MINNESOTA
OFFICE OF THE FOSTER
YOUTH OMBUDSPERSON

Office of the Foster Youth Ombudsperson Report of Findings and Recommendations

Date: 2/27/2026
Case No: 202602-01

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 (DCYF), 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 is 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:

OOFY reviewed the following concerns:

1. Lack of appropriate reporting, assessment, and investigation of possible child maltreatment in a licensed foster home
2. Lack of cross-reporting and communication regarding concerns of maltreatment in a licensed foster home
3. Lack of an Initial Foster Care Phone call between the biological parent(s) and foster parent(s)
4. Lack of appropriate planning and lack of completion of Reunification Structured Decision Making (SDM) Assessments prior to beginning a Trial Home Visit (THV)

5. Insufficient documentation
6. Lack of clarity in decision-making and communication regarding assessment and waiver of parental fees

Investigation Overview:

To explore the concerns, OOFY communicated with:

- Complainant and/or youth
- Agency supervisor and agency director
- DCYF – Continuous Quality Improvement (CQI) Unit, Child Foster Care Licensing Unit, and Child Safety and Permanency Unit
- Local Children's Advocacy Center

OOFY typically includes the Guardian ad Litem (GaL) as a courtesy contact in our communication with the social services agency. Given the amount of time since the agency had closed the case, OOFY did not include the GaL for this investigation.

OOFY reviewed relevant records available in the Minnesota Government Access (MGA) system, as well as records that were requested and/or received from the social services agency and the Child Advocacy Center. Additionally, the following practice guides and statutes were reviewed:

- DHS-7295A-ENG_Ver_3-21_Initial foster care phone calls: Practice guide for social service agencies
- Minnesota's Best Practices for Facility Investigation
- Minnesota Child Foster Care Licensing Guidelines
- Resource Guide for Mandated Reporters of Child Maltreatment Concerns
- Caseworker and child visits best practice guide
- Statute regarding assessment of parental fees Sec. 260C.331 MN Statutes

From time the child entered foster care until they reunified back home with their parent(s) there was no documentation that an "Initial Foster Care Phone Call" (also referred to as a "comfort call") was coordinated at any time.

Case notes included documentation of concerns of possible maltreatment in the foster home with either no indication of follow-up or unclear/ineffective follow-up to assess for child safety. For example, the GaL expressed concern to the caseworker about an observed bruise they described as "obvious" on the child's cheek. The GaL noted to the caseworker that the explanation provided by the foster parent seemed non-credible.

Within the first month of the child's placement in the foster home, the caseworker learned of behaviors from the foster child which they described in their case notes as "red flags for sexual abuse." The caseworker also heard statements from the child that were possibly referencing sexual abuse by one of the foster parents. When scheduling a routine "foster care physical" (described as a well-child visit typically scheduled within the first 30 days of foster care placement to assess the child's overall health and development and determine the need for any follow-up care) with the local clinic, who also provides forensic interviewing services, the caseworker shared about behaviors that displayed red flags for child sexual abuse. However, the caseworker did not specifically request to have a forensic interview/child abuse examination as part of the foster care physical. According to what OOFY learned from this clinic, they rely on the agency caseworkers to specify the type of appointment they would like the child to have.

There was no documentation of any efforts from the caseworker to seek further information nor to consult with a supervisor to help them assess if a mandated report of suspected maltreatment was warranted. No report was

made during the first few months of the foster care placement. There was no documentation of communication between the caseworker and the foster home's licensor about any of the concerns which had been identified early in the placement. It is notable that a few months after the child's placement, the caseworker did communicate concerns about a different aspect of the foster parent's caregiving with the licensor, who took appropriate steps to address the concerns and determine if any corrective action was warranted.

In the fourth month of the child's placement in the foster home, a report of suspected child maltreatment was made, which references the same statement made by the child in presence of the caseworker during the first month of placement. In communication with OOFY, the agency explained that the report was screened out and was not considered a report about a "facility" because it was unclear from the report who the allegations were against. However, the Child Protection Intake Summary report lists the foster parent by name as the alleged offender and lists the screen out reason as "not enough identifying information."

The day the report was made, the child was abruptly moved from the foster home back to the care of their parent(s). Plans had been in place to move to a Trial Home Visit later in the month, but the agency explained that they moved the child after the report of maltreatment "out of an abundance of caution." Although the caseworker, who had observed the same statement from the child earlier in the foster placement and had documented red flags of sexual abuse, was involved in the screening decision for this report, it is unclear if they shared this information during that discussion. From case notes entered by the licensing worker at the agency, it appears the child protection caseworker had been the one to inform the foster parent(s) that they would be moving the child from the foster home to their parent's home due to a report of suspected maltreatment. The caseworker picked the child up and transported them that day. There are no case notes from the child protection caseworker regarding any contact with the child's parent(s), the foster parent(s), the licensing worker, or the child on the day of the maltreatment report and related move of the child or in subsequent days.

