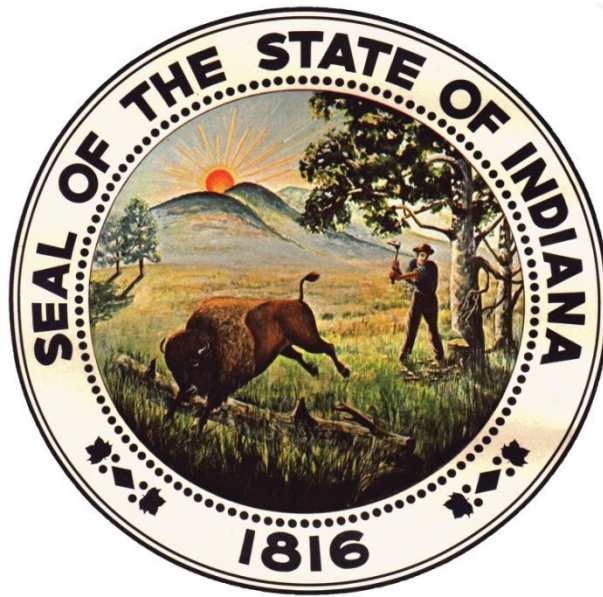


*State of Indiana*

**Department of Child Services  
Ombudsman Bureau**



**2013 Annual Report**

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## **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.



*Report Prepared by: Alfreda Singleton-Smith, Director, DCS Ombudsman Bureau*

*Contributors:*

*Jessica Shanabruch, Assistant Ombudsman - Data Analysis, Graphics*

*Colbi Lehman, Assistant Ombudsman - Editing*



# STATE OF INDIANA

Michael R. Pence, Governor

DEPARTMENT OF ADMINISTRATION  
Department of Child Services Ombudsman Bureau

402 West Washington St. Rm 479  
Indianapolis, IN 46204  
317-234-7361

February 26, 2014

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 2013 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, 2013 to December 31, 2013 and includes information regarding program administration, case activity and outcomes. Included as well is an analysis of the complaints received, recommendations provided to DCS and DCS's responses.

I want 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 Susan R. Hoppe who retired from the position of DCS Ombudsman in April 2013. Director Hoppe is credited with the development and implementation of practices that are the foundation for the DCS Ombudsman Bureau. It is such support that has enabled the Bureau to grow and improve since its inception. It has been an honor to serve the citizens of Indiana as the Department of Child Services Ombudsman.

Respectfully,

A handwritten signature in cursive script, reading "Alfreda D. Singleton-Smith".

Alfreda D. Singleton-Smith, MSW LSW

Director, DCS Ombudsman Bureau

# **Table of Contents**

<b>Executive Summary</b> .....	1
Introduction.....	1
Authority.....	1
Activity Overview .....	1
Administration .....	1
Program Development.....	2
Collaboration with DCS .....	4
Other .....	4
<b>Complaints</b> .....	5
The Process Overview .....	5
Information and Referral Inquiries.....	5
Assists .....	7
Cases.....	8
Referral Source .....	9
Complaint Source.....	10
Complaint Topics .....	11
Complaints by Region .....	12
Response Categories.....	13
Complaint Validity.....	15
Outcomes .....	16
<b>Recommendations and DCS Responses</b> .....	18
Case Specific Recommendations.....	18
Systemic Recommendations .....	25
<b>Reflections and Future Initiatives</b> .....	30
<b>Acknowledgements</b> .....	31
<b>Attachments</b>	
A DCS Ombudsman Bureau Staff	
B Rules of Engagement	
C How We Work/Complaint Process Flow Chart	
D DCS Regional Map	
E Contact Information	

# **Executive Summary**

## **Introduction**

The year 2013 brought significant program growth and change to the Department of Child Services (DCS) Ombudsman Bureau. Director Susan R. Hoppe retired as the Director of the Department of Child Services (DCS) Ombudsman Bureau in May. Alfreda Singleton-Smith was appointed to the Director's position on June 3, 2013. An Assistant Ombudsman position left vacant in August was filled in September, 2013. Despite staffing adjustments, the Bureau increased effectiveness in executing the statutory mandates by: responding to constituent complaints in a timely manner; continuing to enhance and develop program practices and guidelines; increasing the number of constituent responses; expanding outreach initiatives; and updating the website.

## **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 2013 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 607 Information and Referral (I & R) inquiries, conducted 39 Assists, opened 210 Cases and closed 210 Cases, provided 24 Case Specific Recommendations, and 5 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. As noted, there has been significant turnover in staff from May 2013 to September 2013 with the retiring of the DCS Ombudsman (Susan R. Hoppe) in May and the resignation of one Assistant Ombudsman (Jeffrey Gates) in

August. The DCS Ombudsman position was filled in June 2013 with the appointment of Alfreda Singleton-Smith. The Assistant Ombudsman position was filled in September 2013 when Colbi Lehman joined Assistant Ombudsman Jessica Shanabruch. (Attachment A – Staff Biographies) Legal consultation is provided as needed by a Deputy Attorney General. Technical assistance is provided by the IDOA MIS Director.

Mary Beth Bonaventura was appointed as the DCS Director in early 2013. Doris Tolliver and Jane Bisbee filled the vacancy of DCS Chief of Staff and DCS Deputy Director of Field Operations respectively during the summer of 2013. Changes at the DCS Executive Level created new opportunities for strengthening the lines of communication between DCS and the Bureau.

**Budget:** The Bureau was appropriated \$215,675 for the 2013/2014 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.

## **Program Development**

**Update Regarding New Case Categories:** During 2012 the “Assist” category was added to the DCS Ombudsman Bureau database 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 use of the Assist category continues to demonstrate that communication between complainants and DCS is key to resolving differences.

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.

**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 2013. 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’s website was updated in the fall of 2013 to include biographies and pictures of new staff. Considerations for 2014 updates will be adding specific language that clarifies the process for submitting collateral information to support complainants’ concerns. This suggestion came from a

complainant and the DCS Ombudsman Bureau welcomes suggestions that facilitate constituents' access to the agency as well as increase the functionality of the website.

**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 2013 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. The DCS Ombudsman Bureau participated as an exhibitor at the Indiana Youth Institute's Kids Count Conference; The Villages' Fulton Family 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 2012 Annual Report to the Child Services Oversight Committee; the Indiana University School of Social Work; an Indianapolis chapter of the Kiwanis Club and DCS staff and attorneys. The DCS Ombudsman was appointed to the Indiana Supreme Court Committee on Underrepresented Litigants in the fall of 2013 and is also a statutory member of the State 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. There is also a particular interest in exploring opportunities for outreach to older youth.

**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. The 2013 USOA Conference was held in Indianapolis, Indiana in October 2013 and DCS Ombudsman Bureau staff participated in the Reid Institute of Interviewing and Interrogation Pre-Conference as well as other trainings specific to the Ombudsman profession. This 3 day experience also provided a unique opportunity for staff to network with National and International Ombudsman agencies. DCS Ombudsman Bureau staff also participated in trainings provided by DCS; Prevent Child Abuse Indiana; Kids Count Indiana; The Villages' Fulton Family Conference, and Undoing Racism in addition to webinars and the reading of books and articles with information of interest to this office.

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

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

## Collaboration with DCS

**Communication:** The DCS Ombudsman Bureau has scheduled meetings with DCS Executive staff 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 *2013 Data Book Executive Summary* is available in the office of the DCS Ombudsman Bureau and the full Indiana Data Book is available for free at [www.iyi.org/databook](http://www.iyi.org/databook).



