MINNESOTA
OFFICE OF THE FOSTER
YOUTH OMBUDSPERSON

Office of the Foster Youth Ombudsperson Report of Findings and Recommendations

Date: December 30, 2024

Case No: 202405-02

OOFY Overview

The Office of the Foster Youth Ombudsperson (OOFY) is tasked with the power to:

- "Receive a complaint from any source concerning the health, safety, or welfare of a youth in foster care. The ombudsperson may, at the request of another or on the ombudsperson's own initiative, investigate any action of an agency or a family foster home, custodian, parent, or facility licensed by the state, including a residential treatment facility and secured detention facility. The ombudsperson may exercise powers without regard to the finality of any action.
- "Investigate, upon a complaint or upon personal initiative, any action of an agency, including a request from a youth in foster care to examine the physical placement where the child resides."
- "Request and be given access to information from an agency that is necessary for performing the ombudsperson's responsibilities."

The scope and authority of OOFY is outlined in Sec. 260C.82 MN Statutes. OOFY is an independent agency, separate from the Department of Human Services (DHS), Department of Children, Youth, and Families (DCYF), and other Minnesota ombudsperson offices. OOFY maintains a commitment to the United States' Ombudsman Association (USOA) Governmental Standards of independence, impartiality, confidentiality, and a credible review process.

The objective of this review is to identify areas of improvement in Minnesota's foster care system by looking at issues related to policy, procedure, and practice. In line with OOFY's legislative mandate, we aim to "promote the highest attainable standards of competence, efficiency, and justice for youth who are in the care of the state."

Sec. 260C.82 enables OOFY to make recommendations to an agency or judicial officer if a complaint is determined to be valid. OOFY may recommend an agency or judicial officer:

- Consider the matter further;
- Modify or cancel an action;
- Change a ruling or explain an action; or
- Take any other step that the ombudsperson recommends to provide direction or require action by a facility, placement, or custodian providing a residence to the complainant.

Issue Summary and Investigation Overview

The following concerns were brought to the attention of OOFY in May 2024:

- Concern regarding decision-making for out-of-state placement.
- Concerns regarding the conduct of the social worker.
- Concerns regarding the conduct of the foster parent.

After evaluation of the above concerns, OOFY reached out to the foster youth and identified additional concerns regarding the following:

- Communication and in-person visits with the foster youth.
- Communication and coordination between the facility and the agency:
- Supports and safety plan for the foster youth.
- Facility punishment, consequences, and grievances procedures.
- Basic needs, including bathroom access, clothing, palatable food, and temperature-control.
- Connections to siblings.
- Involvement and transparency in case planning.

To gather more information, OOFY met with:

- Complainant
- Foster youth
- Agency social worker and supervisors
- Guardian ad Litem
- Department of Children, Youth, and Families - Child Safety & Permanency Division

Additionally, OOFY reviewed relevant records available in the Minnesota Government Access (MGA) system, as well as records that were received from the involved agency, including records exported from Social Service Information System (SSIS) from March to October 2024 and documentation related to placement decision-making. The "2022 DHS Caseworker and child visits best practice guide," and Foster Care Sibling Bill of Rights were also reviewed.

Documentation provided by the agency indicated that the youth's care team had made efforts to provide in-home mental health services within the foster home before considering a more restrictive setting. The agency sought consultation and clinical recommendations, which supported a need for residential treatment for the foster youth. The only documented placement option in Minnesota included a facility with a waitlist of over one year, so an out-of-state facility was selected.

OOFY sought and received help from the agency in coordinating direct contact with the foster youth as part of OOFY's broader focus on outreach to foster youth in out-of-state placements. OOFY met by phone with the foster youth in July, and identified several areas of concern, including numbers 1 – 4 above. While issues related to the foster youth's safety were raised and prioritized, OOFY also explored concerns regarding sibling connection and case planning.

