State of Indiana

Department of Child Services
Ombudsman Bureau

2014 Annual Report

Mission

The DCS Ombudsman Bureau effectively responds to complaints concerning DCS actions or omissions by providing problem resolution services and independent case reviews. The Bureau also provides recommendations to improve DCS service delivery and promote public confidence.

Guiding Principles

- A healthy family and supportive community serve the best interest of every child.
- Independence and impartiality characterize all Bureau practices and procedures.
- All Bureau operations reflect respect for parents' interest in being good parents and DCS professional's interest in implementing best practice.

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Jessica Shanabruch, Assistant Ombudsman - Data Analysis, Graphics

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STATE OF INDIANA

Michael R. Pence, Governor

DEPARTMENT OF ADMINSTRATION
Department of Child Services Ombudsman Bureau

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The Honorable Michael R. Pence, Governor
The Honorable Speaker and President Pro Tem
Mary Beth Bonaventura, Director, Indiana Department of Child Services
Jessica Robertson, Commissioner, Indiana Department of Administration

In accordance with my statutory responsibility as the Department of Child Services Ombudsman, I am pleased to submit the 2014 Annual Report for the Indiana Department of Child Services Ombudsman Bureau.

This report provides an overview of the activities of the office from January 1, 2014 to December 31, 2014 and includes information regarding program administration, case activity and outcomes. Included as well is an analysis of the complaints received, recommendations provided to the Department of Child Services and the agencies responses to the Department of Child Services Ombudsman Bureau.

I would like to express my appreciation for the leadership and support of Governor Pence, Department of Child Services Director Bonaventura, Commissioner Robertson and the Indiana State Legislature. Appreciation is also extended to the staff of the Department of Child Services and their diligent efforts to support the mission of the Department of Child Services Ombudsman Bureau in 2014. Their commitment to Indiana's family and children and their willingness to work to strengthen the delivery of child welfare services in the State of Indiana is greatly acknowledged! It is such support that has enabled the Bureau to grow and improve since its inception. I am truly honored to serve the citizens of Indiana as the Department of Child Services Ombudsman.

Respectfully,

Alfreda D. Singleton-Smith

Alfreda D. Singleton-Smith, MSW LSW

Director, DCS Ombudsman Bureau

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Executive Summary

Introduction

The DCS Ombudsman Bureau continued to experience substantial program growth in 2014. Following significant staff turnover experienced in 2013, training and supportive efforts were put in place in 2014 by the DCS Ombudsman Bureau to ensure the continued stability of the agency's goals in:

- effectively responding to constituent complaints in a timely manner;
- enhancing and developing program practices and guidelines;
- increasing the number of constituent responses;
- expanding outreach initiatives.

Authority

The Department of Child Services (DCS) Ombudsman Bureau was established during 2009 by the Indiana Legislature to provide DCS oversight. IC 4-13-19 gives the Department of Child Services Ombudsman the authority "to receive, investigate, and attempt to resolve a complaint alleging that the Department of Child Services, by an action or omission occurring on or after January 11, 2005, failed to protect the physical or mental health or safety of any child or failed to follow specific laws, rules, or written policies." The law also provides the DCS Ombudsman Bureau the authority to evaluate the effectiveness of policies and procedures in general and provide recommendations.

Activity Overview

During 2014 the primary activity of the office was to respond to complaints, determine findings, provide recommendations and monitor DCS responses; the recommendations provided were case specific as well as systemic. When case findings were determined to have systemic implications, policies and procedures were reviewed and general recommendations were provided. This year the DCS Ombudsman Bureau responded to 660 Information and Referral (I & R) inquiries, conducted 78 Assists, opened 256 Cases and closed 236 Cases with 19 pending closure in the First Quarter of 2015, provided 24 Case Specific Recommendations, and 10 Systemic Recommendations.

Administration

Location: The DCS Ombudsman Bureau is an independent state agency housed in the Indiana Department of Administration (IDOA). IDOA provides office space, furnishings, equipment and utilities.

Staff/Resources: The DCS Ombudsman Bureau consists of the Director and two full-time Assistant Ombudsmen. (Attachment A – Staff Biographies) Legal consultation is provided as needed by a Deputy Attorney General. Technical assistance is provided by the IDOA MIS Director. It should be noted that one Assistant Ombudsman position was vacant during the

months of November and December 2014. Despite the vacancy, the DCS Ombudsman Bureau was successful in meeting program goals during the three month period and Assistant Ombudsman Jessica Shanabruch's efforts in this regard are applauded! The vacant position was filled on January 5, 2015 when the DCS Ombudsman Bureau welcomed Jamie Anderson to the position of Assistant Ombudsman.

Budget: The Bureau was appropriated $215,675 for the 2014/2015 fiscal year, which is allocated from the general fund. The majority of the expenditures are for personnel, with the remainder devoted to supportive services and supplies. Due to the significant program growth experienced in 2013 and 2014, the DCS Ombudsman Bureau has requested funding to support staff increase during the coming biennium. Additional funding to support outreach efforts has been requested as well. Approvals for those matters are pending as of the end of 2014. Discussions with the State Personnel Department began in the fall of 2014 to address the need for a salary increase for the Assistant Ombudsman position in an effort to recruit and retain talent with skill sets, knowledge, and experience comparable to the job responsibilities. To that end, the current job description is being written to better align with work activities that demonstrate the distinct problem resolution and leadership aspects of the Assistant Ombudsman position.

Program Development

Update Regarding New Case Categories: The "Assist" category was added to the DCS Ombudsman Bureau database in 2012 to reflect those contacts that resulted in the DCS Ombudsman Bureau's office facilitating communication between the complainant and DCS. Assists require more involvement than an I & R response, but less than that of a Review or Investigation. During 2013, the DCS Ombudsman Bureau completed 39 Assists which is 7 less than the 46 Assists reported in 2012. ***The DCS Ombudsman Bureau completed 78 Assists in 2014 which is two times the number completed in 2013. The use of the Assist category continues to demonstrate that communication between complainants and DCS is key to resolving differences between stakeholders.***

During 2012 the DCS Ombudsman Bureau also began participating in "Peer Reviews" in collaboration with DCS. Peer Reviews are conducted following a child fatality/near fatality that involves DCS history within the prior year; the review team is composed of two DCS Regional Managers and the DCS Ombudsman. The purpose of the Peer Review is to identify learning opportunities. The DCS Ombudsman Bureau participated in a number of Peer Reviews during 2014 and was able to provide feedback regarding system strengths and challenges.

Policies and Procedures: The *Procedures and Practices Guidelines* for the DCS Ombudsman Bureau, which is posted on the agency's website, was updated during December 2014. The manual continues to be a viable resource for sharing information regarding the policies and practices of the DCS Ombudsman Bureau. The manual serves as an important mechanism for guiding the operations of the bureau pursuant to statute (Indiana Code (IC) 4-13-19 and informing constituents of the agency's policies and practices.

Website Enhancements: The DCS Ombudsman Bureau continues to monitor the website to ensure that it is functioning properly and that information provided remains relevant to meet the needs of Indiana constituents.

Tracking and Reporting: This office continues to compile quarterly reports to document complaint/case activity each quarter and to track responses to recommendations. The quarterly reports are shared with DCS and serve as a working document for their agency as well. The information from the quarterly reports is used to compile basic information for the Annual Report.

Outreach: In an effort to increase public awareness of the office in 2014 pursuant to IC 4-13-19-5 (a) (5), the DCS Ombudsman Bureau developed several strategies. Educational presentations continue to be available to the public and can be requested via the website. In 2014, the DCS Ombudsman Bureau participated as an exhibitor at the Indiana Youth Institute's Kids Count Conference; the DCS RAPT Conference and Prevent Child Abuse Indiana Conference to disseminate educational material and network with child welfare and other child and family serving professionals. Brochures and posters are available to all local DCS offices. The DCS Ombudsman Bureau also provided information regarding the 2013 Annual Report to the Child Services Oversight Committee; the Indiana University School of Social Work and DCS Regional Managers. The director of the DCS Ombudsman Bureau was appointed to the Indiana Supreme Court Committee on Underrepresented Litigants in the fall of 2013 and is also a statutory member of Indiana's Statewide Child Fatality Review Team, a multidisciplinary team charged with reviewing child fatalities. The DCS Ombudsman Bureau will continue to develop strategies designed to reach constituents, specifically those individuals that are least likely to access DCS Ombudsman Bureau services. These include but are not limited to parents, grandparents and other relatives and service providers.

Training: The DCS Ombudsman Bureau continues to participate in educational programs, including the National Conference provided by the United States Ombudsman Association (USOA). The DCS Ombudsman is a member of the Child Welfare Chapter of the USOA, which is available telephonically for consultation, support and education. DCS Ombudsman Bureau staff also participated in trainings provided by DCS; Prevent Child Abuse Indiana; and, Kids Count Indiana in addition to webinars and the reading of books and articles with information of interest to this office. DCS Ombudsman Bureau staff also participated in the first staff retreat in 2014. The retreat was designed to assess the internal and external challenges (strengths, weaknesses, opportunities and threats) and to develop strategies for addressing identified goals specific to the DCS Ombudsman Bureau's mission.

Metrics: The DCS Ombudsman Bureau continues to track the turnaround time for responses to complaints, completions of reviews, and investigations. The metrics indicate the DCS Ombudsman Bureau continues to exceed the goals established for best practice related to response to constituents as defined below.

Identified Task	Goal	2013 Metric (Average)	2014 Metric (Average)
Days From Inquiry to Response	1 day	.11 days	.18 days
Days Case Remains Open	30-60 days	27.5 days	26.14 days
Days Investigation Open	60-90 days	101.75 days	71.98 days

Collaboration with DCS

Communication: The Director of the DCS Ombudsman Bureau meets regularly with Doris Tolliver, DCS Chief of Staff and Jane Bisbee, DCS Deputy Director, Field Operations to discuss individual complaints, investigations, agency policies, programs, practice and recommendations. All specific case reviews and/or investigations are initiated by contacting the Local Office Director, who ensures that the DCS Ombudsman Bureau is provided all requested information and/or facilitates staff interviews.

Information Access: DCS has provided the DCS Ombudsman Bureau with access to all records on the MaGIK Casebook system and MaGIK Intake, in addition to the DCS reports available on the DCS intranet. The DCS Ombudsman Bureau also has the opportunity to review case files and interview DCS staff as necessary.

Fatalities/Near Fatalities: To ensure this office is aware of child fatalities/near fatalities with DCS history the Hotline forwards all such reports to the DCS Ombudsman Bureau to track and/or assess for further review. In addition, the DCS Ombudsman Bureau participates in the Peer Review process on the cases that meet the criteria.

Other

The DCS Ombudsman Bureau is unable to draw any conclusions about the general status of children in Indiana pursuant to IC 4-13-19-10(b) (2), as the focus of the bureau has been on the complaint process. It is noted, however, that the Indiana Youth Institute annually publishes Kids Count in Indiana, a profile in child well-being data book, which provides data on the general status of children in Indiana. The *2014 Data Book Executive Summary* is available in the office of the DCS Ombudsman Bureau and the full Indiana Data Book is available at no cost at www.iyi.org/databook .