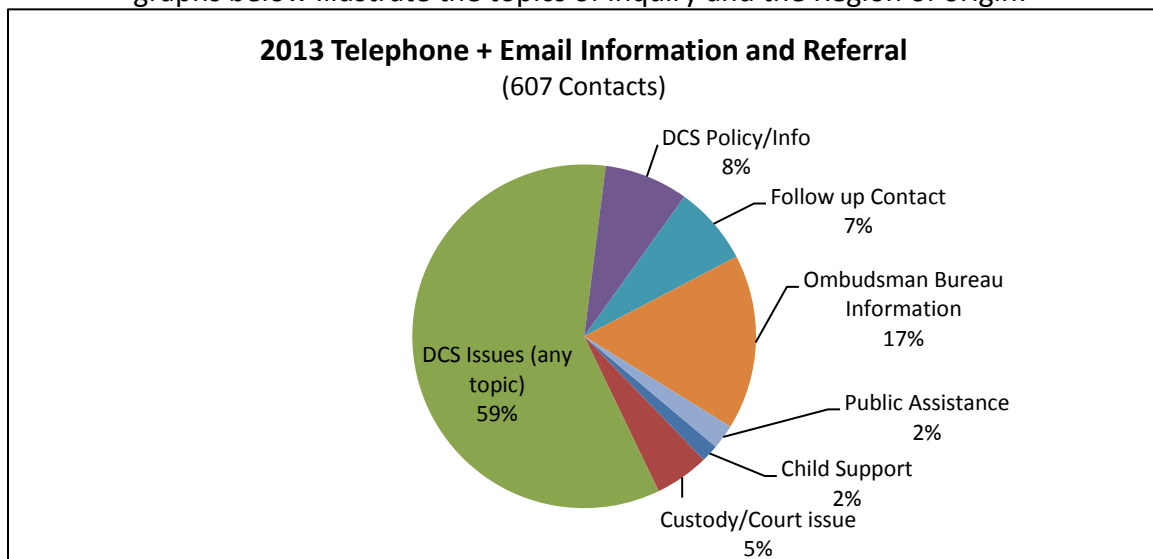
# Complaints

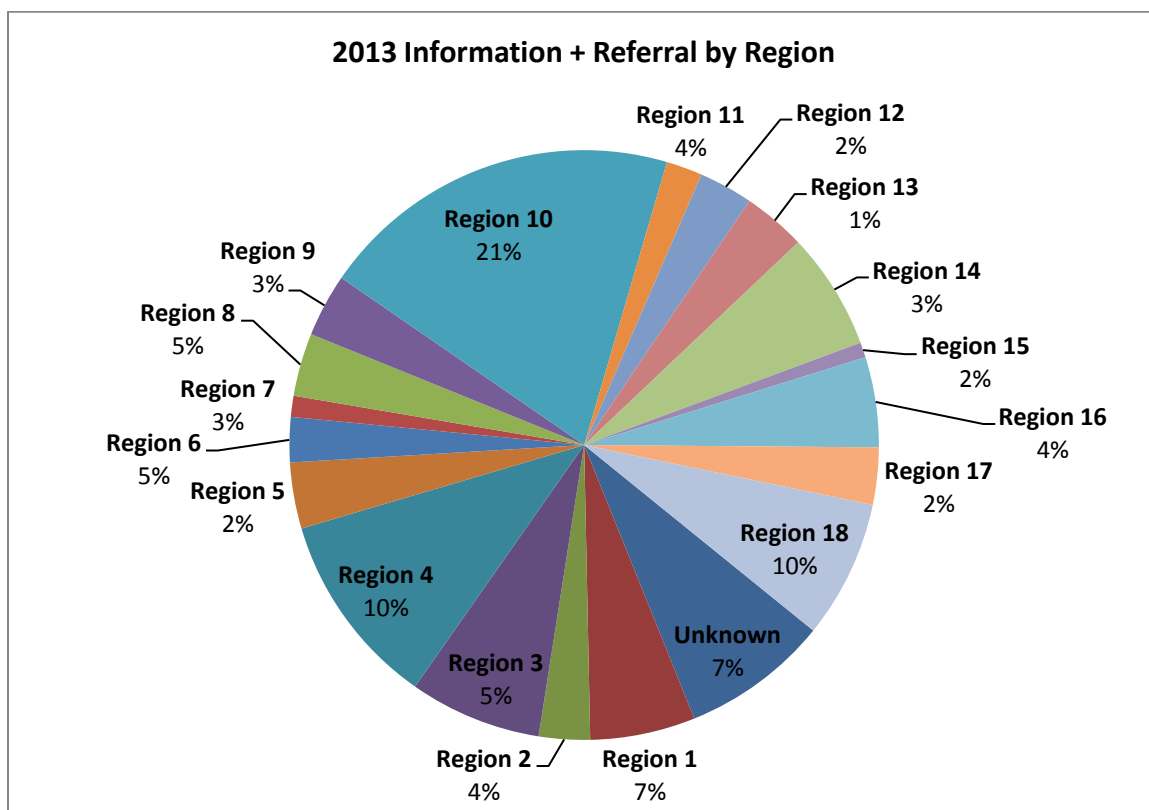
## The Process Overview

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 DSC 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 607 I & R Inquiries during 2013, an increase of 9 from 2012. The graphs below illustrate the topics of inquiry and the Region of origin:

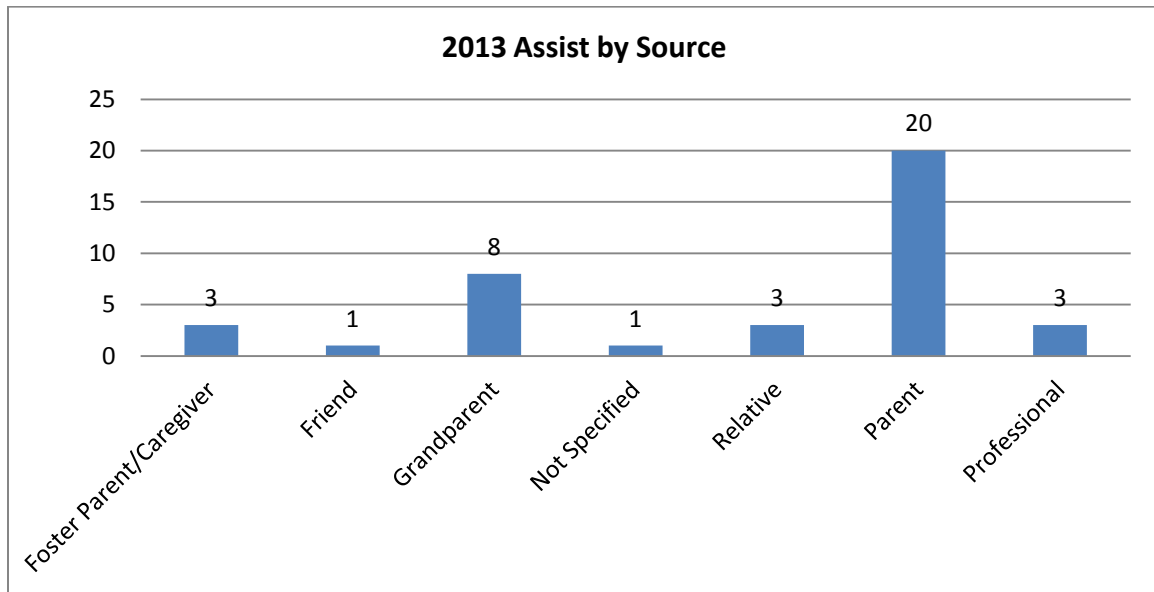
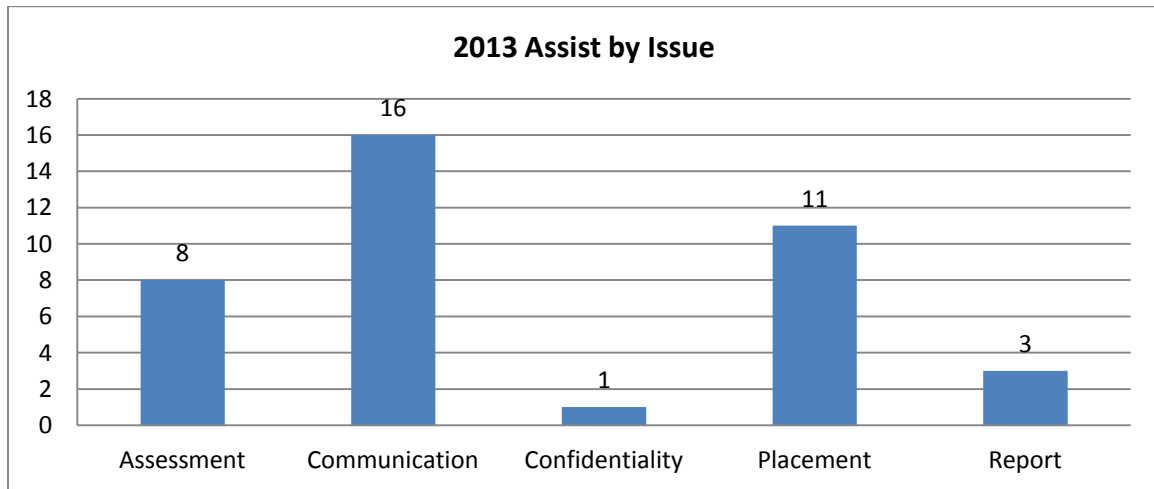


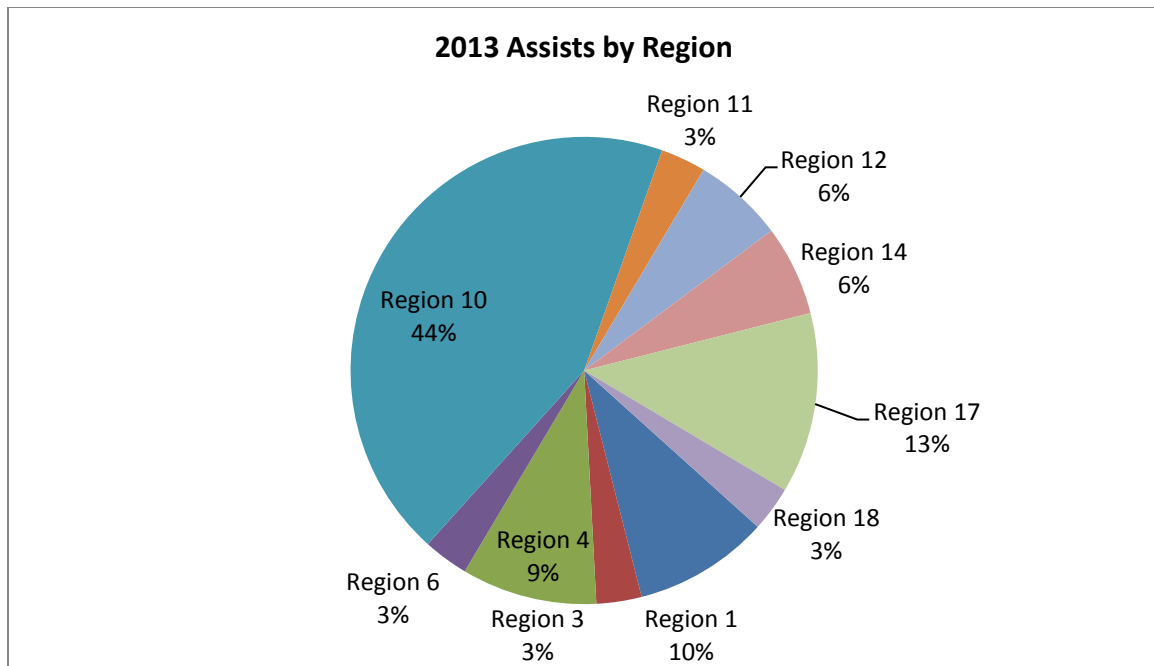


The I & R function has proven to be a valued service for constituents. Providing potential complainants with education regarding the DCS process and/or contact information for DCS staff is often the first step to a successful resolution. It is noted that the number of I & R inquiries has progressively risen 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 2013 the DCS Ombudsman Bureau performed 39 Assists. The following graphs illustrate additional details about the Assists:





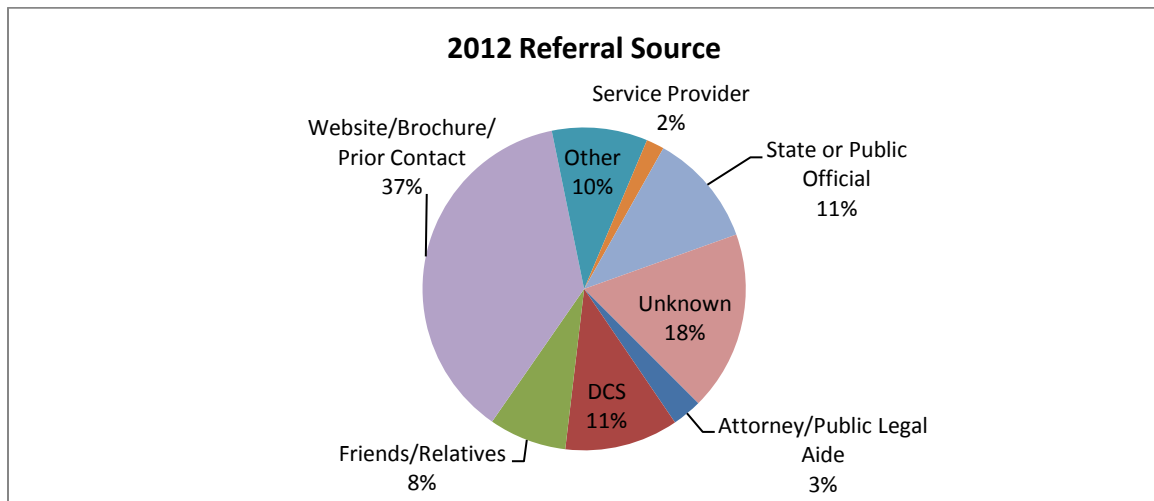
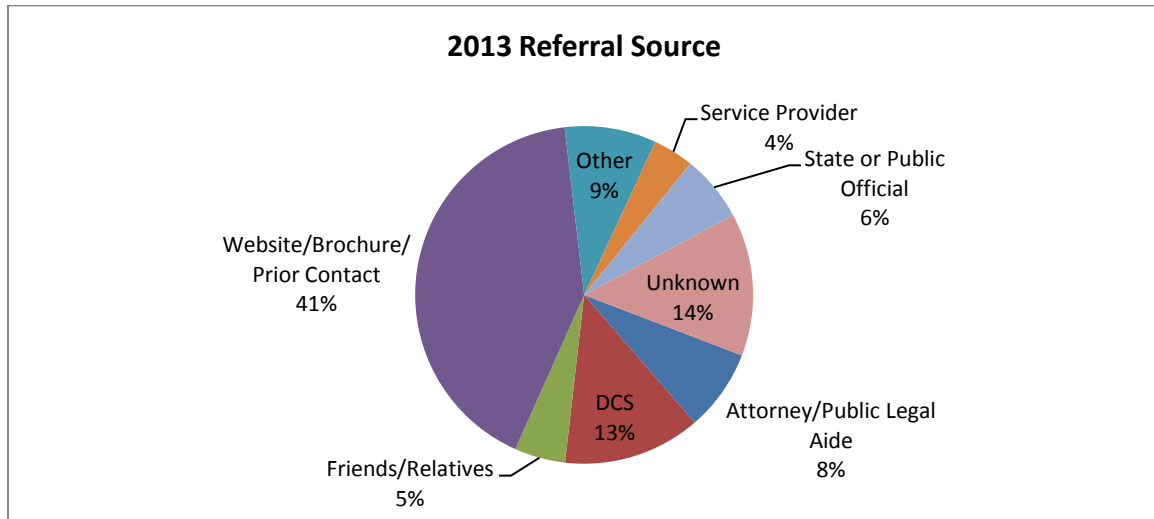
## Cases

During 2013, 210 cases were opened, 210 cases were closed and 267 were active during the course of the year; the cases were generated following the receipt of a formal complaint. This number reflects an increase from the prior two years. The increase in the number of cases in addition to the increase in the number of I & R inquiries suggests heightened community awareness about the DCS Ombudsman Bureau.



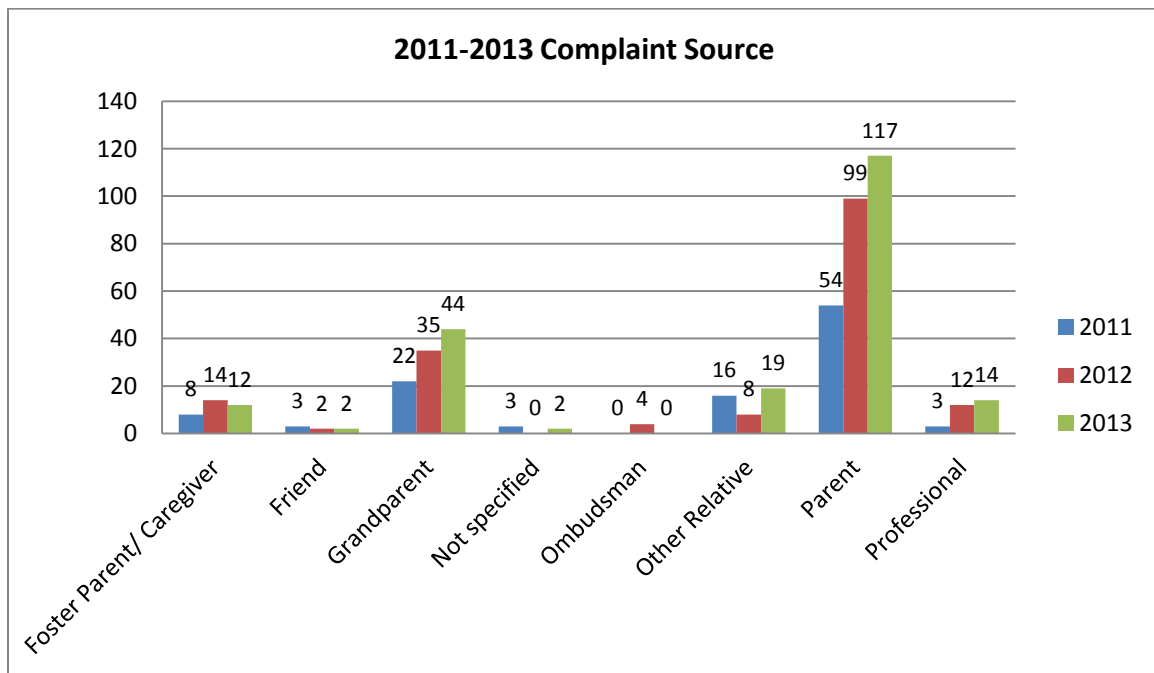
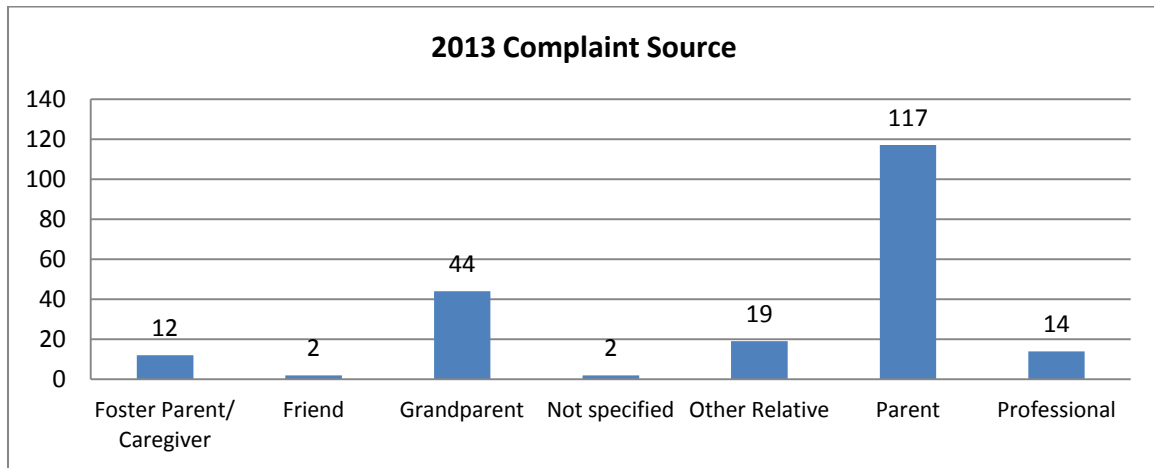
## Referral Source

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 2012 and 2013 data suggest that Website/Brochure/Prior Contact continues to be the largest source of referrals; there has been a slight increase of referrals from DCS (3%), Service Providers (2%), and Attorney/Public Legal Aide (5%). Unknown reflects those individuals that chose not to identify a referral source during intake discussions with the Bureau or on complaint forms.



