

Office of the Foster Youth Ombudsman Report of Findings and Recommendations

Date: 3/6/2026

Case No: 202603-01

OOFY Overview

The scope and authority of the Office of the Foster Youth Ombudsman (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 ombudsman may, at the request of another or on the ombudsman'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 ombudsman 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 ombudsman'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 ombudsman 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 ombudsman 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. Delay in providing adequate medical care
2. Insufficient documentation
3. Lack of access to basic needs in hotel crisis respite settings
4. Inappropriate comments by facility staff
5. Failure to implement and support the Sibling Bill of Rights

Investigation Overview:

To explore the concerns, OOFY communicated with:

- Complainant and/or youth
- Facility case manager and directors
- Agency caseworker, children’s mental health worker, and supervisor(s)
- Guardian ad Litem (GaL)
- Minnesota Department of Human Services – Facilities Licensing
- Minnesota Department of Health – Office of Health Facility Complaints
- Minnesota Ombudsman for Mental Health and Developmental Disabilities
- Minnesota Disability Law Center

Additionally, OOFY reviewed relevant records available in the Minnesota Government Access (MGA) system, as well as over 1000 pages of SSIS case notes, facility notes, and medical records that were received from the involved agency and DCYF.

Before moving into a facility placement, the youth had a routine physical which noted no concerns of back pain, heartburn, or shortness of breath. On the first full day at the facility, the youth reported back pain and shortness of breath to facility staff. The youth was assessed by nursing staff but continued to complain of pain.

According to notes provided by the facility to the caseworker, the following day the youth was “look[ing] for ways to get out of” chores. Throughout the day, the situation continued to escalate, leading to two physical holds/restraints and a resulting bloody nose. At this point, the youth asked to go to the hospital and said that the staff “just don’t give a ****.” The youth was not taken to the hospital. That evening, it is noted that the youth was making “nervous and irrelevant statements, “talking quickly,” and then, “appeared lethargic after crying,” before bedtime. Two days later, an on-site nursing note indicated the youth was seen for reported pain related to the physical holds; they had a bruise, tenderness, and stated difficulty lifting their arm. The youth had been taking over-the-counter medications to manage pain.

Over the next six weeks, records state that the youth complained frequently about back pain and was sometimes reluctant to participate in activities, needing frequent breaks. There are several instances of being seen by on-site nursing staff for various concerns during this time, noted in daily notes but not in the nursing notes. At that time, the youth had a sledding accident. The youth complained of back pain and went to rest in their room. There is no indication they were seen by on-site nursing for the reported pain.

Several days later, the youth was seen for back pain in an office visit. An x-ray identified a fracture in the youth’s back and the youth was admitted to the hospital for surgery. Over the next six weeks, they had three back surgeries and required extended rehabilitation in the hospital.

Findings:

| <u>Concern description</u> | <u>OOFY Finding</u> |
|---|----------------------------|
| 1. Delay in providing adequate medical care | Substantiated |

While several records state that the youth’s back pain was chronic, or that the injury was caused by a sledding accident or a fall years prior, contemporaneous case notes mention significant back pain over a month before the accident, with the youth asking to go to the hospital. It is not possible to identify whether there were pre-existing back issues not identified in the physical exam, or whether physical holds or the sledding accident

exacerbated a back injury. However, it is clear that the youth repeatedly complained of back pain, which did not appear to be assessed by a clinician for 45 days. While the youth may have been assessed by on-site nursing staff, there are no notes or records of such an assessment.

OOFY recognizes the care and concern shown by facility staff that is evident through both meetings and record review, but there must be clear guidance to staff regarding when medical concerns should be assessed by on-site nursing staff or escalated to external clinicians. In any case, these decisions should be documented and shared with the agency. It is not appropriate to assume a youth is lying, being manipulative, or trying to avoid chores when they complain of pain. This injury was severe enough that the surgeon stated, “Most people can’t get out of bed,” but the youth was expected to do chores, shovel snow, and participate in activities despite repeated complaints of illness and pain.

| <u>Concern description</u> | <u>OOFY Finding</u> |
|-------------------------------|---------------------|
| 2. Insufficient documentation | Substantiated |

Incident Reports from the facility: During review of this case, OOFY requested incident reports from the beginning of the youth’s stay until several months after the surgeries but did not receive reports for all relevant incidents. It is not clear whether these reports do not exist or were not included in materials sent to the agency. While some unrelated incidents are logged in detail, the agency, and subsequently OOFY, did not receive details regarding more serious or concerning occurrences. In total, OOFY received two incident reports, for minor incidents:

- “Student Injury Incident Report,” that included details regarding a scrape on the middle finger of the youth’s right hand that was “cleaned, ointment applied, and band-aid applied.”
- “Staff Injury Incident Report,” related to a hold that resulted in a “quarter sized rug burn abrasion on the outer back side of left elbow.”