Although the foster parent was identified as the alleged offender on the Child Protection Intake Summary report, the agency did not consider the report to be a facility investigation and they did not open the intake workgroup in the Social Service Information System (SSIS) under the foster parent(s). The agency explained that they did not have enough information about the allegation nor about who the allegation was against, to effectively screen or assess the report. They worked with the child's parent(s) to schedule a forensic interview to seek more clarity, which occurred a few days after the report. Documentation indicates that there was no further detail gained from the child during this interview. The maltreatment report was cross-reported to law enforcement as required, and law enforcement was present for the forensic interview per typical practice. The foster parent's licensing worker was included in communications about this report, but it is unclear if the concerns observed from the first month of the placement were ever shared with the licensing worker. The child maltreatment report was not cross-reported to the Child Foster Care Licensing unit at DCYF. The foster parent(s) were informed that the reason for the abrupt removal of the child from their home was due to a report of child maltreatment against them, and were never provided information about the nature of the report. The agency determined that a licensing investigation was not necessary based on the inconclusive information gained during the forensic interview.

Prior to initiating the plan for the Trial Home Visit (THV), a Structured Decision Making (SDM) reunification assessment was not completed to help inform decision-making. Documented contact between the caseworker and the parent(s) after the start of the THV was minimal; contact included two text communications in the first month, and a phone call in the second month. There is reference to an in-home caseworker visit scheduled almost 2 full months after the start of the THV, but there is no case note to document whether this visit occurred. The caseworker submitted to the courts a request to return custody to the child's parent(s) 8 weeks after the child returned home, despite no completion of applicable SDM assessments, and minimal contact with the parent(s) and child, including no documented in-person visit since the THV began.

Another report of possible child maltreatment with similar information to the first report, was made approximately two months after the child had left the foster home. This Child Protection Intake Summary report again specifically references the foster parent as the alleged offender. Unlike the previous report, the workgroup in SSIS for this report was opened under the foster parent(s). It was screened out, with reason "all allegations already assessed." The report was cross-reported to law enforcement. There was no documentation or other indication that the report was cross-reported to the Child Foster Care Licensing unit at DCYF.

Documentation from the agency summarizes questions and concern raised by the parent(s) about the assessment of parental fees for their child's out-of-home placement. Agency case notes indicate that the parent(s) expressed reluctance to pay the fees based on concerns that their child was maltreated while in foster care, in addition to their inability to pay. The agency made a determination to waive the fees in full and shared this back with the parent(s) during a phone call. However, the reason provided to the parent/s for the fee waiver is unclear. Without clear documentation in case notes and no written notification to the parent(s), it is unclear if the agency waived the fees due to inability to pay or because of the maltreatment allegations.

Agency leadership met with OOFY to review several areas of questions regarding the above. They acknowledged that multiple concerns reviewed are not representative of their agency's typical practice, including:

- lack of reporting of maltreatment concerns
- lack of clarity in the type of appointment being requested by the local clinic
- lack of communication between the caseworker and licensing worker
- lack of completion of necessary SDM assessments
- minimal contact from the caseworker to the family once the Trial Home Visit began
- insufficient documentation

Agency leadership described holding regular, robust trainings on these topics to their staff, including some co-training with the local clinic/CAC to ensure clarity of roles and process. They described making decisions that always center the child's safety. They noted that they closely follow available written practice guidance from DCYF regarding screening of maltreatment reports and the process for facility investigations. They described their decision-making for the assessment of parental fees and shared with OOFY the written materials they send to parents to inform them of the basis for the fees and the importance of providing financial information to help the agency determine the most appropriate amount. They acknowledged that they did not make efforts to complete the Initial Foster Care Phone Call as required, and that this is an area where additional statewide guidance and training would be beneficial. Since the timing of the entry into foster care for the child who is centered in this report, the agency shared that they have trained all of their child foster care licensors on the importance of Initial Foster Care Phone calls and their role to facilitate these calls.

OOFY appreciates the transparency and communication with the agency throughout our investigative process and recognizes the agency's many efforts to uphold best practice.

Findings:

Concern description	**OOFY Finding**
1. Lack of appropriate reporting, assessment, and investigation of possible child maltreatment in a licensed foster home	Substantiated

There were documented concerns/indicators of possible maltreatment of the child once they entered foster care (i.e. observed bruise on the child's face that did not match description by the foster parent, behaviors identified as red flags for sexual abuse and comments made by the foster child that possibly referenced sexual abuse). Some concerns were not appropriately assessed or reported until the child's fourth month in the foster home. Some concerns never received any follow-up.