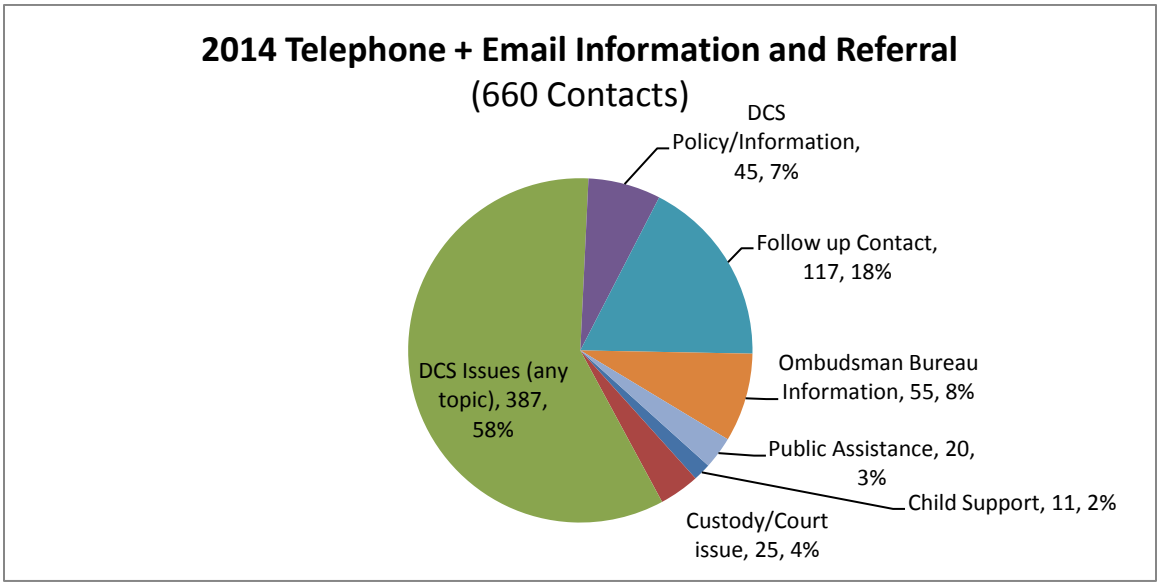
Complaints

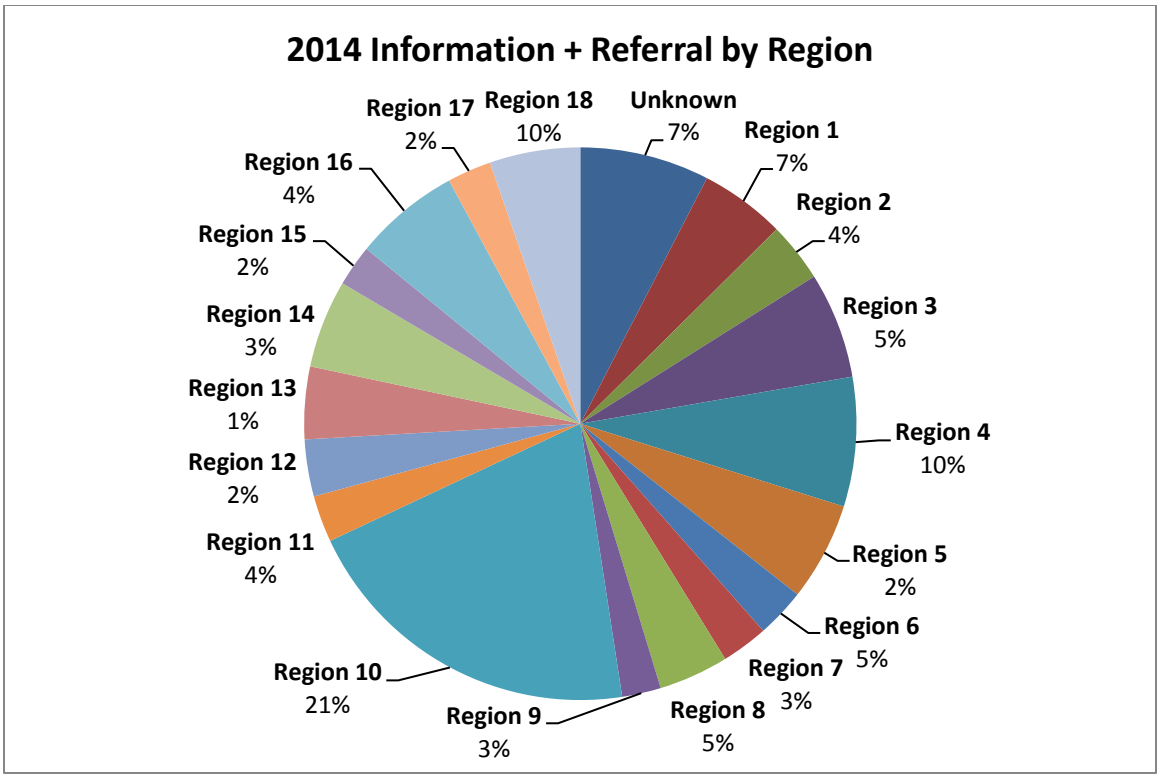
The Process Overview

The DCS Ombudsman Bureau receives many telephone and email inquiries that do not result in an open case, but require an information and/or referral response. To track this service, pertinent information about the contact is recorded in the Information and Referral (I & R) contact log database. Some inquiries require assistance with a resolution, but do not necessitate opening a case file. This level of response is referred to as an Assist; the pertinent information about the Assist is tracked and recorded in the Assist database. A case is opened when a complaint form is received. The complainant is notified of the receipt of the complaint and an intake process is initiated to determine the appropriate response. DCS is notified of the complaint following the intake assessment, after which a variety of responses are possible. The DCS Ombudsman Bureau may initiate an investigation, resolve and/or refer after a thorough review, refer the case back to DCS, refer to Child Protection Team (CPT), file a Child Abuse/Neglect Report, decline to take further action, or close the case if the complainant requests to withdraw the complaint. Following a review the complainant and DCS are informed in writing in a letter as to the outcome. If a case is investigated, a detailed report is completed and forwarded to DCS and complainant if they are a parent, guardian, custodian, Court or Court Appointed Special Advocate (CASA)/Guardian ad Litem (GAL). Other complainants receive a general summary of the findings. If a complaint was determined to have merit, recommendations are provided to address the issue, and DCS provides a response to the recommendations within 60 days. The flowchart in Attachment C illustrates this process.

Information and Referral Inquiries

The office received 660 I & R Inquiries during 2014 which is a significant increase of 53 inquiries over the number received in 2013. The graphs below illustrate the topics of inquiry and the origin by DCS Region of origin.

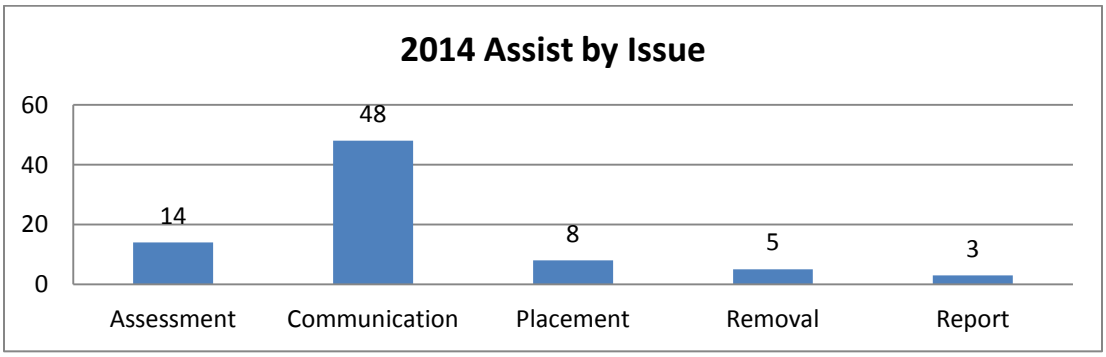


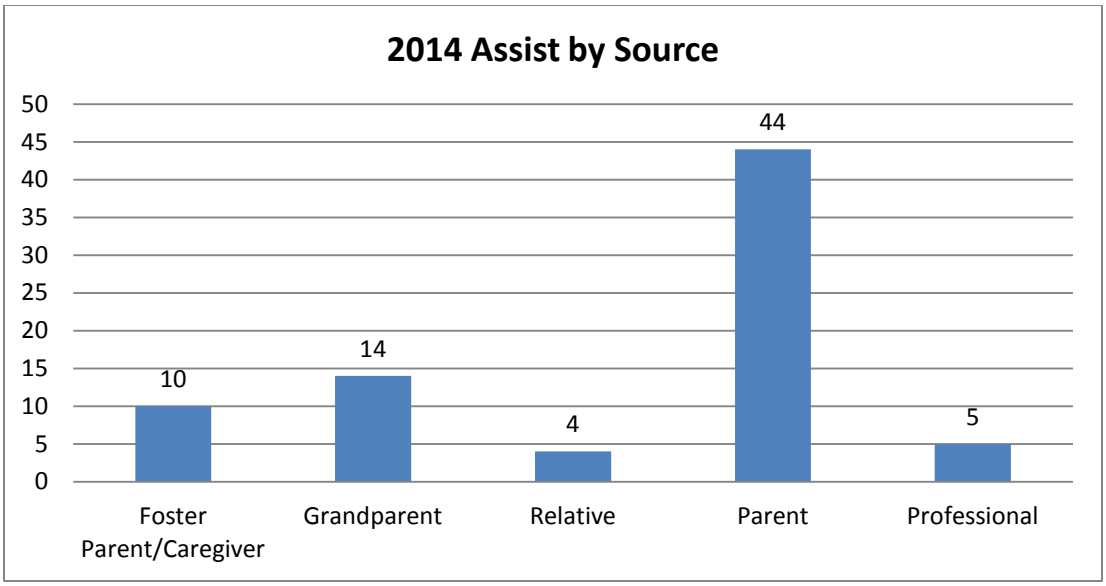


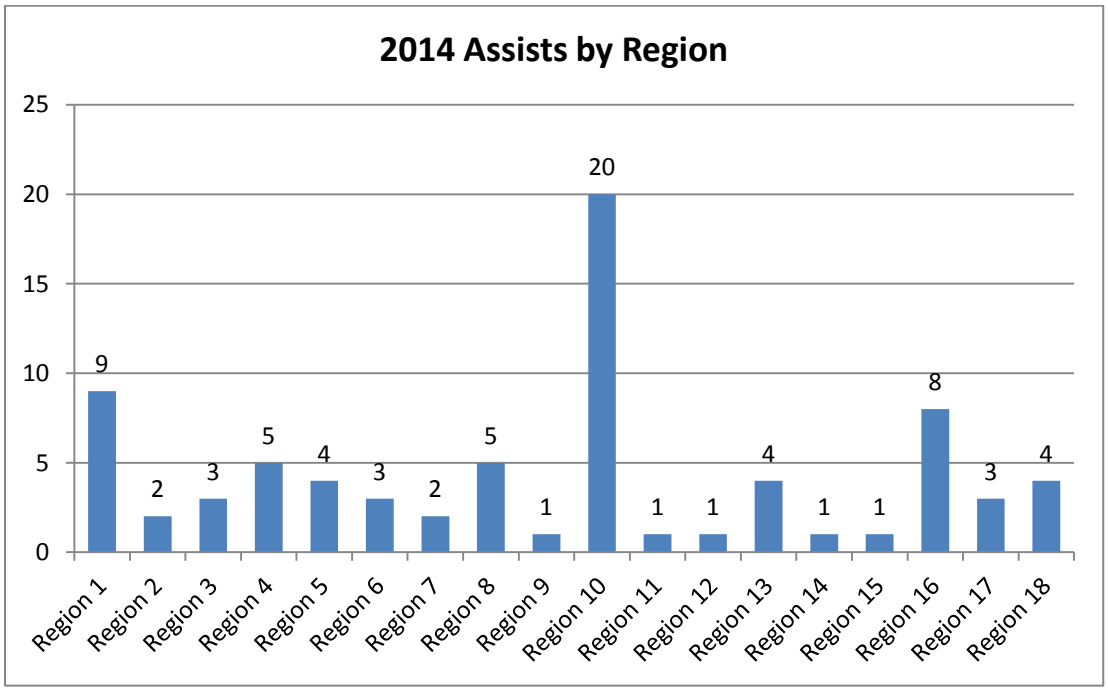
The I & R function has proven to be a valued service for constituents. Providing potential complainants with education regarding the DCS process and/or contact information for DCS staff is often the first step to a successful resolution. It is noted that the number of I & R inquiries has progressively increased each year. (See Attachment C for a Regional map.)

Assists

Assists occur when a formal complaint is not necessary, but a higher level of involvement is required than an I & R response. Assists are appropriate when communication and/or clarity of specific aspects of a case are the main concerns. During 2014 the DCS Ombudsman Bureau performed 78 Assists. The following graphs illustrate additional details about the Assists:





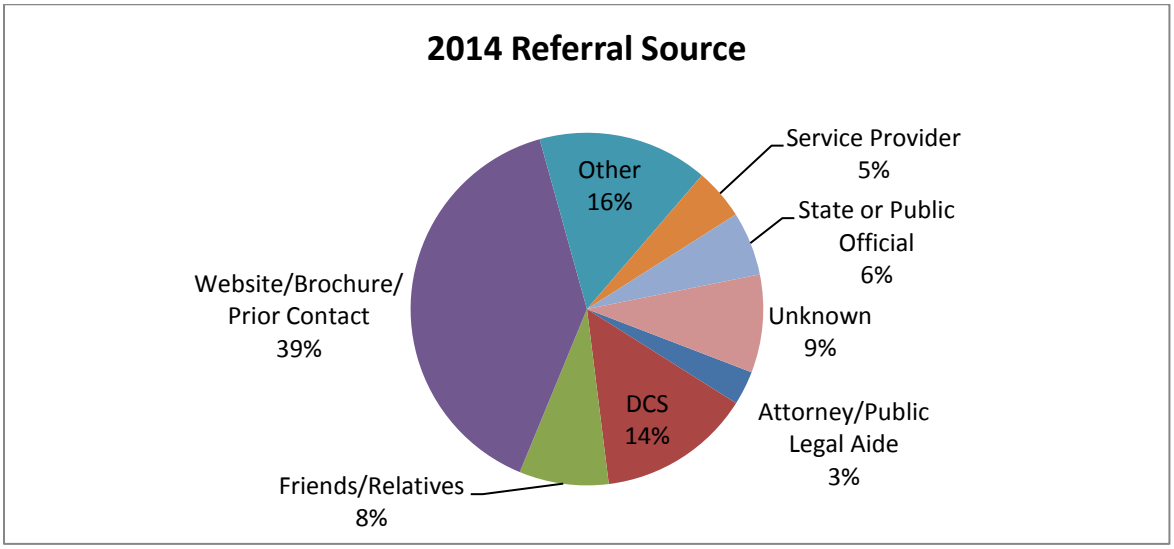


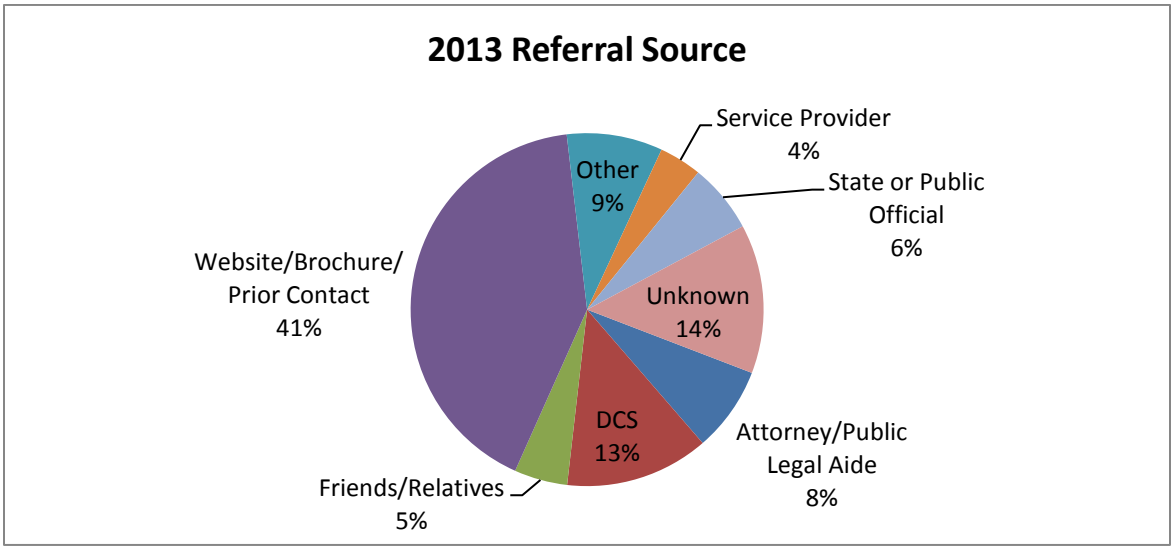
Cases

During 2014, the DCS Ombudsman had 256 active cases; 256 cases opened; and, 236 cases were closed with 19 cases pending validity outcomes in the first quarter of 2015. The increase in the number of active cases in addition to the increase in the number of I & R inquiries (660) and Assists (77) in 2014 suggests heightened community awareness about the DCS Ombudsman Bureau.

