Office of Developmental Disabilities Ombuds

Investigating the Lake Burien Youth Transitional Care Facility

Lake Burien Youth Transitional Care Facility, 2025

January 2026

About DD Ombuds

The Office of Developmental Disabilities Ombuds advocates for the rights, dignity, and humanity of people with developmental disabilities living in Washington-State. RCW 43.382.05 provides the office with authority and identifies its scope. The legislature authorized DD Ombuds to monitor services provided to people with developmental disabilities, review facilities and residences where services are provided, resolve complaints about services, and issue reports.

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Executive Summary

The DD Ombuds has serious concerns with the Lake Burien Youth Transitional Care Facility (Lake Burien) due to its organizational mismanagement, lack of regulatory oversight, widespread abuse and neglect allegations, and the facility's use of isolation and restraint. For these reasons, DD Ombuds is alerting disability advocates to the abusive and neglectful environment found at Lake Burien. To provide humane and therapeutic services, Lake Burien needs to implement independent regulatory oversight, maintain accurate and transparent incident reporting and abuse investigation findings, and end its dependency on physical de-escalation tactics. Finally, DD Ombuds advocates for Washington to re-prioritize investment in community-based care.

The DD Ombuds has serious concerns with Lake Burien Youth Transitional Care Facility (Lake Burien) due to its organizational mismanagement, lack of regulatory oversight, widespread abuse and neglect allegations, and the facility's use of isolation and restraint. Since Lake Burien opened in July 2024, DD Ombuds has regularly visited the facility, spoken with youth and their families, met with Lake Burien staff and Department of Social and Health Services (DSHS) leadership, reviewed the facility's records, and provided recommendations to DSHS to prevent abuse and neglect.[i] However, the DD Ombuds has grown increasingly alarmed by the conditions we have seen.

Despite its mission as a short-term stabilization facility, Lake Burien appears to follow a long-term institutional service model that has not achieved the legislature's intent to fill existing service system gaps. After bringing these issues to Lake Burien and DSHS leadership, we have not seen the facility improve and, despite its many failures, DSHS continues to publicly state that Lake Burien is successfully meeting the needs of its youth residents.[ii] For these reasons, the DD Ombuds is alerting disability advocates to the abusive and neglectful environment found at Lake Burien. DD Ombuds is hopeful that the community will advocate together to make sure Washington youth at Lake Burien are safe and cared for. To provide humane and therapeutic services, Lake Burien needs to implement independent regulatory oversight, maintain accurate and transparent incident reporting and abuse investigation findings, and end its dependency on physical de-escalation tactics. Finally, DD Ombuds advocates for Washington to re-prioritize investment in community-based care.

Just "90 Days": A Brief Background on Why and How Lake Burien Was Created

Lake Burien was created to fill a treatment gap for youth with developmental and mental health needs who are not provided the appropriate in-state services.[iii] The *Washington Thriving Strategic Plan* reports that families are waiting "months or years" before they can access care

and, when there are available services, they are not what youth and families need, especially for youth with complex behavioral health.[iv] Washington does not offer enough meaningful community services to prevent or adequately respond to a youth's behavioral health crisis. Oftentimes, these youth are stuck waiting in general hospital emergency rooms until the state can provide medically necessary services.[v] When Washington's service-system cannot offer necessary services for a youth in-state, they can be sent to harmful out-of-state placements away from their families and community.[vi]

To attempt to fill this gap, in 2024, the Behavioral Health and Habilitation Administration and Developmental Disabilities Community Services (DDCS), divisions within the Department of Social and Health Services (DSHS), received $12.3 million from the legislature to fund a staff-secure, transitional treatment facility in Lake Burien for twelve youth.[vii] The facility is charged with serving developmentally disabled youth, over the age of 13, who have co-occurring mental health disorders and need intensive behavioral health services. Lake Burien's goal is that, after stabilizing, staff will organize services the youth need to have a safe-discharge to a community-based setting, ideally, with their families. So, when the facility opened in July 2024, Governor Jay Inslee praised Lake Burien: "We're giving these kids a real chance to stabilize and begin a brighter future. This facility is the first of its kind in the nation."[viii] But despite optimism from Washington leaders, the environment at Lake Burien has been tumultuous, DSHS boasted Lake Burien was "*stood up in just 90 days*."[ix] However, there is nothing to celebrate when a facility meant to serve vulnerable children opens without proper planning.

