felt that a founded finding was reliant on DNA evidence that was not yet available from law enforcement and that the case had reached the date that it was required to be closed by statute. With regard to the inaccurate findings letter, the supervisor erred in identifying the finding in a request for clerical staff to draft the findings letter. A corrected letter was sent to the subject identifying the finding as "unable to investigate". However, subsequent review of the case identified that there was sufficient evidence for a founded finding and the Department has since issued a founded findings letter.

DEPENDENT CHILD WELL-BEING AND PERMANENCY

DCYF did not submit a termination of paternal rights referral in a timely manner.

In May 2020, DCYF removed a child from the mother's care and filed for dependency. The court entered an order of dependency in September 2020 then ordered a sole plan of adoption for the child in June 2021. In December 2021, the court ordered DCYF to file a Termination of Parental Rights petition within 45 days. Case supervision notes entered in February, March, April, and May 2022 indicated that the social worker was to submit a termination referral. As of May 2022, the child remained in relative placement and the Termination of Parental Rights petition had not been filed.

Violation:

- **DCYF did not file a Termination of Parental Rights petition within 45 days as court ordered.**

DCYF Response:

The local office was unable to locate supporting documents in order to file for termination of parental rights. The mother also began to make progress and the petition was on hold for that reason. The assigned worker has since submitted the petition to the Office of the Attorney General. The local office held a training for the AppExtender program to scan files and search for files in order to more readily locate archived records. Additionally, the acting area administrator discussed the adverse finding at an all-staff meeting and sent a follow up email emphasizing the need to follow court orders.

ICWA VIOLATION

DCYF did not properly notify the tribal social services program as required by the DCYF Indian Child Welfare (ICW) Policies and Procedures.

In September 2021, CPS Intake received a report alleging physical abuse and neglect by the father. The intake identified the father and the two older children as members of a tribe. As required by the DCYF Indian Child Welfare Policies and Procedures, the intake worker called the tribal social worker and left a message advising the social worker of the CPS intake.

The next day, the assigned CPS caseworker completed an initial face-to-face with the children and spoke with the father about the intake allegations.

ICWA VIOLATION

The tribal social worker contacted the CPS worker multiple times in the following weeks regarding the family and recommended that Family Preservation Services (FPS) would be most appropriate for the family. The only documented response from CPS was a note entered in FamLink indicating that the supervisor would approach the family regarding Family Voluntary Services.

Violation:

- **DCYF Indian Child Welfare Policies and Procedures, Section 5 requires the assigned CPS caseworker to contact the tribal social services program within 24 hours of being assigned the intake. This policy also expects ongoing communications with the tribe's social worker throughout the investigation and active efforts to identify what resources are needed to meet the needs of the child(ren).**

  The CPS caseworker did not contact the tribal social worker within the required 24 hours. Additionally, communication about the investigation and services for the family were initiated by the tribal social worker, not the assigned caseworker. Timely communication with the social worker may have led to a more successful engagement with the family as the tribal social worker was familiar with the family.

DCYF Response:

The assigned worker made an inquiry to the Native American Inquiry Request (NAIR) unit and believed that the tribal social services would be notified as a result. The worker now understands that specific notification to the tribal social services must be made. The CPS unit reviewed the ICW intake policy during a staff meeting. Assigning supervisors implemented a plan to review the ICW tab on intakes to ensure proper tribal contact is made. The area administrator also sent an email to remind all staff of the policy and detailed expectations around active efforts.