MINNESOTA
OFFICE OF THE FOSTER
YOUTH OMBUDSPERSON

Office of the Foster Youth Ombudsperson Report of Findings and Recommendations

Date: September 12, 2025
Case No: 202509-02

OOFY Overview

The scope and authority of the Office of the Foster Youth Ombudsperson (OOFY) is outlined in Sec. 260C.82 MN Statutes. 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.

OOFY is an independent agency, separate from the Department of Human Services, Department of Children, Youth, and Families, and separate from other Minnesota ombudsperson offices. Our office 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 for improvement in Minnesota's foster care system by looking at issues related to policy, procedure, and practice. In line with our 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."

OOFY's enabling statute gives us the power to make recommendations to an agency or judicial officer if we determine a complaint was valid. OOFY may recommend that an agency or judicial officer:

- Consider a matter further.
- Modify or cancel an agency or judicial officer's actions.
- Change a ruling or explain an action.
- 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:

1. Failure to provide Sibling Bill of Rights to youth, foster parents, and siblings of youth
2. Insufficient effort in the support of youth establishing and maintaining sibling connections
3. Lack of access to appropriate supports and services
4. Inconsistent or lack of access to basic needs including nutritious food and clothing

5. Over-use of emergency response services, including law enforcement intervention for de-escalation of trauma-based behaviors

To explore the concern, OOFY met with:

- Complainant and/or youth
- Agency social worker
- Agency supervisor(s)
- Guardian ad Litem

Additionally, OOFY reviewed relevant records available in the Minnesota Government Access (MGA) system, as well as SSIS records that were requested and/or received from the involved agency and DCYF. Sibling Bill of Rights, Practice Guide for Maintaining Family Connections for Children in Foster Care, DHS-3799A-ENG (Basics for relatives of foster children) 12-22, Policy on sibling placement, separation, visitation, and contact in permanency were also reviewed.

Findings:

1. Failure to implement and support the Sibling Bill of Rights, including not providing required notification and insufficient effort to support youth in establishing and maintaining sibling connections. In OOFY's recent review of other foster youth cases handled by this agency, similar themes were identified.

   The child entered foster care in early 2020 and the Sibling Bill of Rights notice was not provided by the agency. During OOFY's investigation, the agency expressed their plans to share the Sibling Bill of Rights with the foster youth. The agency also acknowledged they do not have an existing policy or practice to ensure that the sibling bill of rights notification is provided to foster youth, their known adult siblings, and to foster parents as required Minnesota Statutes, section 260C.008.

   While the agency did support some sibling connections, including recent efforts to place the foster youth together with one of their siblings, the agency did not follow best practices to engage and involve *all* siblings in accordance with Minnesota Statutes, section 260C.008. The foster child has two half-siblings who never entered foster care. The agency made efforts to contact the parents of both siblings but only minimally supported the sibling relationships. The foster child has two additional siblings whom they resided with at time of removal from their family home in 2020. Due to the foster child's unsafe behaviors with those siblings, contact was restricted. OOFY found no evidence of agency efforts to re-assess any contact or explore alternative opportunities for contact with these siblings over the past several years.

2. Insufficient effort to ensure access to appropriate therapeutic supports and services related to sexual abuse victimization and/or inappropriate sexual behaviors.

   Records from the child's entry into foster care in 2020 indicate the child disclosed sexual abuse by at least one adult, and records further indicate inappropriate sexual behavior between the foster child and a sibling. Efforts were made for both children to be seen for a sexual abuse consultation at that time. However, the foster child was not able to be seen for the consultation until their mental health and behavior were stabilized. Due to the foster child's ongoing need for significant mental and behavioral health supports, it appears that neither a sexual abuse consultation nor a forensic interview was ever completed. Earlier this year, there were again reports of inappropriate sexual behavior between the

foster child and another sibling whom they were placed with, which led to a placement disruption and subsequent disconnection from the sibling.