"No More Hiccups": Organizational Mismanagement Enables a Critical Lack of Regulatory Oversight

By all appearances, Lake Burien is chaotic, disorganized, and not subject to any independent regulatory oversight. Lake Burien has dozens of abuse and neglect allegations which makes this extremely alarming. Because Lake Burien Burien's record keeping has often

been incomplete or missing altogether, DD Ombuds is unable to report the precise number of allegations.

DSHS opened and began serving youth at Lake Burien without any Standard Operating Procedures (SOPs). SOPs "standardize" a facility's operations so the appropriate protocols, such as how critical incidents should be recorded[x] and medication administered,[xi] are systematized. Leadership directed staff to begin writing SOPs after the first resident was admitted and did not finalize SOPs until five months after opening.[xii] This lack of critical guidance often left staff with contradictory directives from their leadership which is reflected in many aspects of Lake Burien's operations, but especially record-keeping. For instance, as recently as July 2025, there was an inconclusive investigation alleging improper medication administration to a youth. However, a corresponding incident report is not mentioned in the investigator's records review. A corresponding incident report should be typical for tracking medication errors.[xiii] Many of the incident reports that DD Ombuds reviewed were illegibly handwritten, and frequently omitted critical information, such as the names of involved youth, staff, and what occurred during the incident. Lacking cohesive incident reporting means it is next to impossible to form quantitative conclusions about Lake Burien's facility practices which could inform meaningful quality assurance.

Related to quality assurance, Lake Burien opened and continues to operate without any independent regulatory oversight. In a report updating the legislature on the facility's progress, Lake Burien stated they were progressing towards licensure as a residential treatment facility with the Department of Health (DOH) and accreditation through the Joint Commission but, as of January 2026, has yet to achieve this goal.[xiv] Presently, Child Protective Services (CPS), part of the Department of Children, Youth, And Families (DCYF),[xv] has investigative authority over alleged abusive incidents at the facility. Unfortunately, CPS can only investigate *individual* abuse allegations, not *facility* wrongdoing.

The difference between individual and facility abuse is complicated. For example, if an individual staff member allegedly committed physical abuse against a child, CPS could investigate. But if a facility did not train its staff on client rights leading to a staff member physically restraining a child and causing a serious injury, this could likely be a facility-wide problem. In the second example, an investigation outcome could be the facility was found at fault because it was their responsibility to ensure staff had proper training. Facility regulatory oversight, which Lake Burien does not have, ensures accountability for system-wide problems that can cause serious harm. Sometimes, these facility regulators close a facility when it is unable to meet standards.

The only regulatory oversight at Lake Burien is the Statewide Investigations Unit (SIU), DDCS' internal investigations agency.[xvi] However, *SIU cannot issue findings*, only the Lake Burien Executive Officer can "determine whether abuse, neglect, or mistreatment occurred following the receipt of the…investigation report."[xvii] These SIU investigations are not independent and many were incomplete because they did not have the Executive Officer's signature and conclusion on whether abuse or neglect occurred.[xviii] Because these investigations lacked the Executive Officer's decision and signature, DD Ombuds cannot conclude the investigations were reviewed by the Executive Officer at all.

When Lake Burien opened, DD Ombuds conveyed our concerns about the lack of independent oversight, but senior Lake Burien and DSHS leadership repeatedly assured us that CPS investigated alleged child abuse.[xix] However, after further investigation and discussion with senior DSHS and Lake Burien leadership, in September 2025, DD Ombuds discovered Lake Burien did not receive the results of CPS investigations as required. Actually, *the only people at Lake Burien who received CPS' investigation findings were the people accused of abuse*.[xx] When DD Ombuds asked how this miscommunication went unnoticed for so long, we were told that there was a "a bit of a learning curve" that the facility ran into when it was becoming established, but moving forward there would be no more "hiccups."[xxi] This "hiccup" had

continued for more than a year after the facility was already opened. DSHS and Lake Burien were completely unaware that they should have been receiving the CPS investigation results until DD Ombuds brought it to their attention.

"Against Medical Advice": Lake Burien's Track Record of Unsuccessful Discharges

As of August 2025, there have been five total discharges from Lake Burien. After having their abuse and neglect allegations unremedied by the facility, three discharges were parents who took their child home from Lake Burien. These family-members reported being afraid of how their children were cared for. Officially, Lake Burien states that all three youth were brought home "against medical advice."[xxii] The other two discharges were children the facility had removed by law enforcement who were transported via ambulance to a hospital emergency room. After arriving at the emergency room, these youth were stuck for weeks and months, without services they needed. The facility stated that they discharged these youth because they were unable to meet their needs.[xxiii] Despite being created to provide a solution to youth becoming stuck in emergency rooms, Lake Burien put children in the same problematic situation the Washington legislature created the facility to fix. These were not the thoughtful, planned discharges lawmakers intended for Lake Burien to provide.