Referral Source

2012 marked the first year that the DCS Ombudsman Bureau began requesting information from complainant's on how they learned about the bureau. Comparison of 2013 and 2014 data suggest that Website/Brochure/Prior Contact continues to be the largest source of referrals. There has been a slight increase of referrals from Attorney/Public Legal Aide (5%) while other referral sources have remained constant. Unknown reflects those individuals that chose not to identify a referral source during intake discussions with the Bureau or on complaint forms.

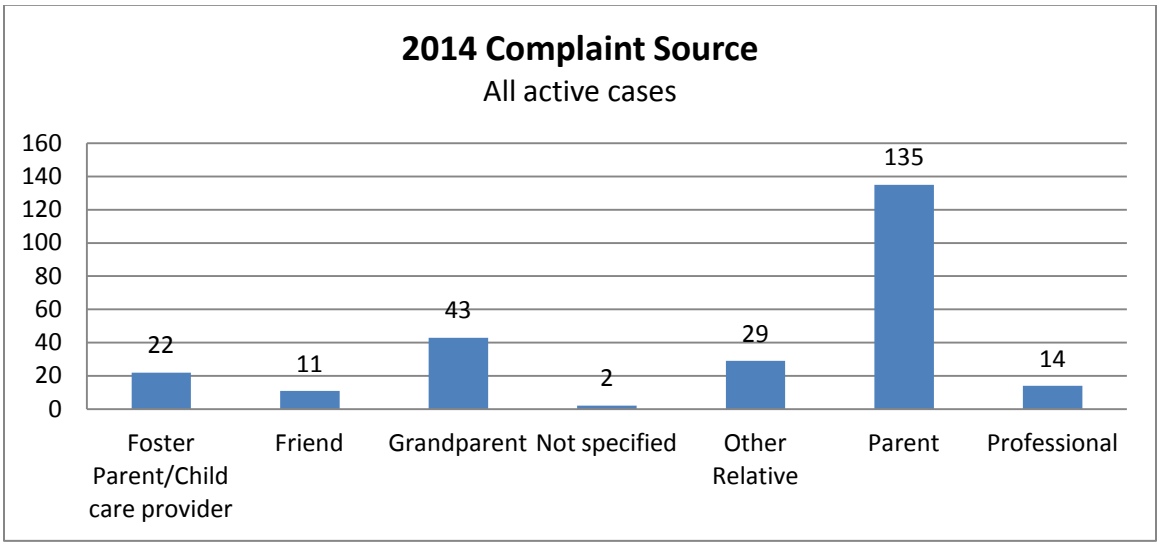


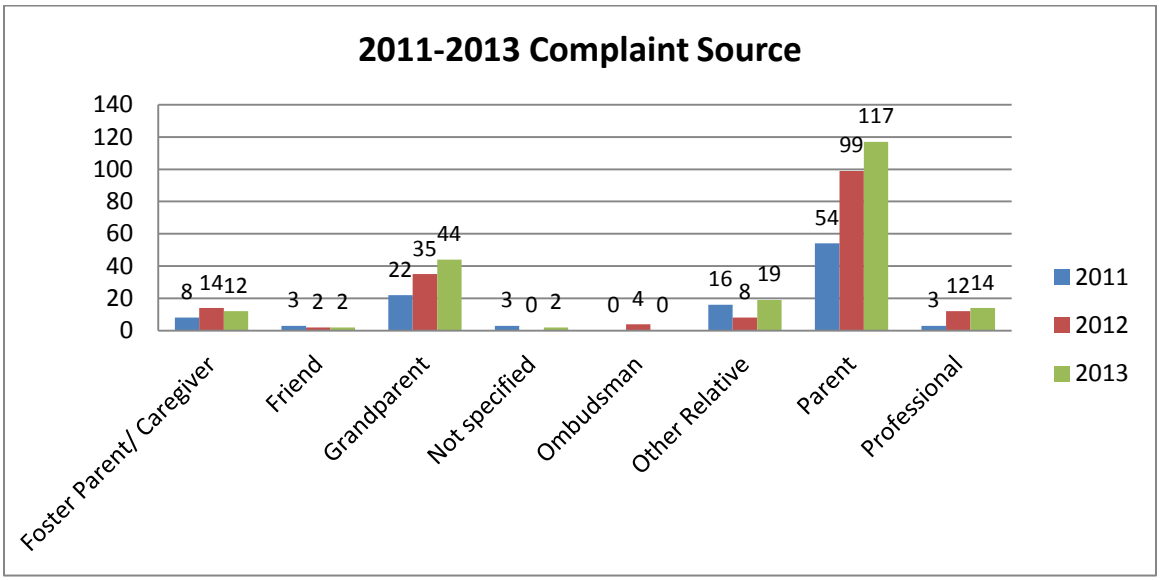


Complaint Source

Except as necessary to investigate and resolve a complaint, the complainant's identity is confidential without the complainant's written consent. The complainant is given the opportunity to provide written consent on the complaint form. During 2014 parents continued

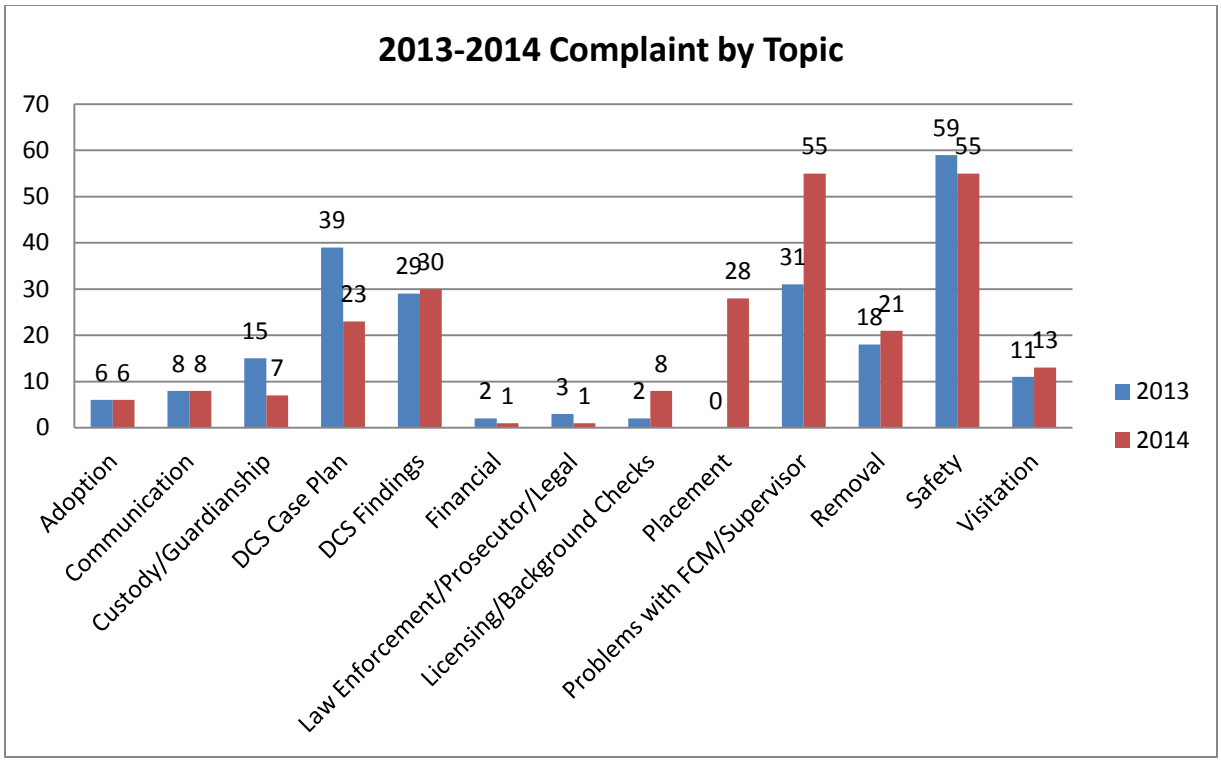
to make up the greatest share of complainants followed by grandparents. It should be noted that there was a slight increase from Other Relatives (29) and Foster Parents/Child Care Provider (22).





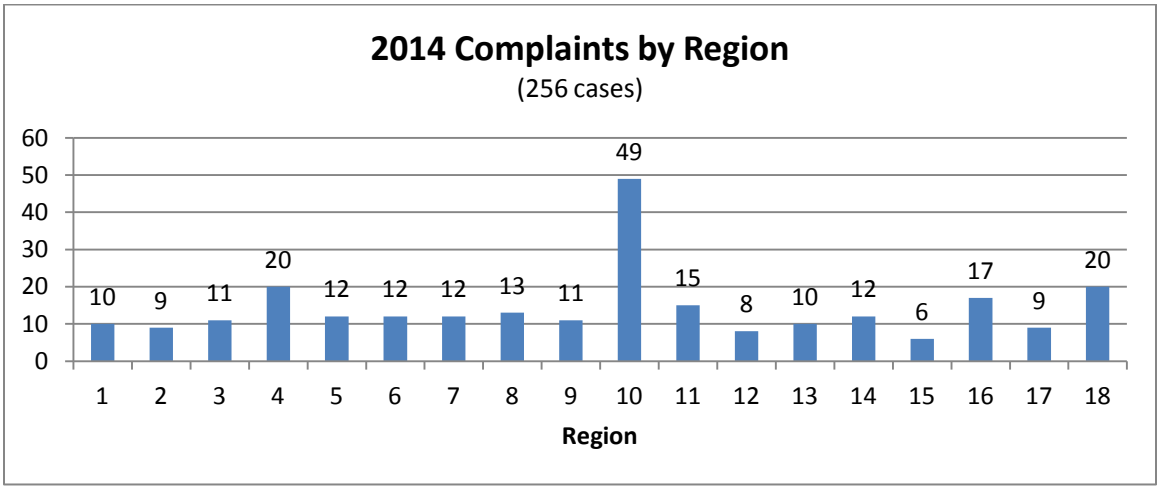
Complaint Topics

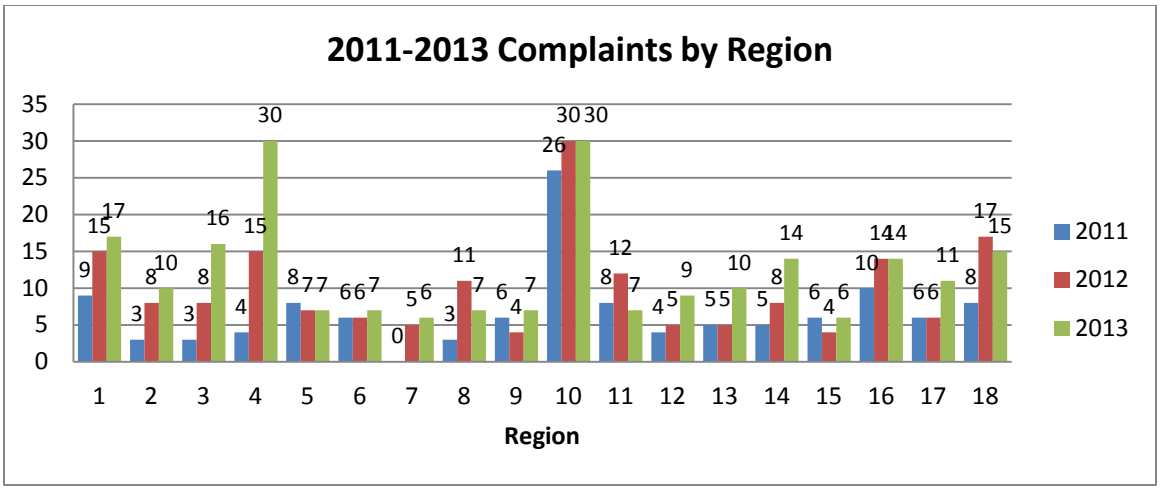
During 2013 the major complaint topics included *Child Safety*, *DCS Case Plan*, *Problems with FCM/Supervisor*, *DCS Findings, and Problems with Family Case Manager/ Family Case Manager Supervisor*. There is a continued trend of complaint topics from previous years, as illustrated in the graph below.



Complaints by Region

As DCS is organized in Regions, the DCS Ombudsman Bureau tracks contacts and cases accordingly. The first graph below illustrates the complaint activity in each of the eighteen regions for 2014. The second graph depicts a comparison from prior years.





Response Categories

When a complaint is filed with the office, a case is opened and a preliminary review is completed to determine the appropriate response. A variety of responses are possible depending on case specifics. Following is a description of each type of response:

Review/Refer or Resolve: This type of response involves a comprehensive review of the case file and documentation provided by the complainant. The local office provides additional documentation requested and responds to questions from the DCS Ombudsman Bureau. Other professionals are contacted for information as needed. While the review is thorough, the focus is on providing a resolution or a strategy that can assist with a resolution. Depending on the circumstances in each case, some cases that are reviewed receive a validity determination and others do not. In either case, the complainant and DCS are notified of the findings in writing. A major portion of the complaints received fall into this category.