3. Insufficient effort to ensure consistent access to basic needs including clothing and nutritious food.

   Documentation reviewed by OOFY included case notes summarizing communication between the foster youth's caregiver and agency worker, where the caregiver inventoried the youth's belongings upon entry to the placement. At that time, the foster youth had only two pairs of underwear. Although the agency worker's communication with the caregiver indicated concern for this issue, it is unclear how long the foster child went without appropriate supply of underwear, due to the caregiver's intention to not provide "too much too fast" to residents to "avoid entitlement," according to documentation from the agency. It is not acceptable for basic needs to be purposely withheld for any reason.

   The availability of nutritious food in the foster child's hotel crisis respite setting is unclear. The crisis respite provider shared with OOFY that food provided is typically fast food and bulk snack items. At the time of OOFY's investigation, the foster child had resided in the crisis respite hotel for two months, with expected transition to the next identified placement being one to four months. Access to healthy food is essential in any circumstance. It is particularly noteworthy considering the extended period of time the foster child is residing in that setting and the child's diagnosis of pre-diabetes.

4. Over-use of emergency response services, including law enforcement intervention for de-escalation of trauma-based behaviors.

   In review of records from the agency, OOFY noted at least two situations involving possibly unnecessary use of police intervention and psychiatric hospitalization in response to the foster youth's escalated behavior.

   The first instance involved the youth's refusal to enter a new school building. The foster youth noted the locked doors and use of physical holds at the school reminded them of a previous placement in residential treatment. Documentation reflects efforts from the agency and placement provider to encourage the youth to attend school as required, as there was not enough staff at the placement to supervise the youth if they did not attend school. At the request of the agency worker, police were called and responded along with EMS, who were successful at calming the youth from their agitated state. However, the youth continued to refuse to attend school that day. The youth was provided the option to go to school or go to the hospital, and upon refusal to attend school, was transported by EMS to the hospital. The youth did not meet criteria for in-patient admission and instead spent five days "social boarding" before returning to the placement setting and agreeing to attend school on an ongoing basis.

   The second instance again involved the youth's refusal to attend school. The agency worker had contacted non-emergency police to seek assistance from crisis mental health workers to help convince the youth to attend school, as the youth would be discharged from the placement setting if they refused to attend school. The youth was not willing to attend school and expressed plans to leave the placement setting to go to a relative's home. The agency worker shared with the youth that the police would be called if they walked away from the placement. The youth expressed fear of police getting involved. The youth continued to refuse to go to school and the police were called by staff at the placement setting, with support from the agency worker. For a second time, the youth was taken by ambulance to the hospital and it was determined again that they did not meet the criteria for admission. The youth stayed in the hospital overnight prior to going to emergency placement with a relative and a sibling. (Of note,

this is the placement referenced in Finding #2, above. This emergency relative placement ended in disruption within two months, after a crisis situation. According to agency documentation, the relative provider called the police, who ultimately handcuffed the foster youth and transported them to the hospital, where the youth remained for six weeks before discharging to the crisis hotel respite setting).

OOFY acknowledges that some of the agency's decision-making and responses are influenced by a broader lack of services and placement options that can best meet foster youth's needs. Even so, the lack of an appropriate safety plan/de-escalation plan and lack of trauma-informed responses from multiple adults responsible for this foster youth's care contributed to multiple avoidable instances of law enforcement involvement and hospital stays for this foster youth. Given the well-documented high percentage of youth who have experienced maltreatment and also "experience arrest, conviction, or overnight stay in a correctional facility by age 17" (2023 OJP article), child welfare workers must consider the impact of frequent law enforcement interactions over time in their decision-making for foster youth. Pervasive racial disparities in both child welfare and juvenile justice involvement further highlight the need for trauma-informed responses.