Reports were not provided for any other incident, including the physical hold (manual restraint) that resulted in the youth having a bloody nose and possible bruising, or the sledding incident that allegedly led to the youth’s back injury.

Nursing notes from the facility: Nursing notes were provided with inconsistent levels of detail. Several minor instances of scratches and scrapes (usually treated with band-aids) are noted but there are no nursing notes for 50 days, and no notes for the physical holds or sledding accident. During this period, it is noted on several occasions in daily notes that the youth was assessed by nursing for back pain, heartburn, illness, etc.

Inconsistent records: The nursing notes after the x-ray state that the youth did not report the sledding accident to “staff or nursing,” even though the daily notes from the day of the accident do mention the youth resting in their room after they got hurt.

It was stated to OOFY that the youth ultimately received medical care because they threatened to run away. Although similar statements (and less significant statements) made by the youth are logged, this statement is not documented in the records OOFY received. It is ultimately unclear what prompted the medical appointment that resulted in the x-ray referral. There are no nursing notes or explanations provided in the daily notes. Additionally, there are no documented efforts from the agency to the facility seeking information about the

injury, or efforts by the agency to obtain documentation from the facility, even after the youth required surgical intervention and a lengthy hospital stay.

Unclear cross-reporting and record retention:

When OOFY requested medical records and notes related to incidents or holds from the responsible social service agency, they did not have these in their possession. OOFY was unable to get more information about what had been communicated to the agency, as the caseworker is no longer with the agency and case notes in SSIS did not include details. Many of the case notes from this staff were entered at once, sometimes over a year after the activity. It should be noted that the second caseworker provided much more consistent and thorough case notes.

Throughout this review, it was unclear what information had been reported to the appropriate bodies regarding the injury and/or suspected maltreatment. OOFY was unable to confirm whether the back injury was correctly cross-reported.

| <u>Concern description</u> | <u>OOFY Finding</u> |
|--|---------------------|
| 3. Failure to implement and support the Sibling Bill of Rights | Substantiated |

It was unclear through discussions and SSIS case notes whether the agency has provided notification of the Sibling Bill of Rights, as required in [Minnesota Statutes, section 260C.008](#). It appears that, while some efforts were made to keep the youth connected to sibling(s) and important adults, these efforts were inconsistent, including long periods of time without contact with a sibling who exited foster care. While OOFY understands there are additional barriers when siblings are not in foster care or when siblings are adults, best practice would be to continue to support and advocate for sibling relationships as critical connections for foster youth.

| <u>Concern description</u> | <u>OOFY Finding</u> |
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| 4. Lack of access to basic needs in hotel crisis respite settings | Inconclusive |

Prior to this facility placement, the youth spent time at a hotel crisis respite setting. It was reported to OOFY that the youth ate only fast food over several months and experienced rapid and considerable weight gain. Additionally, it was documented that the youth did not attend school or receive educational services during these months. OOFY did not request records or meet with providers about these concerns, as this placement was not current and OOFY investigations of similar placements have confirmed the same issues with a lack of nutritious food and educational services. The agency and GaL had shared concerns about this placement with the court, including dishonest statements from staff, lack of supervision, and delay of court-ordered assessments.

| <u>Concern description</u> | <u>OOFY Finding</u> |
|---|---------------------|
| 5. Inappropriate comments by facility staff | Inconclusive |

It was reported that a facility staff made discriminatory comments about the youth's religious beliefs. OOFY was not able to confirm that statements were made but did share feedback with the facility and cross-report to the appropriate bodies.

Recommendations:

As part of OOFY's investigation, feedback and recommendations were shared with the facility. Additionally, items of concern were cross-reported by OOFY to the relevant bodies. For the purposes of this report, recommendations will focus on the duties of the responsible social services agency.

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

1. The agency shall ensure relevant records from a foster youth's placement, which may include medical records, nursing notes, and daily notes or progress reports, are reviewed, retained, and followed up on as-needed. If medical concerns are repeatedly noted, the agency shall ensure responsibilities to provide care for foster youth are met, which may include inquiring about decision-making processes for seeking or not seeking medical care.
2. The agency shall ensure they request and receive appropriate documentation of manual restraints and all injuries for foster youth placed in any setting under their authority. If these events are shared with them informally, such as through phone calls, daily notes, or emails, agency staff must follow up to request appropriate documentation and detail including required incident reports, to ensure the safety and well-being needs of foster youth are met
 - a. [Minnesota Rules, part 2960.0710](#)
 - b. [Minnesota Statutes, section 245D.061](#)
3. The agency shall ensure thorough, timely, and consistent record entry into SSIS through ongoing agency worker training and supervisor oversight.
4. The agency shall ensure that appropriate reporting and cross-reporting occurs.
 - a. This must include:
 - i. Reporting of suspected child maltreatment, no matter the child's placement setting, as required by law and outlined in the [Resource Guide for Mandated Reporters of Child Maltreatment Concerns](#).
 - b. This may include:
 - i. Inquiring if the facility has reported to the [Office of Ombudsman for Mental Health and Developmental Disabilities](#), per [Minnesota Statutes, section 245.94, subdivision 2a](#) and the [Minnesota Disability Law Center](#).
5. The agency shall incorporate the recommendations from OOFY's recent [Issue Report](#), "Lacking Support for Sibling Connections," which includes six recommendations for social service agencies. This includes:
 - a. 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](#).
6. The agency shall consistently ensure that foster youth have timely access to basic needs such as medical care, nutritious food, and educational services.
7. In addition to raising concerns regarding the hotel crisis respite settings, the agency should consider whether future placement in similar settings is warranted and what steps may be taken if they are not meeting a youth's needs.