Investigate: An investigation also involves a review of the case files and documentation provided by the complainant. As needed, DCS staff involved with the case, in addition to the (CASA/GAL) and service providers, are interviewed. Case specific laws, rules and written policies are researched. Experts are consulted if needed. Complaints that result in an investigation tend to have multiple allegations with little indication that a resolution is likely. Upon the completion of an investigation, an investigation report is submitted describing in detail the findings of fact regarding each allegation and a determination of the merit of each allegation in the complaint. The report is provided to DCS and the complainant if they are a parent, guardian, custodian, GAL/CASA, or Court. If the complainant is not one of the above they are provided a summary of the findings in general terms. During 2014, four cases resulted in an investigation.

Refer Back to the Local DCS: Pursuant to statute, the DCS Ombudsman Bureau requires that complainants attempt to resolve their issues with the local DCS office through the DCS internal complaint process prior to filing a complaint with the DCS Ombudsman Bureau. On occasion, it

is discovered during the intake assessment that the complainant overlooked this step and failed to address his/her concerns with the local office before filing the complaint. These cases are referred back to the local office. Appropriate contact information is provided. The complainant may reactivate the complaint if a resolution is not reached.

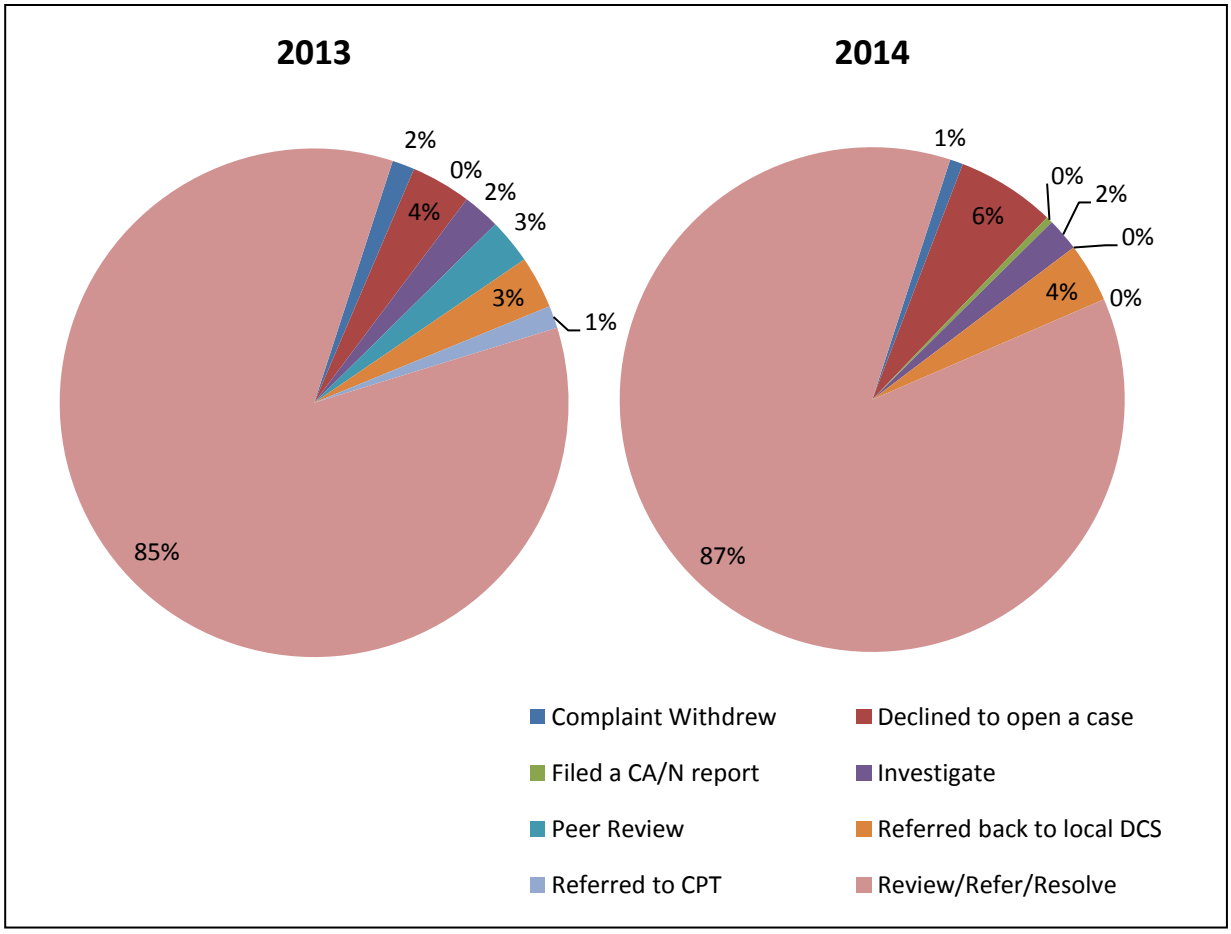
Close due to Complainant Withdrawal: Some cases have been closed prior to completion because the complainant decides to withdraw the complaint during the process.

Decline: Cases that are not within the Ombudsman's jurisdiction or otherwise meet the criteria established in the procedural manual for screening out will be declined.

Refer to Child Protection Team: The Ombudsman has the option of seeking assistance from the local Child Protection Team (CPT) and may refer cases to the team for review.

File a Child Abuse Neglect (CA/N) Report: In the event the information disclosed in the complaint to the Ombudsman contains unreported CA/N, a report is made to the child abuse hotline. This is not a frequent occurrence.

The following graph illustrates the frequency of each type of response for 2013 and 2014.



Complaint Validity

The standard for determining the validity of the complaint is outlined in the statute. If it is determined DCS failed "to protect the physical or mental health or safety of any child or failed to follow specific, laws, rules, or written policies", a complaint is considered valid. All investigations generate a validity finding, but all reviewed cases do not, depending on the specific case circumstances. When determining the merit of a complaint, the following designations are applied.

Merit: When the primary allegation in the complaint is determined to be valid following a review or an investigation, the complaint is said to have merit.

Non-Merit: When the primary allegation in the complaint is determined not to be valid following a review or investigation, the complaint is said not to have merit.

Both Merit and Non-Merit: When there are multiple allegations, each allegation is given a separate finding. This designation is applied when some allegations have merit and others do not.

Not Applicable (NA): Some cases that are opened for a review reach closure without receiving a validity determination. In these instances the findings fall into one of the categories below:

- NA/Complainant Withdrew
- NA/Case Declined
- NA/Reviewed & Referred
- NA/Reviewed & Resolved

Unable to Determine: Occasionally the information uncovered is so conflicting and/or the unavailability of significant documentation renders it impossible to determine a finding.

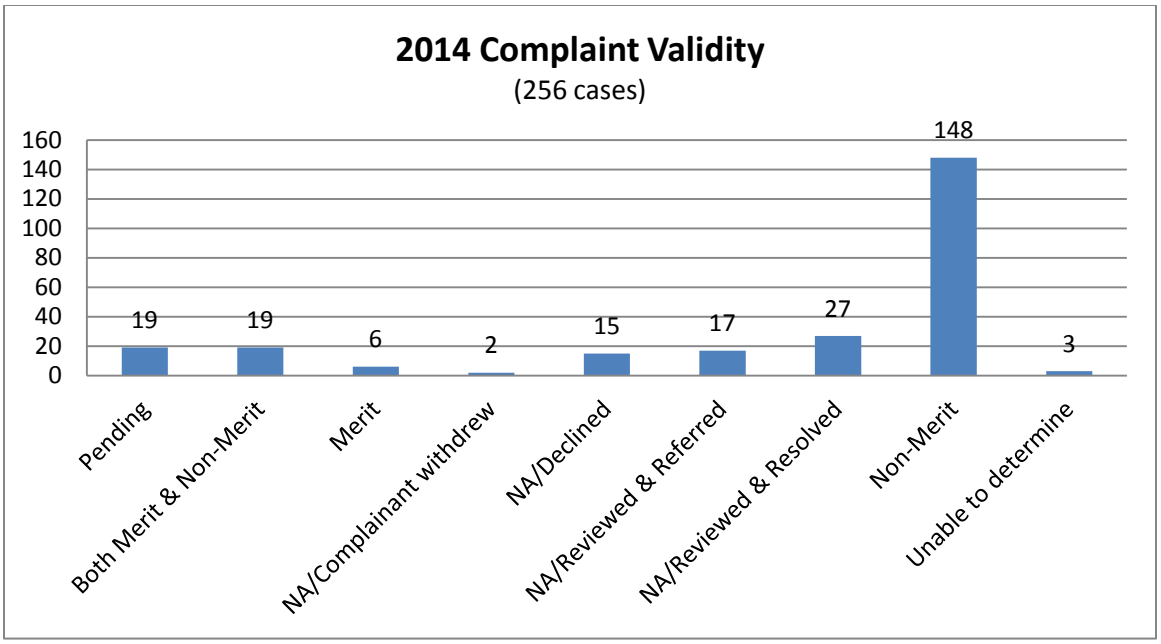
Peer Review: When the Ombudsman participates in a collaborative review with DCS a case is opened to reflect that a review is occurring. However, the peer reviews do not receive a validity determination, and the results of the review are internal and deliberative.

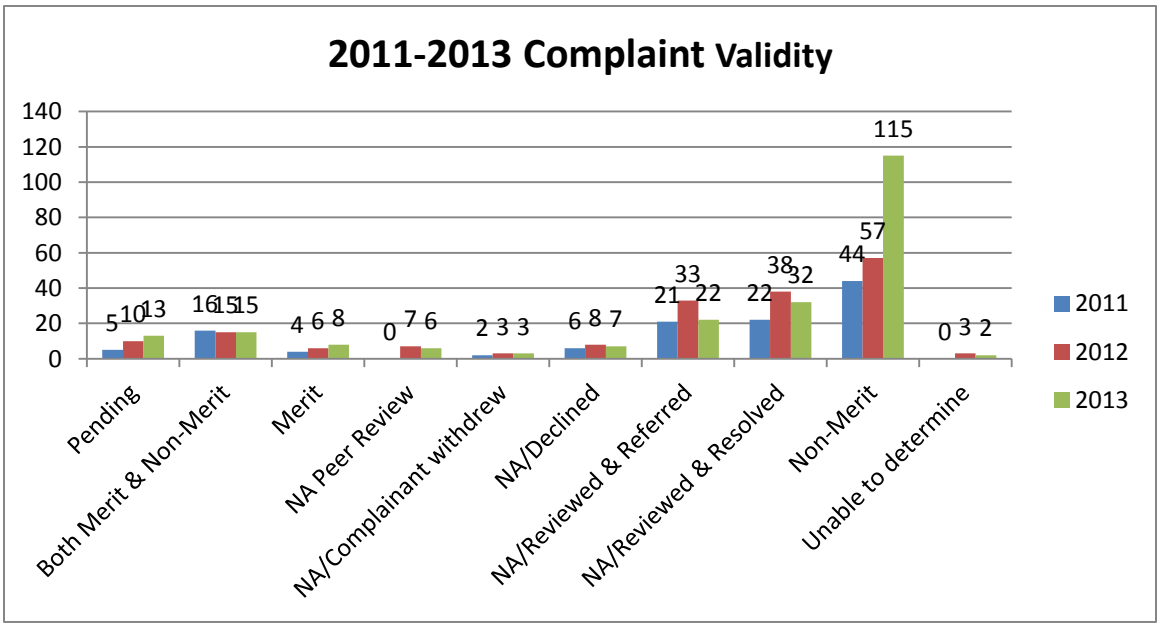
Outcomes

During 2014 validity designations were determined in 256 cases. Of these 256 cases, 6 were determined to have merit, 19 had allegations that were both merit and non-merit, and 148 were determined not to have merit. Thus 11% of the cases with validity designations by the end of 2014 involved an allegation that was determined to have merit, and 62% did not have merit. The other 27% fell into other categories. It should be noted that the 19 complaints pending a validity outcome in 2014 were completed during the First Quarter of 2015.

Based on this information it can be generalized that most of the cases that come to the attention of the DCS Ombudsman Bureau are most appropriately managed by completing a thorough review for the purpose of facilitating a resolution or providing a resolution strategy. For this reason it would be counterproductive to issue a finding. On the other hand, some

reviews, and all investigations, involve the depth of analysis that result in detailed findings that generate recommendations. This latter group comprises a smaller portion of the Ombudsman caseload, but no less significant. There are valuable lessons to be learned from all Ombudsman intervention. The following graphs provide an illustration of the validity outcomes for 2014 as well as a comparison with prior years:





DCS Ombudsman Bureau Recommendations and DCS Responses

During 2015 the Ombudsman offered 38 recommendations on 24 specific cases following a review or an investigation and ten (five carried over from 2013) general recommendations with systemic implications.

Case Specific Recommendations

Pursuant to IC 4-13-19-5 (f), "If after reviewing a complaint or conducting an investigation and considering the response of an agency, facility, or program and any other pertinent material, the office of the Department of Child Services Ombudsman determines that the complaint has merit or the investigation reveals a problem, the Ombudsman may recommend that the agency, facility, or program:

(1) consider the matter further;
(2) modify or cancel its actions;
(3) alter a rule, order, or internal policy; or
(4) explain more fully the action in question."

DCS is required to respond to the recommendations within a reasonable time, and the Bureau has established 60 days for the response time frame. The case examples include a sample of cases reviewed or investigated in 2014 in which the allegations were determined to have merit or both merit and non merit and recommendations were provided and responses received.

These examples are provided to depict the wide range of issues that are brought to the attention of the Bureau and the types of recommendations offered. The DCS Ombudsman Bureau affirms the actions of DCS in the majority of cases reviewed and it is important to maintain this perspective when reviewing cases in which concerns were identified.