Recommendations:

For this case and cases going forward, the Office of the Foster Youth Ombudsperson recommends:

1. Incorporate the recommendations from OOFY's recent Issue Report "Lacking Support for Sibling Connections", which includes six recommendations for Social Service Agencies. Specific considerations identified from OOFY's recent review of cases that should be addressed in the agency's updated procedures and supervisory oversight include:
    a. If a sibling that is not previously known to the foster child is identified by the agency through relative search or other efforts, the agency should make a plan for sharing this information with the foster child in a manner that best considers the child's ability to receive the information, which may include therapeutic support.
    b. Supporting sibling connections between the foster child and *all* siblings, including adult siblings and siblings who are not living together, including post-permanency, in alignment with the Practice Guide for Maintaining Family Connections for Children in Foster Care.
        i. When contacting the parents/guardian of minor siblings who are not in foster care as part of the relative search, the agency should explore creative and thoughtful solutions to barriers to support sibling relationships. If siblings cannot live together or have in-person contact, other connections may include phone or video calls, sharing photos or information, exchanging updates, writing letters, or other meaningful contact.
        ii. The agency should include information on all known siblings on the foster child's Social and Medical History, see Sec. 260C.212 MN Statutes Subd 15(c).
        iii. The agency should "ensure post-permanency communication and contact agreements for siblings who are separated due to adoption or TPLPC are incorporated into a final permanency order. This includes siblings who are not in foster care placement and adult siblings." Policy on sibling placement, separation, visitation, and contact in permanency
2. Further assess the foster child's history of sexual abuse victimization and related needs to ensure they receive appropriate treatment, services, and sexual health education. OOFY encourages the agency to consider the following resources:
    a. Professional consultation with the HELP Program through Foster Adopt MN, who may offer resources and suggestions related to supporting foster youth's sexual health, including

therapists who specialize in supporting youth who have experienced both victimization and unsafe behaviors themselves. In some situations the HELP Program can assist with funding if that is a barrier to accessing therapeutic services. FAM_Why-People-Call-the-HELP-Program.pdf

b. Specific training for the youth's caregivers to better support youth with history of sexual abuse victimization, inappropriate or unsafe sexual behaviors, and general development of healthy sexual behaviors and boundaries, such as: Sexuality for All Abilities Curriculum Training - Mad Hatter Wellness and Addressing Sexual Behaviors with Children and Youth - Foster Adopt Minnesota

3. Consistently ensure that foster youth have timely access to basic needs such as clothing and nutritious food. This may include informing caregivers of expectations and advocating that all basic needs are provided in a timely manner, even when barriers are present due to dynamics with the placement setting.
4. Ensure agency workers and care providers receive ongoing training to respond to trauma-based behaviors and support youth in de-escalation. This includes validating youth's feelings and experiences that may come through as challenging behaviors and ensuring that de-escalation/safety plans are in place to decrease reliance on emergency services.
    a. This page gives clear, actionable ideas on how to effectively support youth through de-escalation, and also how workers can support themselves in doing this challenging work: De-escalation Strategies for Young People and Youth Workers - The Professional Youth Worker
    b. YIPA has many, many trainings and offerings geared specifically toward people who work with youth in different capacities. Almost all of their resources can only be accessed through a membership, (individual or agency). If the agency doesn't already have a membership, this may be worth exploring.

Conclusion:

Placement in foster care, especially in non-relative homes, residential care, and crisis hotel respite settings, involves unavoidable disconnection from a child's family, community, and culture, and thus requires special care and support. Additionally, many of the concerns identified in this investigation require change and solutions at many levels of practice.

Under the authority provided to the Office of the Foster Youth Ombudsperson in Minnesota Law, the 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.

Before publishing, the agency has 45 days to provide a written response to this report in defense or mitigation of OOFY's recommendation or conclusion. The published report will include any statement of reasonable length made to the OOFY by the agency.

We appreciate the cooperation and collaboration with the agency in OOFY's review of this matter. We look forward to continued partnership in the future to promote the health, safety, and welfare of Minnesota foster youth.

Sincerely,

Misty Coonce, MSW, LISW
Ombudsperson for Foster Youth

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.