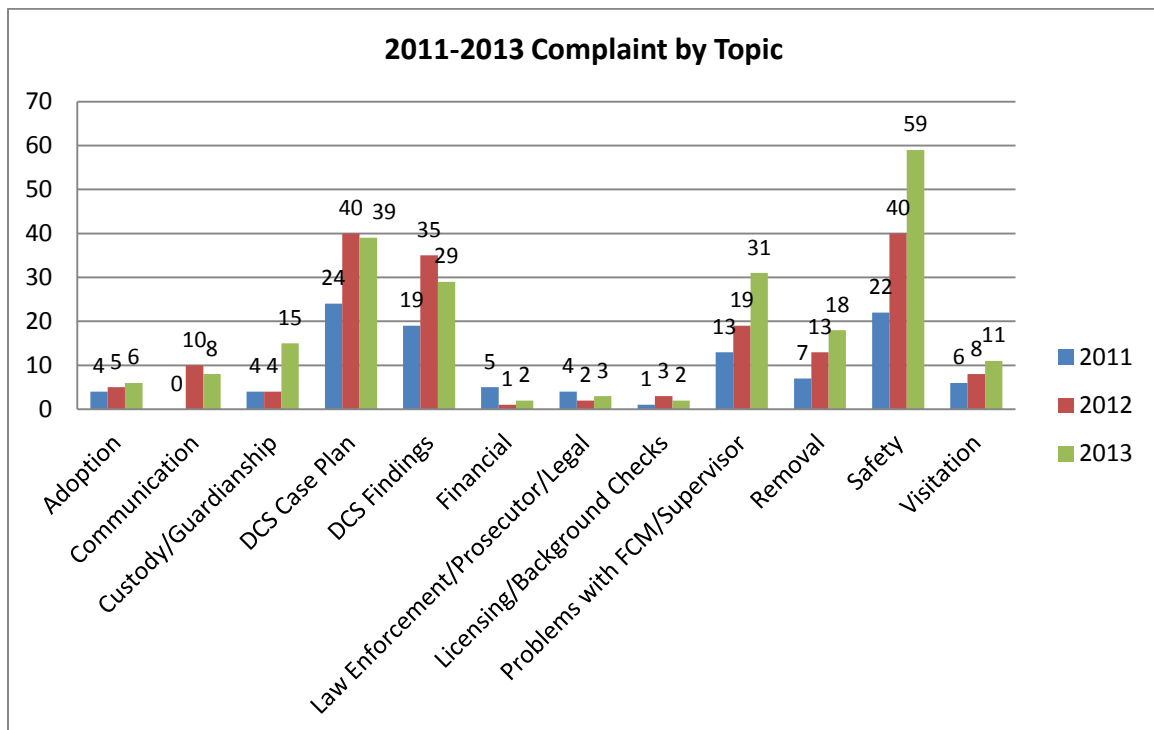
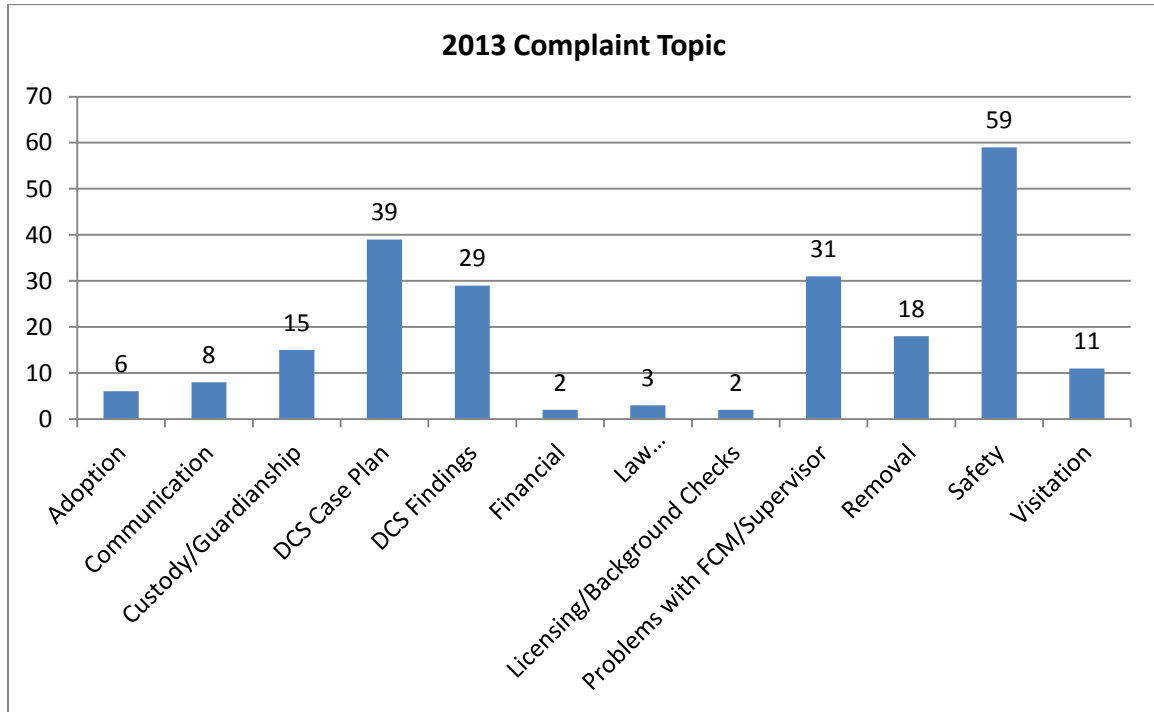
## Complaint Source

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 2013 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 (19) and Professionals (14).



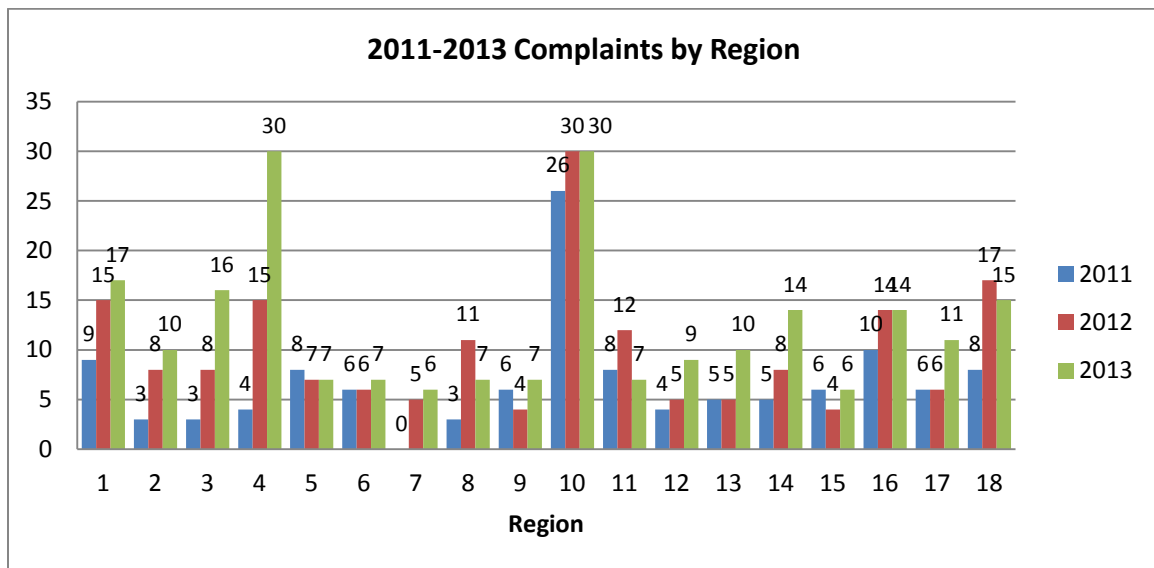
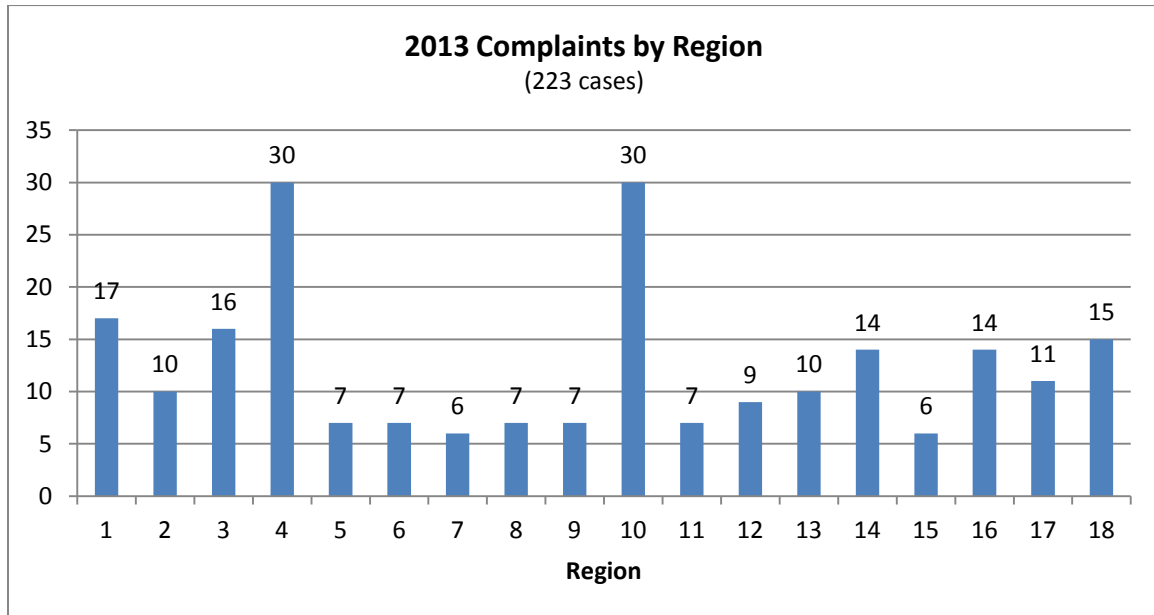
## Complaint Topics

During 2013 the major complaint topics included *Child Safety*, *DCS case plan*, *Problems with FCM/Supervisor*, and *DCS Findings*. With the exception of *Problems with FCM/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 2013. 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 2013, two 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.