CASE EXAMPLE #1:
The complainant in this case alleged that DCS' failure to complete a thorough assessment regarding a report of abuse and neglect, which resulted in the removal of the children from the home of the birth mother and placement in the birth father's home. The complainant also reported concern with the care of the children in their birth father's home, and stated that DCS had delayed in providing counseling services to the family, visitation for the maternal grandparents, and failed to hold a Child and Family Team Meeting (CFTM) in a timely manner.
Findings:
Upon review of case records and documentation provided by the complainant, the DCS Ombudsman Bureau determined that allegations regarding assessment findings were being addressed through the administrative process and that custody issues between the birth mother and birth father as well as grandparents' rights did not fall under the jurisdiction of the

DCS Ombudsman Bureau. The complainant was advised to pursue those issues under the appropriate legal venues. Additionally, documentation revealed that allegations regarding the provision of services for family members were also without merit. It was noted that while there was no merit to the complainant's concerns, there were indications that workflow issues existed as a result of the county's staffing needs. The Local Office had put a plan in place to address issues of timeliness.

Recommendation:

The DCS Ombudsman Bureau was in agreement that the plan presented by DCS was the best approach to manage the workflow issues considering the circumstances. It should be noted that the FCM and FCMS did an excellent job of managing the workflow for this case as well as others during this time. The DCS Ombudsman Bureau requested an update on the county's ongoing plans to address workflow needs as new staff come onboard.

DCS Response:

The Local Office provided a detailed time specific plan that addressed workflow challenges that incorporated existing and newly hired staff. The plan included deadlines to address overdue assessments and case plans.

CASE EXAMPLE #2:

The complainant in this instance alleged that DCS failed to protect a child by ignoring safety concerns raised by the child's birth father, failed to consider the birth mother's history of neglect, and refused to make referrals for counseling for the child and the birth father subsequent to the recommendations of service providers. The complainant also reported that DCS failed to consider relative placement and denied the birth father his parenting time.

Findings:

Upon review, The DCS Ombudsman Bureau found the specific allegations of the complainant to be without merit. All child abuse/neglect reports were assessed according to policy as were all case management decisions made on behalf of the child and the family. However, there was concern that specific documentation was missing from the case record. It is recognized that situations exist where the DCS data entry system, MaGIK, might not reflect some occurrences of actions during the life of the case due to workload and staffing issues or due to the overwhelming amount of information received during a given period. However, pursuant to *Child Welfare Policy 5.2 Gathering Child Welfare Information*, "…the most accurate information should be documented into ICWIS (now MaGIK) or the child's case file as needed."

Recommendation:

The DCS Ombudsman Bureau recommended that the local office initiate a plan to ensure that documentation of case management actions are entered into MaGIK pursuant to *Child Welfare Policy Chapter 5.2 Gathering Child Welfare Information.*

DCS Response:

The Local Office provided a detailed plan to ensure accurate and detailed documentation of case actions during the life of the case.

CASE EXAMPLE #3:

The DCS Ombudsman Bureau received a complaint from a grandparent alleging that DCS failed to protect the child from abuse and neglect while in foster care placements. Further the

allegations included abuse of power by DCS staff and that DCS was pursuing permanent removal of the children from their parents.

Findings:

A review of the case file indicated that DCS completed all assessments in regards to the children in foster care pursuant to child welfare policies. While no merit was found to exist in the allegations brought by the complainant, there was concern that the child's foster parents might be struggling with the challenges of fostering and might not be availing themselves of services and support that would assist them in the long term care of the child should the permanency plan be changed to adoption.

Recommendation:

The local office was advised to schedule a CFTM and to develop a plan of action to encourage the foster parents to participate in therapy and skill building activities.

DCS Response:

The importance of following up on services and CFTMs were discussed with the foster parents. All service providers are pleased with the participation of the foster parents.

CASE EXAMPLE #4:

The complainant alleged that DCS failed to complete a thorough assessment regarding allegations of abuse and neglect because notification regarding the outcome of the assessment was not provided to the birth mother until she requested the Assessment Report some 6 months after the Family Case Manager's (FCM) visit to asses allegations of abuse and neglect of the children. The birth mother noted that the local office had failed to correct information provided on the initial abuse/neglect report. The complainant wanted the case record corrected and the Assessment Report expunged.

Findings:

The DCS Ombudsman review indicated that incorrect information provided by the Report Source was not corrected in the Assessment Report. Facts discovered during the home visit were also not reported accurately and the Assessment Report was well over 185 days late. The Local Office advised that the disparities occurred when the initial Family Case Manager Supervisor (FCMS) left the agency. The newly assigned FCMS had limited knowledge of the case and approved it without making the necessary corrections. The DCS Ombudsman Bureau found merit to the allegations that the Assessment was not completed according to policy. The Local Office worked with the DCS Ombudsman Bureau to make as many changes to the case record as permitted by policy. The complainant was advised that decisions regarding expunging the case records fell outside the jurisdiction of the DCS Ombudsman Bureau and the complainant was provided contact information for the Local Office.

Recommendations:

The DCS Ombudsman Bureau requested that the Local Office provide information regarding current procedures in place to assist FCMS in the accurate, timely review and approval of Assessment Reports during transitions of staff and/or caseloads in compliance with *Child Welfare Policy 4.25: Completing the Assessment Report.*

DCS Response:

The local office reviewed *Child Welfare Policy 4.25: Completing the Assessment Report* with staff and ensured that FCMS would review all reports for accuracy and completeness, and

"Approve" the report as deemed appropriate. The local office also developed an internal tracking system with procedures to assist staff in preventing overdue assessments as well as any future inaccurate reports.

CASE EXAMPLE #5:

The initial complainant alleged that the DCS failed to adequately protect Child A by placing her in a home that could not meet her needs relative to past sexual molest.

Findings:

A review of the case indicated that Child A was adjusting well to the placement. The Foster Care Support Specialists (FCSS) worked closely with the foster parents to ensure they understood the specific needs of children with sexually aggressive behaviors and would be able to protect themselves and others against false allegations by Child A. Additionally, Child A and the foster parents were participating in therapy to address past sexual abuse and issues of anger and aggression. The complainant's allegations were found to be without merit.

However, during the review period, Child A's brother (Child B) who was in a different placement, needed to be moved at the request of his foster mother. The Family Case Manager (FCM) spoke with Child A's foster parents prior to the placement and plans were made to place Child B into the home with his sister. Case records indicate that the RFCS was not in agreement with the planned change in placement, as the RFCS, as the RFCS felt that the foster parents did not fully understand Child B's extreme needs. Despite misgivings about the placement, the RFCS worked diligently with the FCM and the foster parents to transition Child B into the foster home. The Family Case Manager Supervisor (FCMS) supported the RFCS' efforts by following up with the foster parents, identifying the need for a Child and Family Team Meeting (CFTM) to develop a safety plan and requesting that previous foster parents serve as mentors to the current foster parents. The children's FCM also made referrals for family counseling to a local service provider.

Recommendation:

While the original complaint was found to be without merit, the DCS Ombudsman Bureau had the following case management concerns regarding the timely application of the comprehensive Child and Adolescent Needs and Strengths (CANS) Assessment pursuant to *Child Welfare Policy 4.32 Child and Adolescent Needs and Strengths Assessment*; documentation of therapist assessments; and, the necessity for clear communication between DCS staff to ensure that services and safety plans were in place to ensure the anticipated needs of foster children and resource parents.

DCS Response:

The local office provided documentation verifying the timely completion of the CANS assessment and therapist's involvement for the children and the foster family. Communication between FCM staff and FCS staff was addressed on a regional level.

CASE EXAMPLE #6:

The complaint filed with the DCS Ombudsman Bureau alleged that DCS ignored the recommendations of the residential care providers' concerns for the child's physical and mental health. The complainant believed that the FCM failed to consider child's emotional response to

the quick transition from residential treatment into foster care, and also failed to follow policies with regard to communication and planning.

Findings:

An investigation by the DCS Ombudsman Bureau determined that there was no merit to the allegation that DCS failed to consider the child's emotional response to a quick transition from residential to foster care. Rather, records indicated that DCS felt that a longer transition would have caused additional trauma to the child. While the child's transition to the new placement went exceptionally well, it was noted that the impact of a well planned transition should never be underestimated pursuant to practice guidelines noted in *Child Welfare Policy 8.4 Emergency Shelter and Urgent Residential Care Review and Approval*.

The DCS Ombudsman Bureau found merit in the allegation that DCS failed to follow policy with regard to communication and planning. The case had been opened 6 months before a Child and Family Team Meeting (CFTM) was held. *Child Welfare Policy 5.7 Child and Family Team Meetings* requires DCS to facilitate a CFTM at critical case junctures, such as a change in placement, and throughout the life of the case. DCS Policy also states that if a CFTM is not completed, a case conference will be held, which in this case, would have been sufficient to develop a plan for services and the transition.

Recommendation 1:

The DCS Ombudsman Bureau recommended that in the future, DCS consult with the Clinical Specialist to address differences of opinions regarding a child's placement transitions from residential facilities.

DCS Response:

DCS will consult with the Clinical Specialist on all transitions out of a residential facility where there are differences of opinion between the agency and the facility. The local office will try to staff all transitions with the Clinical Specialist to support proper placement and a smooth transition.

Recommendation 2:

Though challenges were noted such as CFTM training and availability, DCS acknowledged that there were opportunities to have a CFTM. These were missed opportunities for team planning to support the desired outcome. For this reason, it was requested that DCS identify appropriate solutions to the challenge that DCS faced in facilitating a CFTM. Specifically, how will DCS ensure that CFTM's or case conferences are facilitated in the future when DCS is low on staff and the FCM assigned is not trained on facilitating CFTM's?

DCS Response:

In the future, DCS will find an alternative to facilitate a CFTM. DCS will utilize another trained FCM, a Supervisor, a Peer Coach, or a Local Office Director to conduct the meeting. The CFTM will be a priority. Supervisors will monitor cases to ensure that CFTM's are held when needed in all cases.

Recommendation 3:

It is recommended that DCS approve a case plan, which will include objectives for the child. In order to do so, it may be helpful to facilitate a CFTM focused on the child's treatment and services. This way the child can participate and feel more empowered by having a say in treatment, and promote client engagement.

DCS Response:

The local office provided a plan to complete CFTM and case conferences in a timely manner. The plan also stated that the child and his/her parents would be a part of the process whenever possible. The local office strongly indicated that children and/or their parents who are a part of the decision making process have a greater chance of success than someone who was simply told what to do. The child had input at the CFTM, was engaged in services, and slowly improved with therapy.

CASE EXAMPLE #7:

The complainant in this case raised allegations that DCS failed to make contact with the birth father in a timely manner; the paternal relatives were not offered placement, even after it was requested by both parents; DCS failed to recognize paternal family's desire to become a part of the case; DCS did not acknowledge the parent's right to consent to the adoption; and, DCS cancelled court ordered visitations with paternal family without rescheduling missed visits.

Findings:

The DCS Ombudsman Bureau found that the complaints had no merit. The birth mother did not provide DCS with identifying information regarding the alleged father of the child. The birth mother eventually recanted information provided and DCS was able to locate the alleged father and a DNA test identified him as the birth father. DCS did eventually make contact with two relative families who failed to follow through on the placement process. Additionally, the case review indicated that while relative visitation was not court ordered, DCS continued to provide visitation to support the child's family connection. While the complaints had no merit, a thorough review of the case records and interviews with local office staff identified missed opportunities regarding establishing paternity and father engagement. DCS failed to locate and make contact with the alleged birth father. Visits and communication with the birth father were minimal and did not demonstrate an attempt to engage the incarcerated parent in the open case. Additionally, DCS did not actively search or pursue other potential relatives at placement.

Recommendation:

The DCS Ombudsman Bureau submitted best practice recommendations regarding father and family engagement. The Local Office was advised to:

1. Identify additional methods that could be utilized to locate absent parents and the county's plan to ensure that paternity is established as quickly as possible in cases with unknown or absent parents.
2. Develop and implement ways for incarcerated families to actively participate in services, court proceedings, adoptions, Child and Family Team Meetings, etc.
3. Describe the county's plan to ensure that efforts are made in contacting all family members who are identified by the parents regardless if they are qualified for placement as they could potentially provide alternative supports for the family.

DCS Response:

DCS provided training to regional staff on the importance of family connections. The information was made available to the DCS Ombudsman Bureau for review. The presentation replicated the findings of the case and provided information identifying DCS policies specific to family engagement. The presentation was shared with other DCS local offices to remind all staff of the need to locate and engage family members.

CASE EXAMPLE #8:

The complainant reported numerous past unsubstantiated reports for the two children in question. The complainant alleged that in the most recent assessment DCS failed to ensure the safety of the children because the mother and her boyfriend admitted to drug use and subsequently failed drug screens. The complainant also alleged that DCS notified the mother before going to the home to initiate the assessment. Concern was also raised by the DCS Ombudsman Bureau because the assessment report stated that the Family Case Manager (FCM) was unable to initiate face to face contact with the children and complete a thorough assessment due to being unable to locate the family during the course of the assessment.

Findings:

The DCS Ombudsman Bureau found no merit to the complaint that DCS failed to follow policy by allowing the birth mother and her boyfriend to use drugs in the home. The FCM utilized a safety plan to ensure a safe home environment. Family members were also engaged to assist the family. There was also no merit to the complaint that DCS failed to follow policy by calling the birth mother prior to visiting the home to initiate the neglect report. Documentation in the case record indicated that unannounced visits were conducted to initiate the reports.

The Bureau found merit to the complaint that DCS failed to follow written policy in regards to ensuring the safety of the children by failing to complete the assessment pursuant to policy. The report was closed with an unsubstantiated finding without conducting face to face interviews with the children or assessing the safety of the home where they resided with a babysitter.

Recommendation:

Due to the findings of this review, the DCS Ombudsman Bureau recommended that a review and/or training be conducted with all staff regarding Chapter 4 of the Indiana Child and Welfare Policy Manual.