Concern description	**OOFY Finding**
2. Lack of cross-reporting and communication regarding concerns of maltreatment in a licensed foster home	Substantiated

Two Child Protection Intake Summary reports identified the foster parent as the alleged offender, but were not considered by the agency to be reports about a facility. (According to written practice guidance from DCYF the definition of a facility includes homes licensed for child foster care). Although information about the screened out maltreatment reports regarding the foster parent(s) were reported/communicated to the licensing worker and child protection caseworker, as well as to law enforcement, they were not reported to the DCYF Child Foster Care Licensing unit as required.

Intra-agency cross-communication between the child protection caseworker and the foster care licensing worker regarding possible maltreatment and caregiving concerns, which may have necessitated additional follow-up and/or investigation from the licensing worker, did not occur until the child's fourth month in the foster home.

Concern description	**OOFY Finding**
3. The Initial Foster Care Phone Call did not occur as required upon the child's entry into foster care.	Substantiated

Minnesota state law effective November 1, 2020 requires coordination of this call between parents and caregivers of children in foster care as soon as practical, and no longer than 72 hours, after placement. There is no documentation that this ever occurred during this child's placement in foster care.

Concern description	**OOFY Finding**
4. Lack of appropriate planning and lack of Reunification Structured Decision Making (SDM) Assessments prior to beginning a Trial Home Visit (THV)	Substantiated

There were no SDM Assessments during this child's placement in foster care over a four-month period. Agency documentation showed minimal contact between the child protection case worker and the parent(s) and child once the Trial Home Visit (THV) started. Despite this limited contact, the caseworker recommended return of custody to the parent(s).

Concern description	**OOFY Finding**
5. Insufficient documentation	Substantiated

The type of medical appointment scheduled by the case worker for the child during their first month in placement is not clearly documented. Over a five month period, agency records include reference to three in-person caseworker visits with the parent(s)/child which were not case noted. No caseworker visit was case noted for two subsequent months during a phase in the case when decision making about the Trial Home Visit and return of custody to the parent(s) was being determined. The child's move from their foster home to their parent(s) home was expedited due to the report of maltreatment in the foster home. There are no case notes

from the child protection caseworker regarding any contact with the child's parent(s), the foster parent(s), the licensing worker, or the child on the day of the maltreatment report or in subsequent days.

Concern description	**OOFY Finding**
6. Lack of clarity in decision-making and communication regarding assessment and waiver of parental fees	Substantiated

Communication to the parent(s) regarding the possibility for fee reduction based on income and/or to support reunification as well as the basis for waiving their fees was unclear. The basis for waiving the parental fees was not clearly communicated to the parent(s).

Recommendations:

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

1. Ensure that concerns of suspected or known child maltreatment are assessed and followed up on in a timely manner, for foster children in any placement setting.
    a. Continue ongoing training of agency workers in accordance with Resource Guide for Mandated Reporters of Child Maltreatment Concerns.
    b. Ensure that licensing investigations are completed and documented as required. The Minnesota Child Foster Care Licensing Guidelines provides detailed guidance on licensing investigations, with these items as especially noteworthy:
        i. "Regardless of the outcome of child protection and/or law enforcement investigations, the licensing agency must always investigate for potential licensing violations. An allegation or complaint may be screened out by children protection, but the licensing investigation may determine a licensing violation occurred related to the same allegation or complaint" (page 126).
        ii. "Every allegation, complaint, or concern about a licensed foster home must be investigated by the licensing agency" (page 127).
        iii. "The disposition of a licensing investigation is 'occurred,' 'did not occur,' or 'unable to determine'" (page 131).

2. Ensure that screened out reports of possible maltreatment in licensed foster homes (and other settings that meet the definition of a facility) are consistently cross-reported to DCYF Child Foster Care Licensing unit or other appropriate body in accordance with written practice guidance.
3. Consistently follow requirements for Initial Foster Care Phone Calls as outlined in written practice guidance. Continue to provide ongoing training and supervision of agency workers to support this practice and consult with DCYF as needed.
4. Ensure Structured Decision Making assessments are completed as required, through ongoing agency worker training and supervisor oversight.
5. Ensure timely case note entry into SSIS, especially for critical case activities such as placement changes and caseworker visits, through ongoing agency worker training and supervisor oversight.
6. Update agency materials related to Parental Fees including the possibility of full or partial waiver of fees based on parent income and/or to support reunification. Update agency processes to ensure clear written communication to parent(s) which describe the basis for full or partial waiver of fees.

Conclusion:

Placement in foster care 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 by Minnesota, OOFY respectfully submits this report. Our goal is for these recommendations to effectuate positive change and 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.