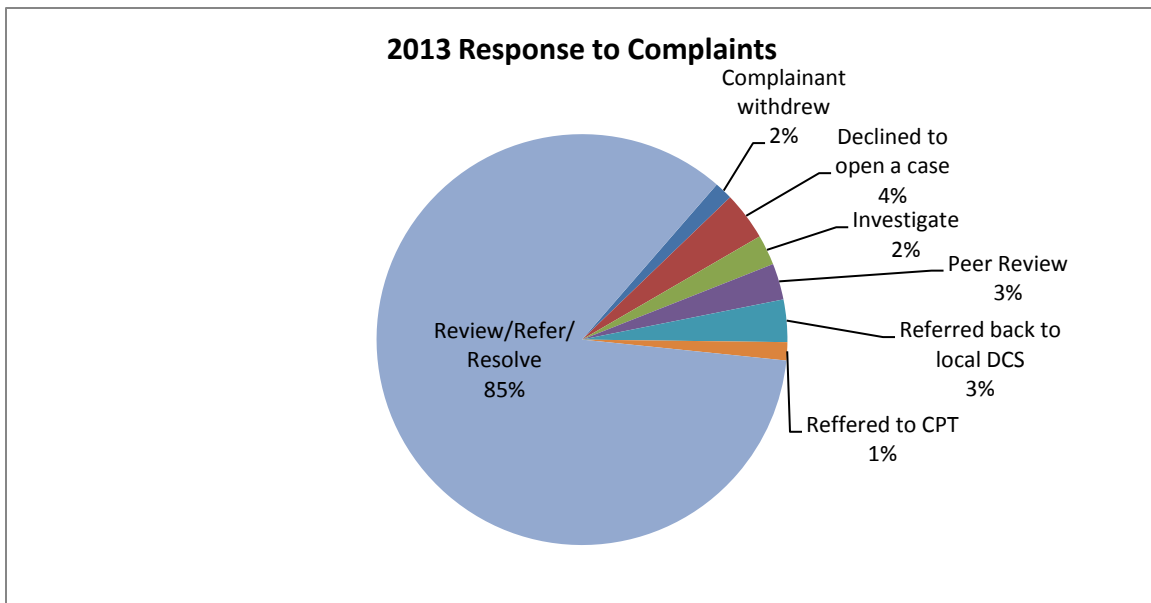
**Close due to Complainant Withdrawal:** Some cases have been closed prior to completion because the complainant decides to withdraw the complaint during the process.

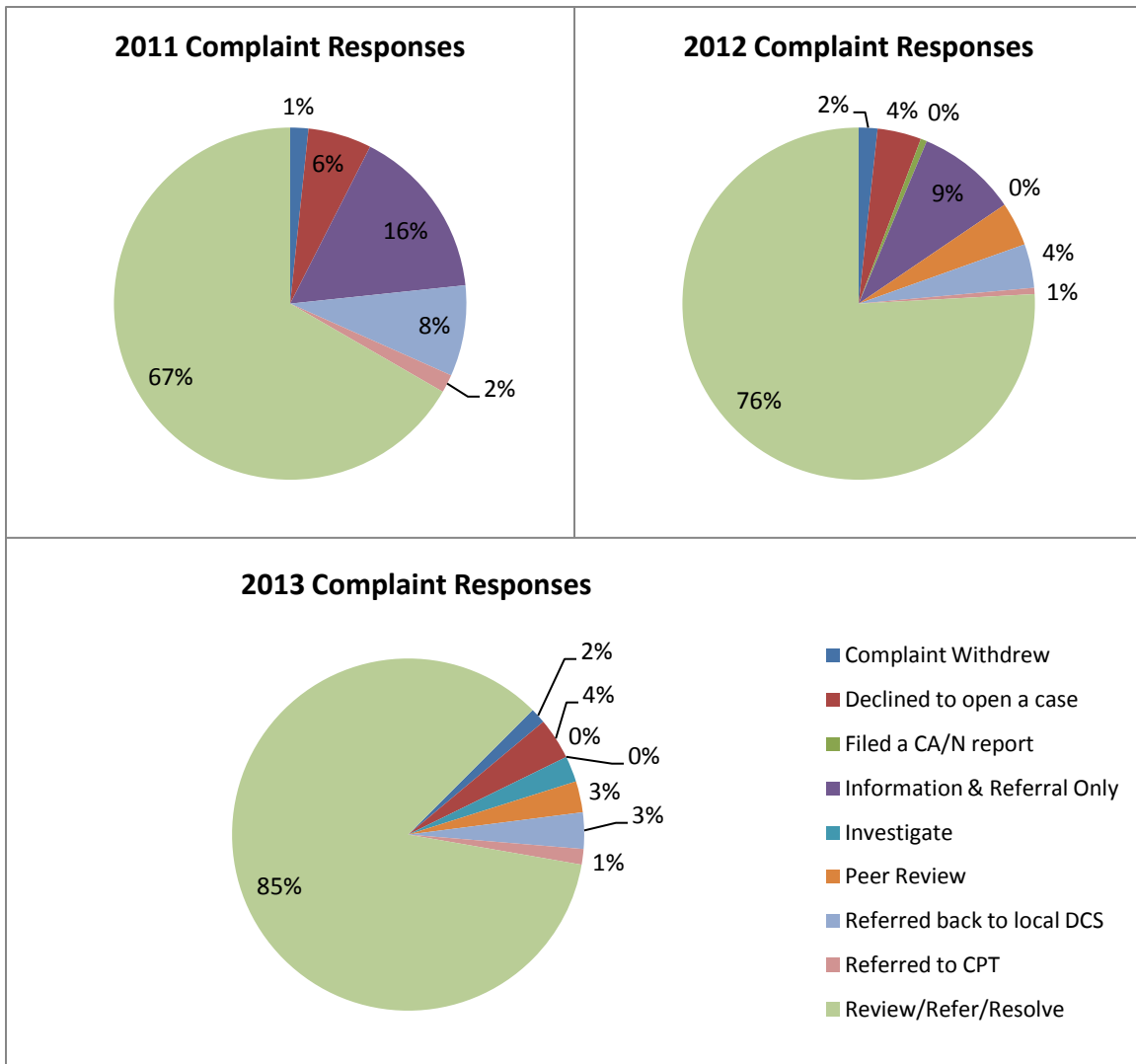
**Decline:** Cases that are not within the Ombudsman's jurisdiction or otherwise meet the criteria established in the procedural manual for screening out will be declined.

**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 followed by a three-year comparison.





## 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

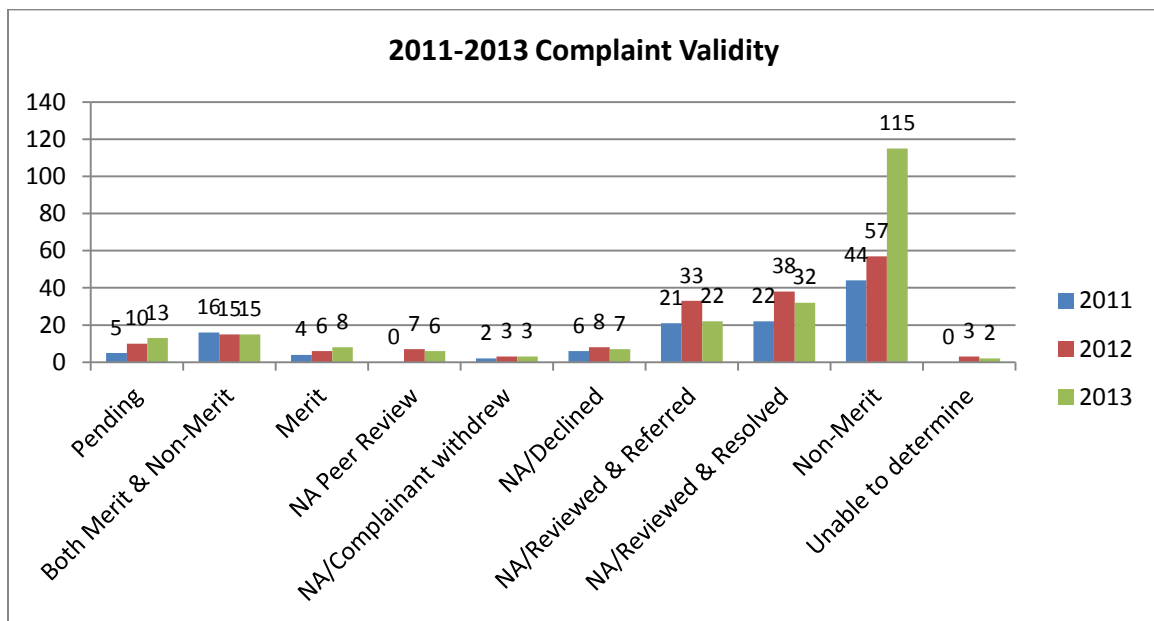
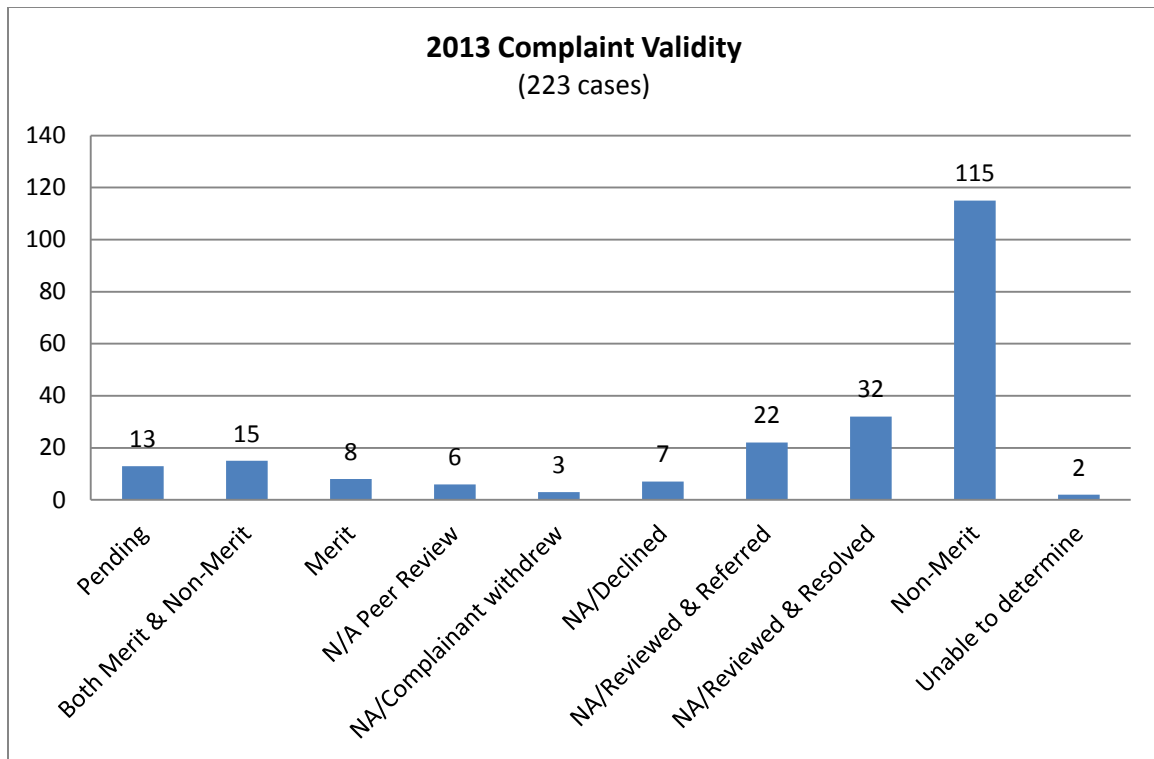
**Unable to Determine:** Occasionally the information uncovered is so conflicting and/or the unavailability of significant documentation renders it impossible to determine a finding.