DCS Response:

As a result of the DCS Ombudsman Bureau's recommendation, the Local Office Director provided 2.5 hours of training to staff on Chapter 4 of the Indiana Child Welfare Policy Manual. The training covered all aspects of the chapter and updates with time for questions. All staff was in attendance

CASE EXAMPLE #9:

The DCS Ombudsman Bureau received a complaint alleging that DCS failed to protect a 20 month old infant by not ensuring the child received medical services from the time the child was placed in foster care in March 2013 until April 2014 when the child was brought to the clinic by the foster mother. The complainant stated that there was no record of the child receiving any immunizations in the statewide immunization registry and the foster mother had confirmed that the child had not received any medical care while placed in her home. The complainant reported that the child's access to medical care was not monitored and DCS had failed to appropriately supervise the child's medical needs. The child had significant developmental delays and due to the lack of medical care, the child missed opportunities for early intervention services. While the child appeared otherwise well, there was concern that the child could have contracted an opportunistic infection due to the lack of vaccinations. The

complainant further questioned whether the situation was indicative of health care provided to children under the supervision of DCS.

Findings:

The DCS Ombudsman Bureau found merit to the complaint that DCS failed to protect the child, by ensuring ongoing Medical Care pursuant to *Child Welfare Policy 8.25: Health Care Services, 8.27: Maintaining Health Care Records – Medical Passport and 8.29: Routine Health Care*. A review of the case records indicated that the foster mother continuously reported that she was unable to schedule visits with the child's doctor or First Steps for services to address developmental needs because she was unable to make contact with either provider. There was no indication that the DCS Family Case Manager (FCM) or the LCPA verified the foster mother's statements. Additionally, neither agency attempted to make contact with providers to clarify or alleviate the scheduling concerns. Both the FCM and the LCPA representative provided information to the case record and subsequently the court that the *"child appeared healthy and developmentally on target"*. However, there was no medical documentation to support their observations. Statements made to the DCS Ombudsman Bureau during the review of the complaint that *"the child has been assessed by First Steps and has been found to be in need of Occupational and Speech Therapy"* were determined to be inaccurate as well. The exact status of the child's First Steps referral was unknown by DCS during the DCS Ombudsman Bureau's review.

Recommendations:

The Local Office recognized the concerns, and initiated a plan for resolution during the course of the DCS Ombudsman Bureau's review. A copy of the Corrective Action Plan for the foster parent and Treatment Status Report from the LCPA was also provided prior to the end of the DCS Ombudsman Review. The local office ensured that applicable child welfare policies were reviewed by staff as well as discussions on the importance of securing verifications of all actions regarding services to the child and/or family. Medical Passports were provided to all staff. While personnel issues fall outside the jurisdiction of the DCS Ombudsman Bureau and were not included in the DCS Ombudsman Bureau review or recommendations, the local office addressed concerns with staff in accordance with DCS personnel policies. The DCS Ombudsman Bureau requested follow up regarding case management concerns:

1. Confirmation that the follow-up visit with the primary health care provider was completed.
2. Confirmation that the child had been seen by a dentist.
3. Confirmation that the First Steps evaluation and recommendations have been completed for this child as the status of his First Steps referral remained unclear.

DCS Response

The Local Office confirmed that all follow-up visits were kept as scheduled.

CASE EXAMPLE 10:

The DCS Ombudsman Bureau received two complaints alleging that DCS failed to follow policy regarding visitation. The complainants alleged that DCS denied the parent any type of communication with the child for approximately 62 days Additionally, the complainants stated that DCS failed to notify the court regarding modification of visitation following parent's

incarceration and failed to provide the parent and the parent's attorney with reports from the child's therapist. The complainant also reported that DCS delayed placement of the child with a relative and denied requests for visitation with relatives. Based on the written complaint, interviews and the jurisdiction of this office, the DCS Ombudsman Bureau opened an investigation regarding the complainant's allegations.

Findings:

The allegation that DCS failed to facilitate visitation for the parent and child was determined to have merit. *Child Welfare Policy 8.12 Developing the Visitation Plan* states "*DCS will develop a visitation plan within 5 days of removal, unless the parental rights have been terminated or the court orders no visitation".* The policy further states *"All Visitation Plans must include alternative forms of contact (e.g., phone calls, cards, letters, photographs, recordings, etc.) if face-to-face visits are not possible."* DCS acknowledged that there was no documented visitation plan. There had been a plan prior to the birth parent's arrest. However, DCS did not review or modify the visit plan to ensure it applied to the changed circumstances Merit was also found concerning the allegation that DCS failed to notify the court regarding the modification of visitation, as the DCS attorney was not made aware of the mother's arrest. Additionally, DCS failed to provide the mother and her attorney with the reports from the therapist, who did not support visitation at the jail, but recommended some form of ongoing communication, as DCS failed to follow up with the therapist to obtain said reports.

The allegation that DCS delayed placement of the child with a relative and denied requests for relative visitation was determined to be without merit. The case review indicated that the child was able to maintain relative contact through regularly scheduled visitation.

Recommendation 1:

The DCS Ombudsman Bureau recommended that DCS staff review *Child Welfare Policies 8.12 Developing the Visitation Plan and 8.13 Implementing the Visitation Plan* and discuss with staff the importance of parent-child contact. Additionally, it was recommended that local office management ensure a documented visitation plan in each case. If visitation is not recommended, it is important that DCS follow up with the providers and obtain documentation of these recommendations to be distributed to the appropriate parties, including the court.

DCS Response:

The presentation of policy information to staff and review of current visitation plans was completed by the Local Office. In addition to the policies identified by the DCS Ombudsman Bureau, *Child Welfare Policies 8.11 Parental Interaction and Involvement, 8.16 Resource Parent (s) Role, 5.7 Child and Family Team Meetings, 5.10 Family Services, 5.15 Concurrent Planning-An Overview, Tool 8.C Supervision of Visits, State Form 53557 Visitation Check List, and Tool 8.B Separation and Loss* were presented to address the visitation comprehensively with a focus on the importance of the parent-child relationship. As a result of the review of all visitation plans by management staff, staff development plans were established for workers whose visitation plans indicated a need for more direct instruction and oversight.

Recommendation 2:

It is critical that the local office attorney is made aware of any and all major changes in a case, especially when such changes impact visitation. It was recommended that when reviewing *Child Welfare Policy 8.13 Implementing the Visitation Plan* special attention should be paid to the reasons listed, in which DCS will seek a court order to change the visitation plan. This would

be an opportune time for the DCS attorney to educate staff on the type of information required.

DCS Response:

In addition to staff education referenced in the previous response, the local office director and attorney met to create internal processes and a form to facilitate better communication on all matters in which the court needs notification.

Additional Findings and Recommendations

In conducting the investigation of the allegations, additional concerns were noted. It is apparent that these allegations stem from the lack of communication among DCS staff. Additionally, the lack of documentation of plans and contacts made it difficult to pinpoint exactly where along the line opportunities started to be missed and whether or not they could have been caught sooner.

Recommendation:

The DCS Ombudsman Bureau recommended that DCS provide this office with an analysis of how this situation occurred and what actions have been taken to ensure that this could not reoccur. Of particular interest are any insights or modifications of policies/procedures around the supervisory role that resulted from this experience.

DCS Response:

This case was assigned to a worker with less than one year's experience who was supervised by a Supervisor with less than 2 years of experience in an office that has been plagued by high turnover. There was inadequate and/or insufficient communication at many levels. This case served as a significant reminder that when resources are limited, the primary and sometimes sole focus of a worker/office becomes assuring child safety. The review of this situation served to remind management of how difficult it is for an inexperienced worker with multiple responsibilities to understand and competently meet the many duties for which they are responsible without significant supervisory support.

CASE EXAMPLE #11:

The complaint involved two allegations. First, the complainant stated that DCS allowed the alleged perpetrator to wait a week to take a drug screen once the assessment was initiated. The complainant also alleged that the assessment was open longer than the 30 day time frame outlined in policy.

Findings:

The DCS Ombudsman found no merit to the first allegation. The alleged perpetrator refused a drug screen when the assessment was initiated. Pursuant to *Child Welfare Policy 4:16 Medical and Psychological Examinations, Drug Screens and Substance Abuse Evaluations*, DCS does not have the authority to require such action. If the parent/guardian/custodian does not agree to voluntary testing, DCS may pursue a court order if such tests are necessary to complete the assessment. In this assessment, the parent voluntarily agreed to submit a screen at a later date.

The DCS Ombudsman Bureau found merit to the allegation that DCS failed to complete the assessment in the 30 day time frame outlined in policy. The Assessment Report was approved by the supervisor 24 days past the 30 day timeframe. Although there is merit to the complaint, it should be noted that the work within the assessment was completed within a timely manner.

The assessment was actively worked on during the initial 30 days. The assessment was initiated within the mandated time frame, safety was ensured, interviews were completed timely, and allegations were properly assessed. The issue of timeliness was the result of DCS' failure to approve the Assessment Report

Recommendation:

It was not the belief of the DCS Ombudsman Bureau that the length of time that the assessment was open had any effect on the work completed by the FCM or created any hindrance to the safety of the child. However, as the assessment exceeded timeframes for completion, this office found merit to the complaint, pursuant to policy. During the course of the review the Local Office Director advised that increased case loads and staff absences due to health issues impacted the completion of the assessment within the 30 days outlined in policy. The DCS Ombudsman Bureau recommended the local office to provide a plan for addressing workload issues resulting from high case loads and staff absences.

DCS Response:

The Local Office Director advised that the workload had been redistributed among Family Case Managers; Family Case Manager Supervisors and support staff as well as the Local Office Director. The local office focused their work on all overdue approvals. As of the first week in November 2014, the local office had reduced the overdue approvals by 20 which brought the total down to 67 assessments awaiting approval over the 30 day timeframe. The ongoing plan was to reduce the remaining overdue approvals by 20 per week with completion by the first of December. The plan also included the utilization of evenings and week-ends to approve the additional work.

CASE EXAMPLE #12:

The complainant alleged that the DCS Central Licensing Unit (CLU) conducted an unwarranted investigation of the foster parent's license, and did not follow policy in making the decision to revoke the license. The complainant further argued that DCS did not use progressive discipline prior to revoking the license. Based on the written complaint, interviews and the jurisdiction of this office, the DCS Ombudsman Bureau opened an investigation.

Findings:

The allegation that DCS CLU unfairly scrutinized Foster Parent's license and failed to use progressive discipline was determined to be without merit. DCS policy and procedures are clear regarding CLU's involvement in licensing by Licensed Child Placing Agencies (LCPA) and transfers between and among DCS Local Offices and LCPA. The CLU cannot turn a blind eye to the licensing concerns regarding the home that were brought to their attention during a transfer even if the transfer does not proceed. It was also clear that Foster Parent's evasiveness and refusal to provide complete and accurate medical and financial information raised concerns and required further inspection. While the complaints had no merit, the DCS Ombudsman Bureau identified missed opportunities to assess the appropriateness of the foster home when Foster Parent requested to transfer the license from the LCPA to the Local Office. A home study was not completed pursuant to licensing policy. A home study would have revealed past challenges and concerns demonstrated during Foster Parent's tenure with previous LCPAs.

Recommendation 1:

It was recommended the Local Office review licensing policies, particularly focusing on the following Indiana Child Welfare Policies: 12.22 Licensing File Requirements, 12.27 Transferring a Foster Family Home License, and 12.31 Financial Verification for Licensure.

DCS Response:

The local DCS Office provided training on policies 12.22, 12.27 and 12.31 to foster care licensing staff per the DCS Ombudsman Bureau's recommendations.

Additional Findings and Recommendation:

Please see Systemic Recommendations

CASE EXAMPLE #13:

The DCS Ombudsman Bureau received a complaint alleging that DCS failed to follow policy regarding the timely transfer of a foster care license from the DCS Local Office to a private Licensed Child Placing Agency (LCPA). The complainant stated that Foster Parent was previously licensed with two private agencies before transferring to the Local Office and that all three of those agencies (LCPA 1, LCPA 2 and DCS) licensed the Foster Parent with no concerns. The complainant felt that DCS' failure to transfer the Foster Parent's license to LCPA 3 in a timely manner was a personal issue. The complainant also voiced concerns about the time it took for Foster Parent to be approved to adopt by DCS.

Findings:

Based on a review of the information, the DCS Ombudsman Bureau has determined that there is both merit and non merit to the allegations that DCS failed to notify Foster Parent of previous foster care licensing concerns. Case records indicate that DCS and the licensing agencies as contractors of DCS failed to follow Child Welfare Policies by failing to document and address licensing concerns regarding Foster Parent's care of children at the time of transfers. LCPA 2 and the Local Office failed to complete home studies when Foster Parent transferred to the agencies pursuant to *Child Welfare Policy 12.27 Transferring a Foster Family Home License.* The failure to adhere to practices set forth in these policies lends credence to the allegation that the agencies failed to notify Foster Parent of any licensing concerns until such times that the Central Office Foster Care Consultant became involved in the process. Thus there is merit to the complaint in these respects as it relates to adherence to policy. While licensing concerns were not documented at case junctures as set forth in policy, there is little merit to the allegation that Foster Parent was not made aware of concerns regarding the care of children in the home, interaction with staff and other concerns.

There is no merit to the allegation that DCS failed to approve and transfer the Foster Parent's License or to respond to the request to be considered to adopt in a timely manner because of personal issues. The case review indicates that requests made by DCS were consistent with DCS licensing and adoption policies.