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. 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,



Hannah Planalp
Deputy Ombudsperson for Foster Youth



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.



Saint Louis County

Public Health and Human Service Department –
www.stlouiscountymn.gov

Linnea Mirsch
PHHS Director

Date: April 14, 2026

TO: Office of Ombudsman for Foster Youth

FROM: Chris Heazlett, Children and Family Services Division Director, St. Louis County

SUBJECT: St. Louis County Response to OOFY

Please find below our agency response to the investigation report (2002603-01) dated March 6, 2026. St Louis County appreciates OOFY's goals of promoting the highest attainable standards of competence for care of foster youth and will strive to follow all recommendations set forth in the report. Please find below additional information and context gathered through our internal record review and interviews with case managers.

Finding 1:

The agency agrees that the youth would have clearly benefitted from medical treatment earlier than occurred. A child's medical complaints should never be dismissed and minimized. The agency respectfully notes the facility provider shared during the course of routine communication with the case manager that the youth complained of back pain as early as December 13th, 2024. The youth was assessed by a nursing professional the same day and later felt well enough to go to the gym and play in a game of Thunder. Subsequent progress summaries provided to the case manager by the facility indicated the youth was engaging in physical activities such as football, ultimate frisbee, basketball, and dodge ball. The youth's unusual symptom presentation likely contributed to the absence of timely diagnosis and the case manager not elevating the importance of further medical follow up. This context is provided to note the information the case manager had at the time and by no means is intended to negate the OOFY finding or diminish the learning opportunities for the agency.

Finding 2:

The facility placement reported they made a report to the Ombudsman when the back injury was diagnosed. Maltreatment was not suspected in this case.

The agency concurs that SSIS case notes should be entered timely. Despite the "batch" recording of notes, it is clear that the primary case manager was actively working this case as evidenced by numerous documented conversations with the youth's caregivers, therapist, treatment center staff, internal consultations include referral to children's mental health, as well as placement

efforts (crisis respite, CADI home, mental health treatment settings), summaries of face-to-face contact, and extended family contacts. The primary case manager also copied email correspondence from the treatment center detailing incident reports and routine progress reports.

Our agency's standard is for a complete social and medical history to be maintained which includes periodic updating of medical records.

Finding 3:

This agency did not provide the Sibling Bill of Rights as required by statute and best practice. Agency case notes do indicate ongoing contact with father, aunt, and grandparents. A brief visit was arranged with the youth's sibling served concurrently by the facility in a separate program. The sibling's adoptive parents ultimately ceased visits due to concerns of behavioral dysregulation. The agency is without legal authority to ensure sibling contact in this matter though continued efforts will be made to promote sibling connections.

Finding 4:

The primary case manager addressed the non-emergent concerns directly with the hotel respite provider and made reasonable efforts to have the youth return to the home county as soon as a local placement became available. The children's mental health worker made regular visits with the child and was told by a staff member that fast food was limited to once per week. There was a kitchenette in the hotel room for cooking. Systemically, waiver crisis resources are typically unavailable due to limited capacity and high staffing needed to meet level of care. The youth could not have been reasonably cared for by county staff in a government building which was the only available alternative. Case manager notes indicate the youth experienced some language barriers and distance from home but generally enjoyed the placement.

Recommendations:

The agency appreciates the recommendations and will make diligent efforts to incorporate in ongoing training for case managers and supervisors. Specifically, the agency intends to conduct training on the Sibling Bill of Rights including the provided You Tube video. The Sibling Bill of Rights Commissioner's Form is now accessible to Children and Family Services staff through SharePoint and the document is now included in case transfer checklists. The agency will reinforce with facility providers that documentation of manual holds and injuries is expected. The agency has already implemented increased oversight protocols when hotel respite needs to be utilized.

Respectfully Submitted,

Chris Heazlett, Division Director
Children and Family Services