DD Ombuds spoke with two of the three families who brought their children home from Lake Burien. The first parent removed their child from Lake Burien because they kept noticing bruises on their body. Lake Burien responded that they still were "determining whether we are logistically capable"[xxiv] of preventing the child from suffering further injuries. The other child's parents reported a wide variety of concerning abuses to DSHS leadership, such as reporting that this child was eating out of the garbage, and when asked why the child claimed they were "starving" at Lake Burien.[xxv] A different report says that this child had a strong body odor and was wearing soiled and torn clothing, they said they had no clean laundry and did not know

where their clothes were.[xxvi] Lake Burien's response was that they were taking these issues seriously, however, DD Ombuds does not see this reflected due to other incident reports around similar issues.[xxvii]

While visiting Lake Burien, DD Ombuds overheard staff members loudly telling youth residents to "get over here", "listen to me", among other commanding directives. DD Ombuds also noticed many of the youth were disheveled, without their personal hygiene needs taken care of and unclean clothing. Furthermore, we observed children with disturbing visible injuries, such as bruises on their neck. While talking with youth, they told us they wanted our help moving to a different facility, a place where staff would be "nice" to them.

In an article commemorating the one-year anniversary of Lake Burien, its Executive Officer said "I do also think our discharges have been successful; we had a discharge last month where the youth was here six months and was able to return to family."[xxviii] The only discharge DD Ombuds is aware of within that time frame was one of the children whose parents took them home without a planned discharge.[xxix] From our conversations with families and youth who have lived at and left Lake Burien, they would not qualify their discharges from the facility as "successful."

"What These Kids Need": Lake Burien's Concerning Usage of Isolation and Restraint

For a facility meant to provide therapeutic transition services, Lake Burien depends on using seclusion, isolation, and restraint against their youth residents. Certain youth are ordered to be confined to their living quarters by staff due to "safety concerns," staff lock the entrances and exits, and the only way in or out is via a staff keycard. During visits, the only "therapeutic" activities the DD Ombuds observed were children watching television in a completely bare room apart from two couches and a television bolted to the wall behind plexiglass. Certain youth do

not leave to attend school or recreational activities, sometimes, teachers will come to the cottage to teach the youth, but not on a regular schedule.

Aligning with Lake Burien's overuse of physical interventions, DD Ombuds is concerned by a potential over-reliance on law enforcement to physically de-escalate youth at the facility. Dependency on law enforcement is especially worrying because, as of August 2025, out of sixteen total Lake Burien residents, nine have been Black, Indigenous, People of Color (BIPOC). Statistically, disabled BIPOC youth are overly criminalized,[xxx] and, furthermore, disabled people make up a third to one half of all people killed by law enforcement.[xxxi] In conversations, Lake Burien leadership frequently mentioned "needing" to call law enforcement when a child was in active crisis.[xxxii] When DD Ombuds asked Lake Burien leadership how law enforcement involvement is tracked, leadership explained the facility does not record this data. Not recording data on when staff are calling law enforcement or there are law enforcement uses of force against youth highlights leadership's lack of systemic bias awareness. Leadership should consider how dependency on law enforcement traumatizes and physically endangers Lake Burien's majority BIPOC youth.

DD Ombuds reviewed numerous incident reports detailing disturbing alleged abuse against children at the facility. After reviewing many of these incident reports and SIU investigations, it appears facility staff lack critical expertise, skills, and training to safely support the vulnerable youth living at Lake Burien. This potentially explains why staff appeared to develop an over-reliance on restraining escalated youth. For example, one SIU investigation,[xxxiii] details a report alleging that a lead staff, on at least two different occasions, placed a child in a face-down prone restraint with their arm pulled up behind their back and their knee on the child's hip. The report specifically mentioned that the child looked "frightened." When asked if it was an appropriate hold, the lead staff said,

> *"I know it may seem a little aggressive, but…this is what these kids need."*[xxxiv]

Later, it was reported that the lead staff aggressively pushed another child. Afterwards, this child was seen stimming by moving their hands up and down, repeating the words "calm down" to themselves. The investigation reports concerns that lead staff was intentionally agitating children to justify physically restraining them.