Recommendations:

The DCS Ombudsman Bureau recommended that the Local Office review licensing policies, focusing on the following *Indiana Child Welfare Policies 12.15: Annual Review; 12.27: Transferring a Foster Family Home License, and 12.31: Financial Verification for Licensure*. Particular attention is to be paid to policy regarding the completion of home studies for resource families transferring into the Local Office. It was further recommended that the Local Office review *Indiana Child Welfare Policy 12:11 and 12:12A: Family Preparation Assessment*

with the appropriate Local Office staff as the information relates to preparing home studies for the purposes of adoption and presenting Resource Families to the SNAP Council.
DCS Response:
Marion Co. foster care staff reviewed the current transfer policy with staff on 6/11/14, based on similar recommendations from a previous complaint. While the updated policy has not been formally released yet, Central Office management staff reviewed and facilitated discussion regarding the updated changes to that policy
Management staff from the Foster Care Licensing, Policy, and Adoption units in Central Office attended a Local Office licensing unit meeting per the recommendations of the DCS Ombudsman Bureau. The policies were reviewed and management staff facilitated discussion with staff regarding expectations for presenting to SNAP Council and recommending families for SNAP. On this date, the changes to the policy on Transferring a Foster Family Home License (12.27) were also reviewed and discussed.

Additional Findings and Recommendation:
Please see Systemic Recommendations

Systemic Recommendations

Pursuant to IC 4-13-19-5(b) (2), (4), and (6), the DCS Ombudsman Bureau may also review relevant policies and procedures with a view toward the safety and welfare of children, recommend changes in procedures for investigating reports of abuse and neglect, make recommendations concerning the welfare of children under the jurisdiction of a juvenile court, examine policies and procedures, and evaluate the effectiveness of the child protection system. Each quarter, general recommendations are provided to DCS regarding systemic issues, and DCS responds to the recommendations within 60 days. During 2013 five recommendations were offered. They are included in this report to indicate DCS progress. Five recommendations were offered in 2014. The following is a summary of these recommendations and the DCS responses. The recommendations are based on information derived from the volumes of information reviewed in the course of case reviews and investigations with systemic implications, in addition to information gleaned from various reports and discussions with stakeholders.

2013

Recommendation #1 – Staffing/Caseloads

It was previously recommended that DCS increase staff in order to ensure caseloads within the 12/17 limit and DCS responded by advising that additional staff had been approved and hiring was in process. However, an interim need still exists because of the time it will take to hire and prepare additional staff. Furthermore, there are concerns that the numbers used to calculate need do not always accurately reflect the situation. It is recommended DCS provide an update on the progress with caseload size, staffing and caseload calculations. It is also recommended that the numbers used to reflect caseload size only reflect actual caseloads. If staffing remains a problem in the short term, it is recommended an interim plan using “floaters” be considered.

DCS Response 2013 and 2014:

Pursuant to IC 31-25-2-5, enacted in the spring of 2007, DCS is required to ensure that Family Case Manager staffing levels are maintained so that each region has enough FCMs to allow caseloads to be at not more than: (1) twelve active cases relating to initial assessments, including assessments of an allegation of child abuse or neglect; or (2) seventeen children monitored and supervised in active cases relating to ongoing services. The 12/17 caseload standard is consistent with the Child Welfare League of America's standards of excellence for services for abused and neglected children and their families.

A number of factors lead to an increase in caseloads during SFY 2013, including an increased number of cases and staff turnover. DCS implemented many strategies during SFY 2013 to reduce caseloads and staff turnover, and ensure compliance with the 12/17 standard. One strategy was addressing staff compensation, as previously discussed, by providing raises to field staff based on their tenure with the Department. Another strategy to ensure compliance with the 12/17 standard was to seek funding for additional staff. The legislature appropriated funding for 136 additional Family Case Managers and 75 new Family Case Manager Supervisors during the biennium. By the end of SFY 2013, 97 of the 136 new FCM positions had been filled, albeit some of the new staff remained in training.

With the addition of new staff DCS was one step closer to meeting 12/17 standard, however additional measures were needed. In order to get workers in the field carrying a caseload faster, the Department increased the frequency of new worker trainings beginning in January 2013. New FCM training cohorts increased from every three weeks to every two weeks. In conjunction with increased frequency of training, class sizes were increased. During SFY 2012, DCS averaged 15 individuals per cohort, compared with 25 in SFY 2013. These two strategies combined allowed DCS to hire and train 550 workers in SFY 2013, compared with only 286 in SFY 2012, a 92% increase.

DCS has been approved to create 110 new Family Case Manager positions. This will allow the Department to be fully staffed at 12/17, while still maintaining vacancies and acknowledging that staff in training are unable to carry caseloads for a twelve week period of time from the date of hire. DCS determined that 110 positions would be appropriate to meet 12/17 based on analysis of data from SFY 2012 and SFY 2013.

All of the efforts taken in SFY 2013 and those planned for SFY 2014 will continue to move the Department in the right direction of maintaining staffing consistent with the 12/17 statutory requirements. DCS recognizes that this work is never complete and as such the Department will continue to evaluate ways to make changes in the future to ensure that appropriate staffing levels are maintained in order to serve Indiana's abuse and neglected children.

Recommendation #2 - Timeliness of Fatality and Near Fatality Determinations

In 2012, The DCS Ombudsman Bureau recommended that DCS develop a plan to ensure timeliness of Fatality and Near Fatality Determinations. DCS formed a committee to assess

practice current at the time and to develop and implement approaches to address issues of timeliness. The Bureau requested an update on DCS progress in this area.

DCS Response 2013:

The DCS response is still pending on this issue. However the Department clarified that a number of different factors impact the length of time it takes to finalize a fatality review assessment. Fatality review assessments completed by DCS rely on a number of outside reports and information, such as the coroner's report, toxicology report, etc. In addition, DCS seeks to work closely with law enforcement and the prosecutor's office to ensure that the Department's involvement does not interfere with any on-going criminal investigation or prosecution.

DCS Response 2014:

DCS has streamlined the fatality process. An additional staff member was assigned to this unit several months ago.

Note: As a member of the State Fatality Review Team, the DCS Ombudsman Bureau had the opportunity to participate in Fatality Specialist Training provided by DCS in during the Third Quarter. This training provided an overview of DCS' Fatality Review Process and the responsibilities of the Fatality Review Team.

Recommendation #3 - Differential Response:

It was previously recommended that DCS consider a Differential Response system, and DCS responded that a work group was being formed to study this. This office is requesting an update on the status of the work group and expresses an interest to participate in some of the sessions if/when appropriate.

DCS Response 2013:

DCS has formed a work group to look at this model. However, research and discussions are still in the early stages.

DCS Response 2014:

Differential Response has been tabled as DCS moves forward with review of front end processes.

Recommendation #4 - Reviewing Histories in the Assessment Process:

Based on case reviews as well as Peer Reviews, it is frequently observed that some Assessors review DCS history as part of the Assessment process, while others do not. It is suspected the rationale for not reviewing history is to foster objectivity and avoid any preconceived notions. However, when history is not reviewed it appears to be a missed opportunity to have information that is critical in assessing the big picture. FCMS should be able to guide staff in appropriately processing the role of the history in critical decisions. It is important to remember that while protective factors are as important as risk factors, it is the analysis of the integration of the two that provides a more accurate picture. It is recommended DCS staff be reminded and/or educated on the appropriate use of history in the assessment process.

DCS Response 2013:

DCS has begun to initiate training in the areas of Risk and Safety at all levels of the organization. This has included a review of Risk and Safety Tools and the impact of the family's history on staff decision making.

DCS Response 2014:

Reviewing history has been discussed in the Regional Manager's meetings. This was a general discussion about the importance of reviewing history. In addition, there has been a high emphasis at the Hotline to ensure this information is included on all reports as applicable.

Recommendation #5 – Future Project – Repeat Maltreatment

The DCS Ombudsman Bureau requested statistics on repeat maltreatment in anticipation of reviewing sample cases in this category. While the objectives and process of these reviews is still being formulated, we would be interested in working collaboratively with DCS on such a project, similarly to the Assessment Focus Group from 2012.

DCS Response2013 and 2014:

DCS continues to review and study this Practice Indicator and would be open to working with the Ombudsman on this issue.

2014:

Recommendation #6 – Staffing/Caseloads

In 2012, The DCS Ombudsman Bureau launched a task force to study the DCS Assessment/Investigative process to evaluate opportunities for providing additional support to those performing this critical function. The DCS Ombudsman Bureau report, "The Critical Initial Response: DCS Assessment", applauded positive improvements in DCS practice and provided recommendations regarding key challenges. Those barriers have been addressed previously in Annual Reports. In 2014, the DCS Ombudsman Bureau continued to identify DCS staffing needs and caseload size as impediments to standards surrounding case record documentation and timely completion of assessments. DCS Local Offices responded to recommendations to address these concerns while DCS leadership worked to identify solutions to remedy systemic challenges in these areas. At the end of 2014, despite the addition of these new positions, DCS had not met the 12/17 regional caseload average, as outlined in Indiana statute. In November2014, DCS presented plans to address the issue to the State Budget Committee which included commissioning an analysis of the current workload of DCS Family Case Managers. The resulting report was planned for completion during the first quarter of 2015.

Recommendation:

The DCS Ombudsman Bureau requests updates on the progress of DCS in this area.

DCS Response:

Pending

Recommendation #7 – Licensing Complaints

Reviews of Resource Parent complaints in 2014 identified significant missed opportunities by DCS Local Offices and Licensed Child Placing Agencies (LCPA) to identify concerns and initiate and monitor corrective action plans to support, develop and retain Resource Parents as a viable resource for the care of children. Certain Child Welfare Policies exist to provide a blueprint for managing licensing processes and documenting actions taken. Most importantly, DCS Local Offices and LCPA are charged with the responsibility to follow laws, rules, policies and best practice guidelines designed for the specific purpose of providing a safe, stable nurturing environment for children in DCS' care. The failure of the agencies to follow the policies in these instances creates an environment that increases the potential risk for children placed in

resource homes. The DCS Ombudsman Bureau recommended DCS work with Local Offices and Licensed Child Placing Agencies to ensure that identified concerns are addressed and documented pursuant to foster care licensing policies.

DCS Response:

Several months ago, DCS developed a Licensing Complaint Response form that allows for back and forth communication regarding licensing concerns and interventions. This form has been a helpful means of ensuring comprehensive and thorough response when concerns are brought to Central Office. DCS Central Office has numerous other opportunities to provide ongoing clarification regarding the expectations of addressing and documenting licensing concerns and resolutions. DCS Central Office conducts monthly conference calls with LCPA's. While the topics of appropriately addressing licensing complaints and expectations for transfer of a home have been addressed previously, these topics have been added as refreshers on the upcoming agenda. Additionally, DCS Central Office has an annual training with LCPA's, which will be held in February or March. Licensing complaint expectations and appropriate resolutions were already planned to be a topic for that training. As to DCS licensing staff (Regional Foster Care Specialists), DCS Central Office has monthly staff meetings with the RFCS Supervisors, and this topic will be reviewed at an upcoming meeting.

Recommendation #8 – Foster Home Transfers

Following several concerns involving transfer requests by foster parents, the DCS Ombudsman identified inconsistent application of DCS policies and procedures by Local DCS Offices and Licensed Child Placing Agencies (LCPA). As a result, the DCS Ombudsman Bureau recommended that DCS review policy, procedure and practice of transferring foster care licenses to ensure consistency and accountability.

DCS Response:

Child Welfare Policy 12.27 Transferring a Foster Family Home License

This policy was revised at the request of the Ombudsman. The revisions made were to ensure that the process for the transfer of a foster family home license from one agency to another is clear and includes the Central Office Licensing Unit.

Recommendation #9 – Special Needs Adoption Program:

A 2014 investigation revealed that a concern that the brief departure of the DCS Special Needs Adoption Program (SNAP) Supervisor from the agency from December to February provided an opportunity for Foster Parent to be recommended by the SNAP Council despite a myriad of concerns that had not yet been resolved. The DCS Ombudsman Bureau requested clarity on how the SNAP Program/Council would ensure ongoing consistent decision making when concerns regarding prospective adoptive families occur.

DCS Response:

The Adoption Program Manager has reiterated to all members of SNAP Council the importance of calling management's attention to any concerns/issues that may arise so that this type of situation is not repeated. Furthermore, as of last month, the Adoption Program Manager has assumed direct responsibility for the preparation and facilitation of all SNAP Council meetings. Additionally, Adoption and Policy staffs are working on revisions to *Child Welfare Policy 10.8:*

Families Recommended for the Special Needs Adoption Program (SNAP), to provide more clarity on the communication of the decisions that come out of SNAP Council.

Recommendation #10 – Support to Resource Families to Prevent Placement Disruptions

This office has reviewed a number of complaints from Resource (foster, kinship and adoptive) Parents. In most cases complaints have involved the removal of a child from a resource for reasons other than abuse/neglect, or the DCS decision not to approve transfers of a foster home license from one agency to another. These usually involve instances of Resource Parent non-compliance with DCS expectations and/or the case plan. In most of the cases reviewed, DCS's reasons for the placement change could be supported, but the process frequently involved conflict which in turn would result in an abrupt removal and complaint to the DCS Ombudsman Bureau. While the bureau found the DCS actions to be warranted, initial and on-going development and support to Resource Families seemed to be an ongoing issue for many Local Offices. In the fall of 2014, the DCS Ombudsman and DCS initiated discussions regarding the roles of Foster Support Specialists and Supervisors at the Local and Regional levels and how these roles can be fine tuned to support the family development needs of Resource Families. The DCS Ombudsman Bureau recommends that DCS continue to take steps in the direction of providing staff development and opportunities to support the retention of Resource Families and decrease placement disruptions for children.

DCS Response:

Pending

DCS Ombudsman Bureau Reflections and Future Initiatives

Agency Growth

In 2014, the DCS Ombudsman Bureau continued with its mission of responding to complaints concerning DCS actions or omissions by providing problem resolutions services, independent case reviews and recommendations to improve DCS service delivery thereby promoting public confidence. Constituents accessing the DCS Ombudsman Bureau have experienced services and support delivered in a timely, efficient and effective manner. The increase in the number of calls to the agency is attributed in part to outreach efforts developed and implemented by the DCS Ombudsman Bureau. Open communication between the DCS Ombudsman Bureau and DCS at the state and local level has supported the resolution of challenges and strengthening of best practice policies, procedures and programs.