OOFY met with the agency by phone on 7/23 and requested they reach out directly to the foster youth to have a private conversation about the foster youth's concerns. During this call with the agency, OOFY inquired about the typical frequency of contact with foster youth placed in out-of-state placements and shared concern about experiences of isolation and disconnection for the foster youth in these types of placements. OOFY followed up with the agency via email on the following dates to inquire when someone would have private contact with the foster youth: 8/2, 8/15, 8/22, 9/3, and 9/26. While OOFY did receive responses from the agency on 8/7, 9/3, and 9/26, the responses did not address whether contact with the foster youth occurred as requested. The 9/26 email from the agency noted a plan to visit with the foster youth in person the following week.

The records OOFY received from the agency reflect that three 15-minute phone calls between the caseworker and the foster youth did occur between approximately July to September 2024. There are no records of in-person or video visits with the youth for the months of July, August, and September.

In meeting with the agency, they noted that this frequency of in-person visits was not consistent with their expected practice. The agency shared their official written policy for staff visiting foster youth in out-of-state placements requires a face-to-face (in-person) visit during the first month of placement, and then every third month thereafter. They referenced guidance received from DHS/DCYF that supports this practice; however, the guidance referenced is specific to Child Welfare Targeted Case Management (CW-TCM) rather than the federal and state guidance for monthly caseworker visits. The agency shared that their policy includes encouraging staff who are visiting out-of-state clients to travel at the end of the month and the beginning of the following month to spend multiple days with the resident (e.g. 9/30 and 10/1).

During at least five of the reviewed contacts from June to October 2024, the notes reflect concerns around bullying, aggression, and threats by peers, discussion or evidence of self-harm, and inappropriate conduct by staff at the treatment facility. At least three of the contacts mention concerns around basic needs, including bathroom access, clothing, and temperature-control.

While reviewing records, OOFY identified concerns regarding the timeliness of data entry into SSIS. Case notes for documentation of activities and contact related to the case from April to October 2024 are noted as being entered into SSIS over two occasions in October 2024, after OOFY submitted a record request to the agency.

Additionally, OOFY found that serious incidents—including unapproved medication stoppage, chemical restraint and resulting hospitalization, and incidents of self-harm—were 1) not appropriately communicated by the facility to the agency and 2) were inconsistently recorded into SSIS by the caseworker. OOFY recognizes the worker's efforts made with the facility regarding missed reports, medication stoppage, etc., but are also of the opinion that additional accountability with the facility was warranted to ensure the youth's safety and well-being needs were addressed in a timely fashion.

Findings:

1. OOFY was unable to substantiate concerns regarding the conduct of the social worker or foster parent that falls outside of policy or practice expectations.
2. OOFY finds that the agency followed appropriate processes regarding out-of-state placement decisions.
3. OOFY finds that the agency's communication and in-person visits with the foster youth were insufficient.
4. OOFY finds that the agency's policy is not in compliance with state and federal requirements for monthly caseworker visits.
5. OOFY finds that serious concerns regarding the foster youth's safety and basic needs were raised and required further attention by the agency.
6. OOFY finds that the agency did not enter records into SSIS in a timely manner, including case notes entered five months after the activity occurred.
7. OOFY finds that communication and coordination between the facility and the agency was insufficient to ensure the youth's safety and well-being.
8. OOFY finds that best practices regarding case planning were not followed, including a lack of engagement with the youth in the creation of an independent living plan.
9. OOFY finds that the agency made minimal efforts to support sibling connections.

Recommendations:

Related to the above findings, the Office of the Foster Youth Ombudsperson recommends:

1. The agency should follow the recommendations as documented in the "2022 DHS Caseworker and child visits best practice guide," particularly regarding quality, timely, in-person visits with foster youth. Specific recommendations include:
    a. Agency leadership, supervisors, and staff review the 2022 guide in detail.
    b. Agency policy on requirements for monthly caseworker visits be updated to ensure alignment with the federal and state laws in which the 2022 guide is based on; most notably, the policy should be updated to clarify the requirement for **monthly face-to-face** caseworker visits.
    c. Agency staff receive training to understand the updated agency policy.
    d. Anyone being used as "another person" (as described in the 2022 guide) to complete monthly caseworker visits, receive training on the expectations for the visits, including reporting the monthly visit to the agency to be documented in SSIS. The Out-of-home Placement Plan should accurately reflect who may be used to complete monthly caseworker visits, including contracting with an agency or other state, as applicable.
2. Due to the isolation and vulnerability of out-of-state youth, agencies should ensure that sufficient time is spent during phone or video visits, whenever in-person visits are not possible. Best practice would be to connect privately with the foster youth for long enough to thoroughly discuss their concerns, particularly with regards to safety and basic needs.
3. The agency should have timely record entry into SSIS. While OOFY understands the inefficiency and time-burden of data entry, the agency should have consistent practice.
4. The agency should be responsive to the concerns of foster youth, particularly regarding safety and well-being.
5. When concerns about a facility are reported by the local Minnesota agency to child protective services in the state/region of the facility, the Minnesota agency should take steps to address the safety concerns with the facility and/or move youth to another placement. This has increased importance for facilities outside of Minnesota.
6. The agency should communicate with the foster youth regarding their case planning, including possible future moves.
7. The agency should provide notification of the Sibling Bill of Rights, using the required form . The agency should facilitate and encourage contact and connection between siblings, whether foster, biological, or adoptive. If there are safety concerns, alternative communication methods, such as letter-writing, or other supervised communication may be considered.

Conclusion:

Under the authority provided to the Office of the Foster Youth Ombudsperson in Minnesota law, OOFY respectfully submits this report of findings and recommendations. These recommendations may effectuate positive change and can improve the lives of similarly situated children and youth in Minnesota's foster care system.

OOFY may choose to share this report publicly. The agency has 45 days to provide a written response to this report. A published report will include any statement of reasonable length made to the OOFY by the agency.

Sincerely,

Misty Coonce, MSW, LISW
Ombudsperson for Foster Youth

Hannah Planalp
Assistant Ombudsperson

Data related to individual complaints and cases is classified as private or confidential (Sec. 13.876 MN Statutes).

Neither the ombudsperson nor any member of the ombudsperson's staff shall be compelled to testify or to produce evidence in any judicial or administrative proceeding with respect to any matter involving the exercise of the ombudsperson's official duties.

No proceeding or civil action except removal from office or a proceeding brought pursuant to chapter 13 shall be commenced against the foster youth ombudsperson for actions taken under sections 260C.80 to 260C.82, unless the act or omission demonstrates malicious intent or was grossly negligent (Sec. 260C.82 MN Statutes).

MEMORANDUM

DATE: January 24, 2025

TO: Office of Ombudsman for Foster Youth

FROM: Alex Cleaveland, Interim Deputy Director, Ramsey County Children and Family Services

CC: Sophia Thompson, Social Services Director

SUBJECT: Ramsey County Response to OOFY

We appreciate your guidance and partnership with Ramsey County Children and Family Services in addressing gaps in service, improvements that can be made and recommendations to the department. Ramsey County is addressing the concerns outlined regarding trainings, documentation, out of home placement plans, communication with facilities and visits to out of state facilities. We will be following the recommendations from OOFY to ensure compliance and most importantly, to be present and available for foster youth in residential care. We are implementing a more robust response to serious concerns that will include onsite visits by the assigned social worker within 10 days of placement, and a site review by management within a month of placement.

We did not meet the expectation of client visits for various reasons, all of which are inexcusable, and we are implementing changes to ensure we meet the state, federal and foster youth requirements for in-person visits. Ramsey County has clear and defined expectations and policies regarding documentation, and we will be adding additional trainings for staff and supervisors and additional supervisor check-ins with staff to guarantee compliance.

Regarding moving the child from the treatment program, this issue was discussed at length with the GAL, CHIPS attorney, CLC attorney, staff, and providers as well as the facility which should have been documented thoroughly but was not. There were discussions regarding moving the youth to a different PRTF or program via a waiver, but it was determined that a move would be more detrimental to the youth as the youth showed signs of improvement and the youth had reported to different professionals that she was doing well and progressing in treatment. We were working on a planned d/c date for December 2024/January 2025 and successful completion of treatment. Furthermore, the youth was a participant in case planning with the social worker.