The investigations drew the following conclusions: staff "purposefully antagonize[d] the child", it was "more likely than not" that lead staff used unapproved physical restraints, and the child's arm was "aggressively pulled…behind them on several occasions."[xxxv] Furthermore, the investigations stated that the facility did not notify law enforcement or guardians of these incidents and expressed concern at the statement "'staff are doing the best they can and some situations do not always get reported.'" [xxxvi]

DD Ombuds cannot say whether these SIU investigations resulted in any findings. As previously mentioned, like many other investigations, the section where the Executive Officer is supposed to make their decision about whether abuse or neglect occurred is blank. Ultimately, the lead staff in these reports was not terminated by Lake Burien and continued to be employed for months after these incidents were reported.[xxxvii] If antagonizing and physically abusing the children at Lake Burien is the "best" that staff can do, DD Ombuds wonders what troubling events are going unrecorded.

A "Brighter Future": Moving on From Institutional Care for Washington's Disabled Youth

Lake Burien was created to fill a treatment gap for developmentally disabled youth with high behavioral health needs but has yet to provide appropriately therapeutic services. Lake Burien Youth *Transitional* Care Facility does not provide a transitional, therapeutic service setting. DSHS continues to misrepresent Lake Burien's failures as successes[xxxviii] which, for all intents and purposes, masks a chaotic, disorganized, unsafe, and harmful environment.

In conclusion, the "brighter future"[xxxix] that Washington decision-makers envisioned for these youth is not possible at Lake Burien. Lake Burien is not the "first of its kind,"[xl] it returns to a history of Washington's reliance on institutional care to serve its young people. People who care about disabled youth need to demand action from our Washington policymakers. We affirm that disabled youth deserve to be provided the services they need to allow them the possibility of a future free from isolation, restraint, abuse, and neglect.

Recommendations

Achieve regulatory oversight

Stop new admissions to Lake Burien until independent regulatory oversight is in place. Independent regulatory oversight is the *bare minimum* to ensure the children's wellbeing and to hold the facility accountable. If Lake Burien cannot receive Department of Health (DOH) licensure and Joint Commission accreditation, then Lake Burien must be closed.

Ensure accurate and transparent incident reporting and abuse investigations to inform meaningful quality assurance

Lake Burien must maintain uniform and accurate records on incidents and abuse investigations at the facility. Accurate record-keeping would inform meaningful quality assurance, as well as prevent abuse and neglect. The data collected in these incidents and findings should be made available to the public to foster transparency and accountability.

End dependency on physical interventions

Lake Burien must end its dependency on physical interventions, including but not limited to the facility's uses of isolation, restraint, and a potential over-reliance on law

enforcement for de-escalation. Instead, Lake Burien needs to hire and retain staff with the appropriate expertise to serve behaviorally complex youth, as well as receive training on non-violent de-escalation.

Make LBYTCF a transitional facility

Lake Burien Youth Transitional Care Facility's service-model needs to be re-evaluated and re-organized to ensure it is truly providing person-centered, short-term, transition services in a safe and therapeutic environment. Lake Burien should request technical assistance from successful short-term stabilization services so they can provide the services they claim to offer.

Re-prioritize and reinvest in community-based services

Simply having complex behavioral health needs should not mean these youth are placed in an abusive institutional setting. The $12.3 million[xli] originally allocated to Lake Burien should be used to institute recommendations in *Washington Thriving's Strategic Plan*[xlii] and the *Bridge Forward*[xliii] report. The best way to support youth with high behavioral health needs is to provide them with the community services they need *before* youth decompensate into a behavioral health crisis. Both reports detail a critical need for "a complete continuum [of care]"[xliv] that extends beyond merely focusing on facility-based settings by building capacity for the system to serve "high-need populations and those with complex conditions."[xlv]

Dedicated to the legacy of Mike Raymond

The late Mike Raymond (1947-2025),[xlvi] spent his childhood and young adult life in an abusive institution, Rainier Residential Habilitation Center in Buckley. [xlvii] After leaving Rainier, Mike lived a full, wonderful life surrounded by his loved ones, including his wife, Diane, their daughter, and his Grandson. Mike was an incredibly powerful self-advocate who dedicated his life to helping other disabled people, especially youth, live free from segregated and isolated settings, encouraging others by saying "If I can do it, you can do it." In Mike's memory, we continue his work to ensure that young disabled people can live freely in the community.

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Endnotes

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