DCS Ombudsman Bureau Initiatives

Staff Retention:

Staff retention is an important part of any workplace and the DCS Ombudsman Bureau is no different. Much time and effort is spent recruiting and training talent. The responsibilities of the DCS Ombudsman Bureau require experienced staff proficient in the areas of child welfare and criminal justice issues; problem resolution; research; and, the ability to understand public policy and law and apply the same to constituent concerns. Additionally, the individuals must have above average oral and written communication skills, provide excellent customer services while engaging stakeholders with diverse needs and expectations. In 2014, the DCS Ombudsman Bureau held the first staff retreat in an effort to identify and develop strategies to support the retention of staff. The experience provided an opportunity for staff to reflect on their work and provide feedback on their strengths as well as challenges. The DCS Ombudsman Bureau will continue to use the information gained during the staff retreat to chart a course for retaining current staff and recruiting new staff as the agency grows.

In an effort to address staff retention concerns, the DCS Ombudsman Bureau began discussions with the State Personnel Department to indentify strategies to better align the Assistant Ombudsman job description with the actual tasks performed. The current salary does not sufficiently support staff retention as indicated by staff turnover experienced in 2013 and 2014. An increase in salary would not only support retention efforts for current staff, it would support recruitment efforts in securing experienced talent.

Budgeting Requests:

The DCS Ombudsman Bureau currently employs two Assistants with the responsibility of responding to constituent concerns. In an effort to meet the increasing requests for services, the Director of the DCS Ombudsman Bureau initiated two strategies to support the staffing needs of the agency. First, a request to increase the DCS Ombudsman Bureau's budget from two Assistants to three was made during the 2014 budgeting process. An additional Assistant Ombudsman would not only support the response to the steadily increasing numbers of calls but it would allow for the opportunity restructure the agency to support better work flow. A request to for funding necessary to increase outreach efforts and staff development was also requested. While the DCS Ombudsman Bureau currently seeks to provide these activities at low

to no cost, certain outreach and training efforts are stymied because of budgetary constraints that limit activities to the Central Indiana area. The results of these requests were pending at the end of 2014.

Data Entry System:
The DCS Ombudsman Bureau began discussions with the Government Efficiency and Financial Planning Division of the Office of Management and Budget in the fall of 2014 on the possibility participating in efforts to assist certain state agencies in securing case management systems to support their data entry needs. The DCS Ombudsman Bureau is being considered as a participant in this project which will greatly enhance the agency's current data entry system. If approved, these efforts will begin in 2015.

Acknowledgements

The DCS Ombudsman Bureau acknowledges the many individuals who submitted their concerns for resolution. The willingness of these stakeholders to align their efforts with the resources of the DCS Ombudsman Bureau to resolve concerns is greatly appreciated. Additionally, the efforts of the Department of Child Services at the state and local level do not go unnoticed. The agency's commitment to address identified concerns and participate in intentional dialogue around program strengths and challenges with the DCS Ombudsman Bureau does much to further the goals of best practice services and support to vulnerable families and children in Indiana.

ATTACHMENTS

Attachment A
DCS Ombudsman Bureau Staff

Director

Director ***Alfreda Singleton-Smith*** was appointed to the position of the DCS Ombudsman in June, 2013 by Governor Michael R. Pence. She brings over 30 years of child welfare experience in the public and private sector to her role. Director Singleton-Smith worked for DCS from 1986 – 1997 at the local level in Marion County, Indiana as a children services case worker, supervisor, trainer, assistant division manager and division manager. She was previously employed by The Villages of Indiana, Inc. where she served as Senior Director of Client Services, responsible for providing statewide support to agency stakeholders in the areas of program planning, foster care, adoption and kinship care. She holds a BS from Western Kentucky University and an MSW from Indiana University. Ms. Singleton–Smith has served on numerous local, state and national initiatives in support of children and families. She is a licensed social worker; a certified RAPT Trainer and Adoption Competency Trainer and a member of the United States Ombudsman Association.

Assistant Ombudsman

Jessica Shanabruch is native to the Indianapolis area. She graduated from Bishop Chatard High School and went on to earn a Bachelor's degree in Criminal Justice from IUPUI in 2011. She was hired as an Assistant Ombudsman in August 2011 and divided her time between the DCS Ombudsman and the DOC Ombudsman offices. She began working for the DCS Ombudsman full time in March 2012. In addition to conducting reviews and investigations, Jessica has taken on the role of managing the agency's data system and coaching new staff members.

Jamie Anderson grew up in Indianapolis, IN. She graduated from Indianapolis Public Schools and holds a Bachelor's degree in Psychology from Purdue University. Jamie worked as a Family Case Manager for the Department of Child Services from 2006 – 2009 where she enjoyed assisting children and families in reaching their goals. She has since completed ombudsman work for Indiana public assistance programs as well as served as a Care Coordinator in the mental health field. Jamie joined the DCS Ombudsman Bureau in January 2015.

Attachment B
Rules of Engagement
DCS Ombudsman Guidelines

Agency and Complainant Rights and Responsibilities
in the DCS Ombudsman Bureau Complaint Process

Complainant Rights

Complainants are entitled to:

- A timely response acknowledging receipt of the complaint.
- Professional and respectful communication from agency staff.
- An impartial review.
- A credible review process.
- Contact by the Bureau if additional information is required.
- Communication regarding the outcome of the review.

Complainant Responsibilities

Complainants shall:

- Attempt to resolve problems with the local office prior to filing a complaint.
- Complete the complaint form as directed.
- Ensure that the allegations in the complaint are pertinent to the role of the ombudsman.
- Ensure the accuracy and timeliness of requested information.
- Communicate respectfully with agency staff.

DCS Ombudsman Bureau Rights

The Bureau may:

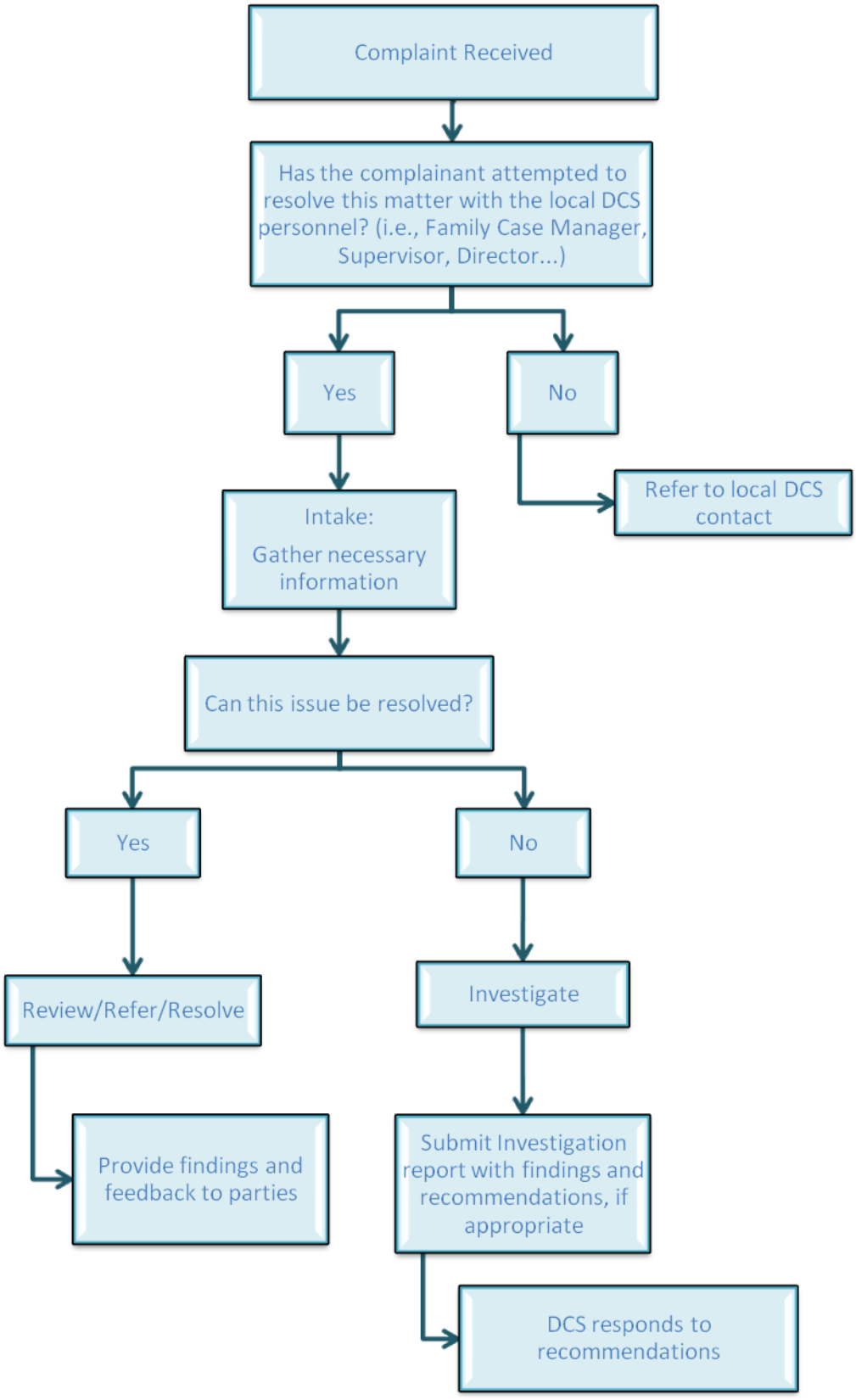
- Decline to accept a complaint that does not fall within the jurisdiction of the Bureau.
- Determine the level of review, the documentation and interviews necessary for gathering the information required to determine findings.
- Expect the complainant to provide any additional information requested.
- Determine when a case requires no further action.

DCS Ombudsman Bureau Responsibilities

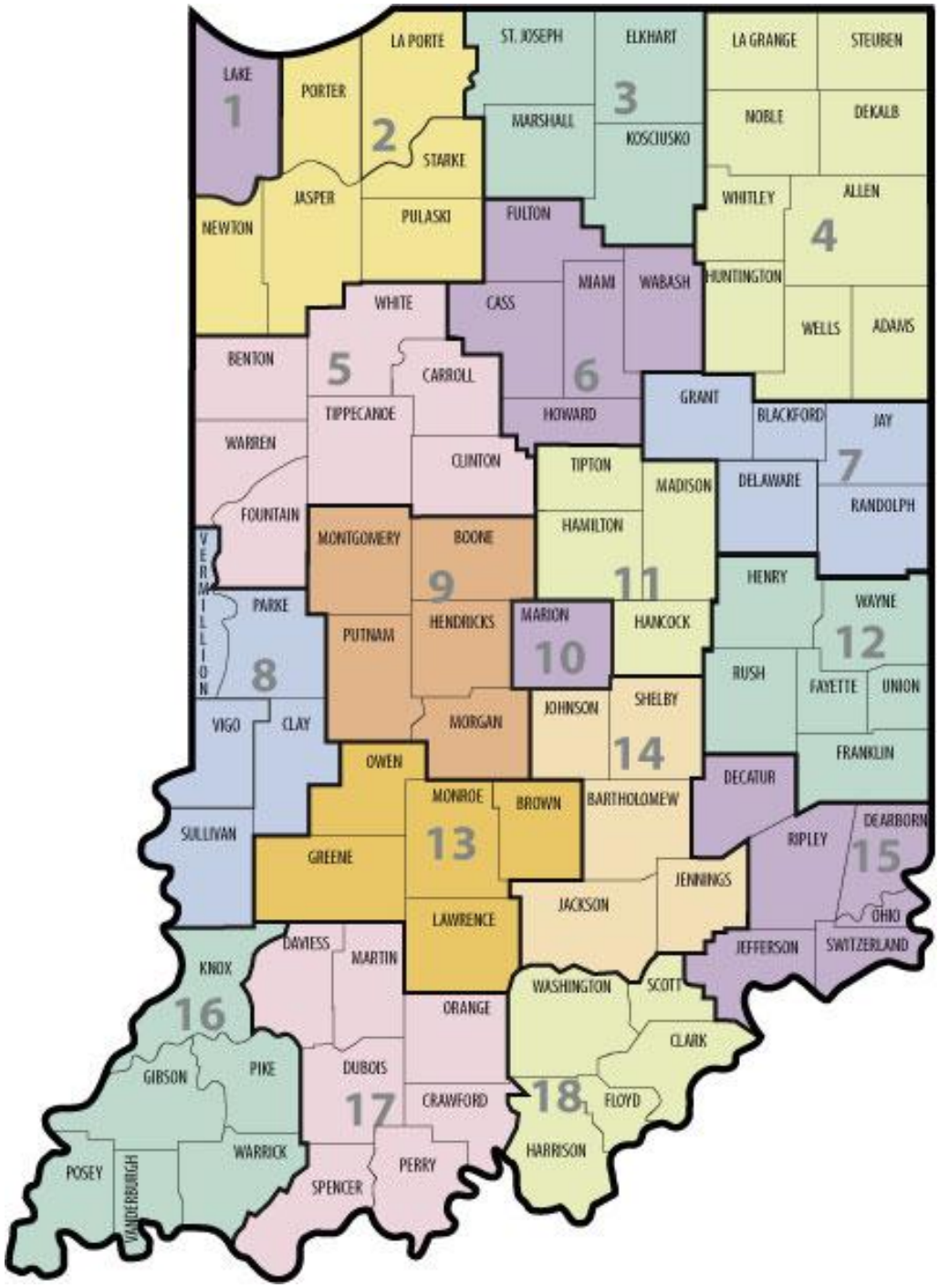
The Bureau shall:

- Complete reviews in a timely manner.
- Complete a thorough and impartial review.
- Ensure professional and respectful communication.
- Provide the results of the review to the complainant in accordance with IC 4-13-19-5.

Attachment C
How We Work



Attachment D
Regional Map



Attachment E
Contact Information

DCS Ombudsman Bureau

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8:00 am to 4:30 pm

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