**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 2013 validity designations were determined in 138 cases. Of these 138 cases, 8 were determined to have merit, 15 had allegations that were both merit and non-merit, and 115 were determined not to have merit. Thus 17% of the cases that received a validity determination involved an allegation that was determined to have merit, and 83% did not have merit.

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 2013 as well as a comparison with prior years:



## **Recommendations and DCS Responses**

During 2013 the Ombudsman offered 24 recommendations on specific cases following a review or an investigation and 6 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 first seven case summaries include 2013 cases in which the allegations were determined to have merit or both merit and non merit and recommendations were provided and responses received. Case examples eight and nine include cases in which the allegations were reviewed and referred to the Child Protection Team (CPT) for response and/or future action. The last case example does not to have merit, but recommendations were provided and follow up requested due to other issues identified.

\*It is noted that this office affirms the actions of DCS in the majority of cases reviewed and it is important to maintain this perspective when reviewing cases in which problems were identified. 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.

**Case Example #1:** This complaint involved two families, two counties, many allegations with different alleged perpetrators and a valid ethics issue requiring attention. There were allegations that the failure to appropriately assess this situation put the child at risk.

**Findings:** Due to the complex presenting issues, it was determined that the allegations rose to the level of an investigation. The allegation that all of the reports were not investigated had merit. The allegation that a conflict of interest regarding the DCS employee representing their spouse in the child support case was outside the scope of this office and was referred to the DCS Ethics Officer. The allegation that DCS failed to protect the child by returning the child to the parent who is an alleged perpetrator was

determined to not have merit. The allegation that the Family Case Manager (FCM) broke confidentiality was unable to be determined.

**Recommendation:** A recommendation was made for the DCS Ethics Officer to review the ethics question. With regard to the Assessment issues, it was recommended that the local offices develop a plan to ensure that all of the allegations in a report are addressed and a plan to ensure communication between counties when assessments are transferred between counties. It was further recommended that the local office address the role of bias in the decision making process with the FCM, in this case and in general, and consider assigning a different FCM to future assessments involving this family.

**Response:** The DCS Ethics Officer reviewed the matter in question and appropriate action was taken. In addition, the following response was provided by the Local Office Director (LOD) involved in most of the assessments:

All assessments that appear to be duplicates will be sent to the LOD for consideration. If the LOD agrees that the assessment will be withdrawn due to being a duplicate, the LOD will review both the new assessment and the assessment that had previously been assigned for assessment to ensure that a withdraw is appropriate because the allegations are the same or similar in nature. The Regional Manager (RM) will then be sent a copy of the information and notified of the withdrawn assessment. If the LOD agrees that the allegations in the assessment are insufficient to warrant an assessment, the withdraw is the correct action. If at any time, the LOD does not agree with an assessment being withdrawn, the assessment will be returned to an FCMS for assignment to an FCM.

The issue of bias in decision-making has been discussed with the Family Case Manager Supervisors (FCMS). All FCMS will discuss this at their next staff meeting with their employees, and it will continue to be addressed as a reminder that DCS staff are to always keep an open mind when conducting assessments and making assessment decisions.

**\*\*As a follow-up, it is noted that another report with similar allegations was made following the DCS Ombudsman Bureau involvement, which resulted in the removal of the child from an unsafe environment.**

**Case Example #2:** The complainant was extremely concerned about his grandchildren who were recently the victims of sexual abuse by the mother's boyfriend's brother. The complainant contends there were similar allegations in 2009 indicating a pattern of mother failing to protect the children. The complainant was concerned because DCS could not locate this history and failed to remove the children, considering the alleged perpetrator was immediately arrested and mother's life style did not change.

**Findings:** Upon review, the DCS Ombudsman Bureau believed the complainant had points worth exploring further. DCS did not substantiate neglect on the mother even though the abuse occurred in her home while she was present and law enforcement had enough evidence to file criminal charges. In addition, mother's living circumstances were still unstable and questionable.

**Recommendation:** This office requested further clarification regarding the local office's assessment of the children's safety and referred the matter to the CPT. It was also recommended that if the mother failed to continue to provide therapy for the children, that DCS intervene further.

**Response:** DCS explained that because mother was responsive to services and they believed she was unaware of the abuse, that there was not a preponderance of the evidence to substantiate. They further identified her stated intention to divorce the AP's brother as a protective factor. The case was reviewed by CPT, and while there was some concern about mother's ability to sustain stability, DCS's actions were affirmed. DCS agreed to advise the therapist to file a report if the mother failed to follow through with counseling for the children. DCS subsequently advised the DCS Ombudsman Bureau that a new report was received and mother tested positive for methamphetamine and marijuana; an Informal Adjustment (IA) was initiated.

**Case Example #3:** The complainant in this case alleged that DCS was not moving forward with reunification even though the mother had complied with the requirements. There were also allegations that DCS was allowing one of the children's fathers to have less restrictive visitation, despite his noncompliance with services.

**Findings:** Upon review this office found merit to some of the allegations. The mother complied with services, yet visitation was progressing very slowly. It became apparent that one of the main issues was communication and planning. The DCS Ombudsman Bureau primarily believed that the case lacked direction and did not reflect the primary principles of the Practice Model. During the course of this investigation, case log notes documented negative and unprofessional communication from the service provider.

**Recommendation 1:** It was recommended that the local office work with the State Practice Model Director with regard to planning and effective communication. Additional recommendations were made by the consultant from the State Practice Model Team. The bureau supports these recommendations, which involve placement, visitation, and planning.

**Recommendation 2:** It was recommended that the issue of unprofessional communication be addressed with the service providers and their agencies.

**Response 1:** DCS worked with the State Practice Model Director, who facilitated two team meetings. The FCM had many discussions with the State Practice Model Director and the team regarding placement, visitation and the father's services. The plans that were discussed during the team meetings have been put into place.

**Response 2:** The LOD had a meeting with the service providers and their supervisor. The Director went over the DCS mission, vision, and values as well as professional communication and the code of conduct. Each person provided their signature and date showing that they attended the meeting.

**Case Example #4:** The complainant alleges that the assigned FCM promised to help the relative placement with financial resources, but did not, which resulted in the children being placed in foster care. The complainant also alleged that the FCM rarely followed



up with the children or the parents and their services which resulted in DCS pursuing Termination of Parental Rights.

**Findings:** The merits of the specific allegations were difficult to determine because of the lack of documentation in the case, which is a violation of policy in itself. The LOD advised that the FCM was no longer with the agency, and that the quality of her work and communication with the FCMS was an identified problem that had been addressed. Per DCS, the complainant never brought these issues to the attention of the FCMS. While we were unable to determine the validity of these details, the fact that there was no documentation and that no one from the department could provide additional information was an indication of a systemic problem at the county level.

**Recommendation:** It was recommended that the LOD provide the DCS Ombudsman Bureau 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 modification of policies/procedures around the supervisory role that resulted from this experience.

**Response:** Documentation by supervisors is important and specific directions, established tasks, and deadlines should be noted in the electronic case files; When FCMs are no longer able to serve a family due to medical leave, cases should be reassigned immediately and an inventory should occur of services, permanency goals and tasks to be attained and completed. The FCMS should also hold newly assigned team members accountable for assuming all case management responsibilities. The phrase “temporarily assigned” should no longer be used; it should be effectively communicated with caregivers, relatives, providers, and other relevant providers when a case has been assigned. This can be accomplished by the Supervisor, FCM or clerical support;

A Child and Family Team Meeting (CFTM) should be scheduled immediately by the newly assigned FCM to glean identified needs, services and permanency goals and plans that are in place; supervisor contact information should be relayed to parents, providers, and caregivers at the beginning of DCS involvement. This information should be shared at the CFTM to include the chain of command; immediate staff management concerns should be discussed with the Division Manager (DM) for direction and support.

**Case Example #5:** The complainant in this case alleged that DCS did not properly address allegations of physical abuse made against her and that DCS failed to communicate details related to the assessment. Additionally the complainant alleged that the FCM did not provide financial support as promised, and as a result, the electricity was turned off in the home.

**Findings:** A review of the case revealed that an IA was signed in February, 2013 and there was no contact between DCS and the complainant until April, 2013. It was determined that several issues occurred during the transition from the assessment FCM to the FCM that would be providing on-going services. The complainant was in the midst of moving and waived back and forth about following through with services. There was not a smooth transition between FCMs due to caseload sizes and vacations and other family emergencies. During this time, the assessors were averaging 20

assessments per worker. The state standard is 12 assessments per assessor. DCS affirmed that there were missed opportunities to fully engage the family in the teaming process and issues were not addressed promptly. The complaint was filed with the DCS Ombudsman Bureau 5 days prior to DCS approving the payment of utility bills.