Date: 10.20.25

To: Office of the Foster Youth Ombudsperson
From: Bobbi Jo Potter, Deputy Director of Children and Family Services
Subject: Findings and Recommendations Report

Dear Misty,

Ramsey County appreciates the opportunity to review and respond to the findings and recommendations outlined in the Office of the Foster Youth Ombudsperson's (OOFY) report dated 9.12.2025. We value OOFY's role in ensuring accountability and improving the quality of services provided to Minnesota's foster youth.
We share OOFY's commitment to trauma-informed, rights-respecting child welfare practice. After careful review of the report, we have outlined below our response and planned corrective actions.

I. Response to Findings and Recommendations

1. Implementation of the Sibling Bill of Rights & Support for Sibling Connections

We acknowledge the concerns regarding insufficient support for sibling connections and lack of notification about the Sibling Bill of Rights. In response, we are taking the following actions:

- **Process Review and Procedure Update:** We are reviewing our procedure and tracking process to ensure timely provision of the Sibling Bill of Rights notice to all eligible youth, siblings, and foster parents, as required by Minn. Stat. §260C.008.
- **Training:** All staff and supervisors will receive updated training on the statute, expectations, procedure, sibling engagement, documentation, and reassessment of sibling contact restrictions.
- **Ongoing Review:** Supervisors will review sibling contact plans regularly to ensure efforts are active, documented, and consistent with best practices.
- **Supportive Practices:**
    - Ensure newly identified siblings are introduced to foster youth in a developmentally appropriate and therapeutic manner.
    - Maintain sibling relationships across all settings, including with adult and non-placed siblings, and post-permanency.
    - Document all known siblings in the child's Social and Medical History (MN Statute 260C.212 Subd. 15(c)).
    - Support including sibling contact agreements in final permanency orders when appropriate, ensuring that contact is safe, in the child's best interests, and not restricted by court decisions.
    - Ensure efforts are made to locate and engage siblings and offer visitation opportunities when appropriate.

2. Access to Therapeutic Supports for Sexual Abuse Victimization

We agree that timely access to trauma-informed therapeutic services is essential. Corrective actions include:

- **Assessment & Planning:** Strengthen assessment and service planning for youth with a history of sexual abuse.
- **HELP Program Utilization:** Explore the HELP Program's offerings to support youth and caregivers, including funding assistance and therapeutic referrals.
- **Caregiver Training:** Explore training through Foster Adopt MN and other community agencies to support caregivers of youth with sexual abuse histories.

3. Access to Basic Needs

We acknowledge the need for consistent access to clothing and nutritious food. Actions include:

- **Policy Clarification:** Reinforce expectations that children and youth consistently have access to clothing, hygiene items, and nutritious foods through ongoing communication with caregivers and social workers.

- **Supervisory Oversight:** Supervisors will verify that youth have adequate clothing and personal supplies.
- **Ongoing Evaluation:** Continue to assess and ensure youth's basic needs are consistently met, including in crisis respite settings.

4. Overuse of Emergency Response and Law Enforcement

We recognize the importance of trauma-informed responses and minimizing law enforcement involvement. Actions include:

- **De-escalation Training & Plans:** Ensure trauma-informed crisis responses through staff training and coordination with care teams on individualized safety or de-escalation plans when appropriate.
- **Crisis Collaboration:** Strengthen partnerships with mobile crisis teams and community-based mental health providers to reduce reliance on police intervention.

II. Implementation and Monitoring

To ensure accountability and sustainability of these improvements:

- **Training & Policy Tracking:** Updates will be tracked through the agency's learning management system.
- **Case Reviews:** Supervisors will conduct regular case reviews to ensure compliance with changes identified.
- **Leadership Oversight:** Progress will be reviewed regularly by the agency's leadership team, with adjustments made as needed.

III. Conclusion

We are grateful for OOFY's continued advocacy and collaboration in improving outcomes for youth in foster care. Ramsey County remains committed to continuous improvement, transparency, and partnership in this work.

Sincerely,

Bobbi Jo Potter
Deputy Director, Children and Family Services