**Recommendation:** The bureau requested that the LOD provide a plan to address follow-up with the family and a plan to address the follow-up on transitioning case from Assessment to Case Management.

**Response:** The LOD advised that the IA would expire in less than 2 months. They did not participate fully with home based services but they continued to participate in outpatient counseling for their child with special needs. A CFTM will be held in August to establish on-going family/system support and safety plans. The LOD developed a transition plan that identifies areas where a case might “fall through the cracks”. Supervisors will provide closer oversight to avoid case management delays as experienced in this case

**Case Example #6:** This complainant did not believe DCS conducted an appropriate assessment by scheduling a visit with a parent when the allegations included deplorable home conditions, among other things.

**Findings:** The review confirmed that the FCM made a scheduled visit five days after the parent was notified of the report. As there is no policy per se regarding this practice, the RM’s were queried and agreed that the expectation would be to make an unannounced home visit in these circumstances. When the local office was questioned regarding this decision, it appears that workload was a factor. The log notes indicate the parent was also somewhat resistive to a home visit.

**Recommendation:** It was recommended that the local office ensure that staff is aware of this practice expectation.

**Response:** The County will conduct initial unannounced home visits on all environment allegations and the following practice will be implemented to improve performance in this area:

Home Visits:

On all environment allegations FCM’s will conduct the following case management actions:

- 1) The first visit in the home will be unannounced. This means the FCM will make as many unsuccessful home visits until this task is successfully completed to meet policy expectations. Do not leave a card as it will tip-off the alleged perp. The goal of this task is to obtain a daily normal observable accurate picture of the environment in the mandated time frame.
- 2) In the MaGiK contact narrative, the FCM will document that the visit was unannounced and will upload all pictures taken of the environment.
- 3) Failure to execute this request could result in discipline action.

**Case Example #7:** The complainant alleged that DCS did not properly assess allegations of physical abuse made against the children’s mother. The complainant stated that relevant information was not included in the report and that the information was not

taken into account when assessing the allegations. The report of abuse was filed following an incident of domestic violence between two teenage girls and their mother. Law Enforcement Agency (LEA) was called to the scene by the mother. The allegations were found to be unsubstantiated following an assessment by DCS and LEA as the girls and their mother all had bruises and a clear perpetrator could not be determined. The girls admitted to enjoying “pushing their mother’s buttons” and that they were not afraid of her. No charges were filed on the mother or the girls. All parties were advised to continue in counseling. One of the girls was completing probation. The girls live with their father and two younger brothers reside with their mother. They visit the other parent on alternating week-ends. There are continual custody struggles between the parents which negatively impact the children.

**Findings:** The DCS Ombudsman Bureau noted that while the findings were found to be in compliance pursuant to policy, there was a concern that the assessment ran 41 days late. It should be noted that the complainant contacted the bureau once the case was closed to request an opportunity to submit additional information to the bureau. The DCS Ombudsman Bureau agreed to review the material and subsequently submitted additional concerns to the LOD regarding inaccuracies in the assessment report. The LOD affirmed that there were inaccuracies and that the assessor was a newer employee who was behind on data entry which resulted in the delay in the submission of the assessment.

**Recommended:** The DCS Ombudsman Bureau requested the LOD to provide a plan of action to ensure that assessment reports are completed accurately and timely according to policy.

**Response:** The LOD has addressed the concerns with supervisors and staff.

**Case Example #8:** The complainant stated that the child was removed from the birth mother and DCS planned to give custody to the birth father, with parenting time for the birth mother agreed upon by the parties. The complainant stated that everyone was in agreement but the plan was changed by DCS to reunification because the birth mother was doing much better. The complainant noted that the birth mother had a significant history of mental illness and was on house arrest at the time. The complainant felt that DCS was failing to protect the child by working toward reunification with the birth mother.

**Findings:** Upon review it was determined that at one point in the case the birth mother was considering giving the father custody, with an equal timesharing arrangement, but she subsequently changed her mind. The case plan was never officially changed and it was always reunification with the birth mother. While birth mother’s significant history generated concern, the documentation supported substantial progress. The DCS case plan was found to be appropriate and services are also being provided to the birth father. DCS is also encouraging a custody order when the case closes.

**Recommended:** The Ombudsman Bureau requested a CPT review.

**Response:** A CPT review was held on April 17, 2013. There was agreement by the team that the birth mother was doing well and that the current reunification plan should continue. Further it was determined that based on past drug use, the case would remain

open for a period of time after the child was returned to the birth mother's care. The team members (specifically the DCS Attorney) also went to great lengths to explain the concurrent plan of reunification with birth mother and custody with birth father. Birth father was angry and may not have understood or heard the plan. The county will follow-up with the father to ensure that he understands the concurrent plan. At this point DCS has done everything they can to provide support for a successful reunion.

**Case Example #9:** The complainant was extremely concerned about his grandchildren who were recently the victims of sexual abuse by the mother's boyfriend's brother. The complainant contends there were similar allegations in 2009 indicating a pattern of mother failing to protect the children. The complainant was concerned because DCS could not locate this history and failed to remove the children, considering the AP was immediately arrested and mother's life style did not change.

**Findings:** Upon review, the DCS Ombudsman Bureau believed the complainant had points worth exploring further. DCS did not substantiate neglect on the mother even though the abuse occurred in her home while she was present and law enforcement had enough evidence to file criminal charges. In addition, mother's living circumstances were still unstable and questionable.

**Recommendation:** This office requested further clarification regarding the local office's assessment of the children's safety and referred the matter to CPT. It was also recommended that if the mother failed to continue to provide therapy for the children, that DCS intervene further.

**Response:** DCS explained that because mother was responsive to services and they believed she was unaware of the abuse, that there was not a preponderance of the evidence to substantiate. They further identified her stated intention to divorce the alleged perpetrator's brother as a protective factor. The case was reviewed by CPT, and while there was some concern about mother's ability to sustain stability, DCS's actions were affirmed. DCS agreed to advise the therapist to file a report if the mother failed to follow through with counseling for the children. DCS subsequently advised the DCS Ombudsman Bureau that a new report was received and mother tested positive for methamphetamine and marijuana; an IA was initiated.

**Case Example #10:** Numerous reports were made regarding abuse by the custodial parent. The complainant alleged DCS refused to protect the children from abuse by failing to properly investigate reports which resulted in further abuse and neglect of the children; that DCS failed to include the Reporting Source in the assessment interviews; and, there was a conflict of interest between the birth mother and DCS.

**Findings:** The bureau reviewed all assessment reports and found that the complaint had merit in one instance in that DCS did not interview the Reporting Source during the course of the assessment pursuant to DCS policy. Allegations that a conflict of interest existed between DCS and one of the birth parents were found to be without merit. The DCS Ombudsman Bureau found that the county was providing appropriate services to assist the birth mother and the children. This is a custody issue with the birth parents sharing visitation per the custody order. There are constant reports alleging abuse and

neglect by the birth mother. DCS has continued to follow up on reports pursuant to policy. The birth mother and children were participating in services however; a psychological evaluation for the children and their parents was pending completion at the time of the complaint.

**Recommendation:** The DCS Ombudsman Bureau requested to be notified upon the completion of the psychological evaluation.

**Response:** DCS reported that the psychological evaluation was completed and specific services for the family were identified and set in place. The case was recently closed due to the satisfactory compliance of the mother and children with services.

## **Systemic Recommendations**

Pursuant to IC 4-13-19-5(b) (2), (4) and (6), the Ombudsman 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 who are under the jurisdiction of a juvenile court, and 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. The following is a summary of four Recommendations that were pending from the last quarter of 2012. The DCS Ombudsman Bureau offered 5 recommendations during 2013.

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 DCS reports and discussions with community partners.

### **2012**

***\*Recommendations #13 through #16 were provided the last quarter of 2012***

**Recommendation #13:** Based on feedback from the local offices and the hotline staff, there appeared to be some confusion as to when and how reports are referred to the Institutional Unit for Assessment when sexual abuse allegations involve two minors and the alleged incident occurred in a facility. It is recommended DCS provide clarification to staff regarding the above and develop a plan for ensuring that the Hotline, Institutional Unit, and the Local Office receive the same information regarding the process.

**Response:** Hotline staff met with the ICPS unit and developed a plan to ensure that the intake report is routed properly. Any reports in which neglect by a facility is alleged will be sent to the Institutional CPS Unit. If there are also allegations of a child on child contact, the Institutional CPS Unit will request an assist by the local office if needed. If the report alleges inappropriate activity (usually sexual abuse) between children and no

allegation of neglect by the facility, that report will be sent to the local office. The local office will request an assist by the ICPS Unit if it appears there may be neglect on the part of the facility. Examples below:

- Anonymous Caller reports sexual activity between two children in a facility and suggests the facility should have provided better supervision = CPS with an assist by local office if requested.
- Facility reports only sexual activity by 2 children, i.e. no neglect = local office assesses with an assist by ICPS if possible neglect discovered.

**Recommendation #14:** The DCS Ombudsman Bureau has reviewed a number of cases in which a child has been moved from a foster home for reasons other than abuse/neglect or a Court order. These usually involve instances of foster parent non-compliance with DCS expectations and/or with 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 foster parent complaint. While DCS complied with the foster parent resolution process in these instances, the complainants continued to express a desire to be heard, as there appeared to be a misunderstanding regarding DCS's authority with regard to the final decision. It is recommended DCS expand the Foster Parent Resolution Policy to include what outcomes can be expected from this process and DCS's authority in these matters.

**Response:** The Policy section will amend the current Foster Parent Complaint Resolution Process to more accurately describe the purpose of the meeting and possible outcomes as well as DCS' authority being final.

**Recommendation #15:** The name of the Report Source (RS) is entered on the abuse/neglect report, if applicable, but there is no place on the form to add the RS's relationship to the child victim. It is recommended that RS's relationship to the child be added to the 310 forms.

**Response:** Currently the intake process does identify a relationship between the RS and victim in the RS demographics field. However, that information is not populated to the 310. DCS will make this a priority in MaGik following the completion of the new Hotline related intake changes. It should be in production by the end of March 2013.

**Recommendation # 16:** Sometime during 2010 the DCS Ombudsman Bureau began receiving notices of Fatalities/Near Fatalities that are reported to the Hotline and assigned for investigation. Upon tracking these reports it was learned that some of the investigations were taking nearly two years to complete. The Ombudsman tracking system revealed documentation for the average turnaround time for the past three years. To address this issue DCS implemented a policy on January 1, 2012 requiring Fatality/Near Fatality Assessments to be completed in 180 days. Based on the data collected by the Ombudsman Bureau, there has been noted improvement, but there are still many Assessments that will not be completed within this time frame and outstanding from prior years. Not only does this impact the interpretation of data, but a timelier turnaround time would provide DCS with needed information while working

with the family. It is recommended DCS continue to monitor this process and identify and address any barriers to completing the reports during this time frame. It is also recommended that DCS establish a timeframe for eliminating the backlog. Furthermore, the effort to eliminate the backlog could influence the annual fatality report, as the Assessments included in that report consist of those that were substantiated in that particular fiscal year. It is recommended DCS consider adding the year that the fatality occurred to the annual report information.

**Response:** DCS has appointed a committee to examine the process and look for efficiencies in both processing and reporting Fatalities/Near Fatalities. Additionally, outstanding fatalities are being reviewed to develop processes to address backlogs. This is an on-going process.

**Note:** The DCS Ombudsman Bureau requests to be kept apprised of the committee's process

### **2013**

***Recommendation #1: Caseloads and Staffing:*** 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 use 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.

**Response:** 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.

***Response:*** 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.

***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.

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



***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.

**Response:** 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.

***Recommendation # 5: Future Project – Repeat Maltreatment:*** The DCS Ombudsman Bureau has recently 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.

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

## **DCS Ombudsman Bureau Reflections and Future Initiatives**

Since its inception in 2009, every year has brought forth substantive change for the DCS Ombudsman Bureau and 2013 was no different. Susan Hoppe, Director of the DCS Ombudsman Bureau retired from service to the state of Indiana in April 2013. Alfreda Singleton-Smith was appointed to the position in June 2013. Staff turnover occurred at the Assistant Ombudsman level as well. Jeffrey Gates resigned his position in August 2013 and Colbi Lehman joined the DCS Ombudsman Bureau in October 2013. The DCS Ombudsman Bureau is comprised of three full time staff. The loss of two-thirds of the staff in the space of six months had the potential of slowing down the bureau's ability to respond timely to client's needs. However, policies and procedures put in place by Director Hoppe provided a consistent "road map" to guide staff during the period of adjustment. Assistant Ombudsman Jessica Shanabruch is credited with providing consistent services to those contacting the Bureau during this period as new staff became acclimated to the statutes, policies and practices of both the DCS Ombudsman Bureau and DCS.

Given the staff changes, the primary focus for 2013 was as follows and preceding data demonstrates that 2013 goals were met in all instances:

1. Meeting or exceeding goals for responses to constituent complaints;
2. Continued efforts to develop lines of communication between DCS and other community stakeholders with a vested interest in the needs of children and families;
3. On-going staff development;
4. Enhanced Outreach efforts.

2013 also marked a year of change for DCS. As stated previously, Director Mary Beth Bonaventura assumed leadership of the agency in early 2013 and Chief of Staff Doris Tolliver and Deputy Director Jane Bisbee and were placed in their positions in the spring/summer of 2013 respectively. They have continued to support the Bureau in its statutory efforts by making themselves and DCS staff and records available for the purposes of responding to constituent concerns. The Ombudsman has worked with DCS in preparing reports for the Child Services Oversight Committee as well as discussions on case specific and systemic concerns and recommendations. The DCS Ombudsman Bureau looks forward to strengthening existing lines of communication with DCS within the context of our Mission and Guiding Principles.

The DCS Ombudsman Bureau made five over arching Systemic Recommendations to DCS during 2013 and the DCS response to these recommendations is provided in preceding pages. The Bureau acknowledges steps taken in late 2012 and 2013 by DCS to develop and implement strategies to promote best practice in these areas. The DCS Ombudsman Bureau will continue to monitor these initiatives during 2014 and is available to work with DCS in these important efforts.

## Acknowledgements

The DCS Ombudsman Bureau extends a heartfelt ***Thank You!*** to the parents, relatives, professionals, foster parents and others who provided the Bureau the opportunity to address their concerns and learn from their experiences. I want to recognize DCS field staff that has enthusiastically cooperated with DCS Ombudsman Bureau reviews and investigations. This response has enabled the Bureau to adhere to our high review standards. The DCS field staff is under the able direction of Deputy Director Jane Bisbee, who has continued to ensure that lines of communication between DCS and the DCS Ombudsman Bureau are open and collaborative. I am particularly grateful for the hard work and dedication of the Bureau's Assistant Ombudspersons Jessica Shanabruch, Colbi Lehman and Jeff Gates. During their tenure, they have each demonstrated a sincere commitment to providing quality support and services to those accessing the DCS Ombudsman Bureau.

## **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 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.

**Colbi Lehman** grew up in Linton, Indiana. She attended Linton-Stockton High School and graduated in 2005. She then went on to Indiana University in Bloomington, Indiana and graduated with a Bachelor's Degree in Education. Colbi worked as a Family Case Manager for the Department of Child Services from 2010-2012 where she focused primarily on assessing abuse and neglect reports. She then went to work as an applied behavior analysis therapist from 2012-2013 providing therapy for children on the Autism Spectrum. In August 2013, Colbi joined the DCS Ombudsman Bureau.

# 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.

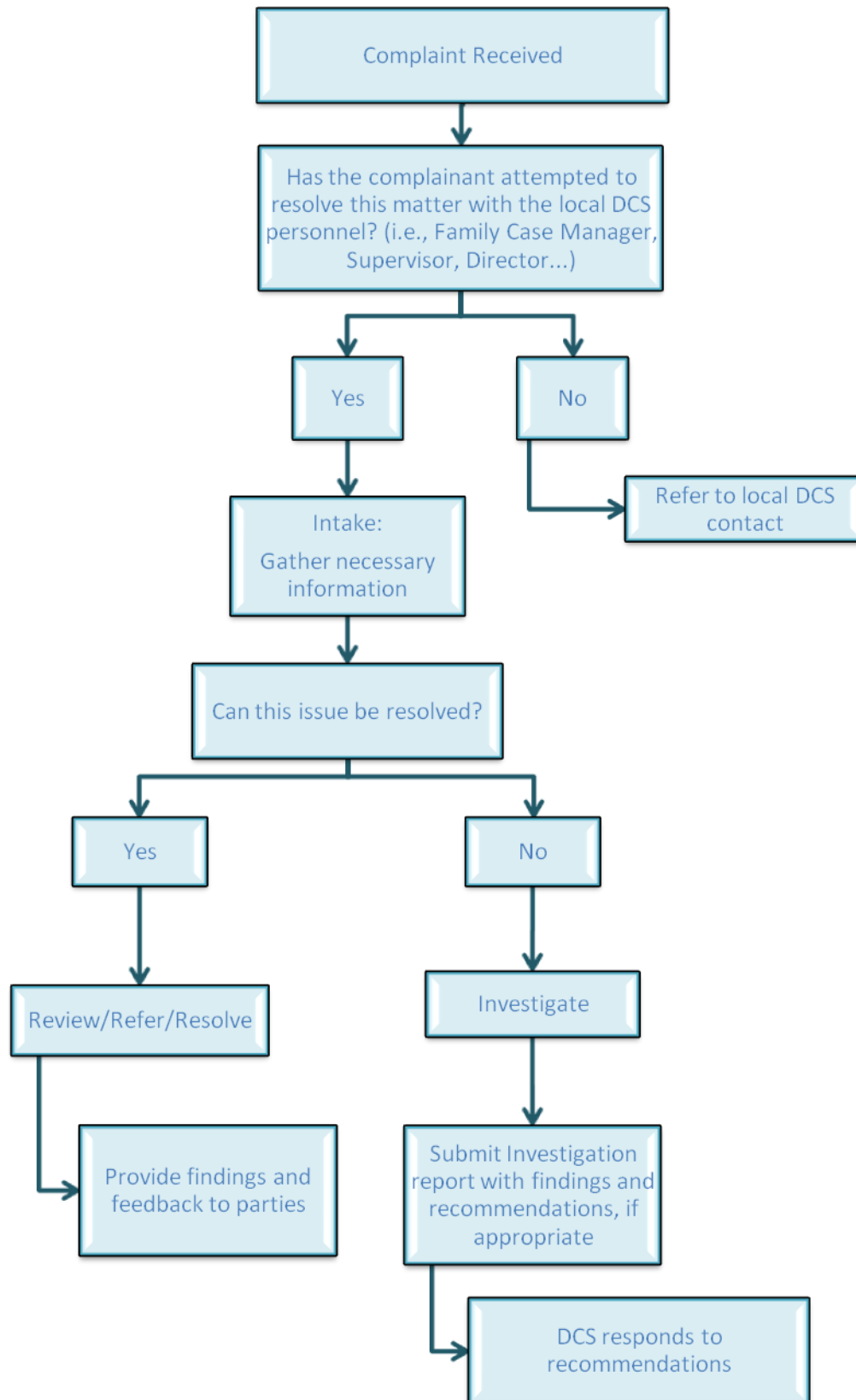
#### **DCS Ombudsman Bureau Responsibilities**

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.

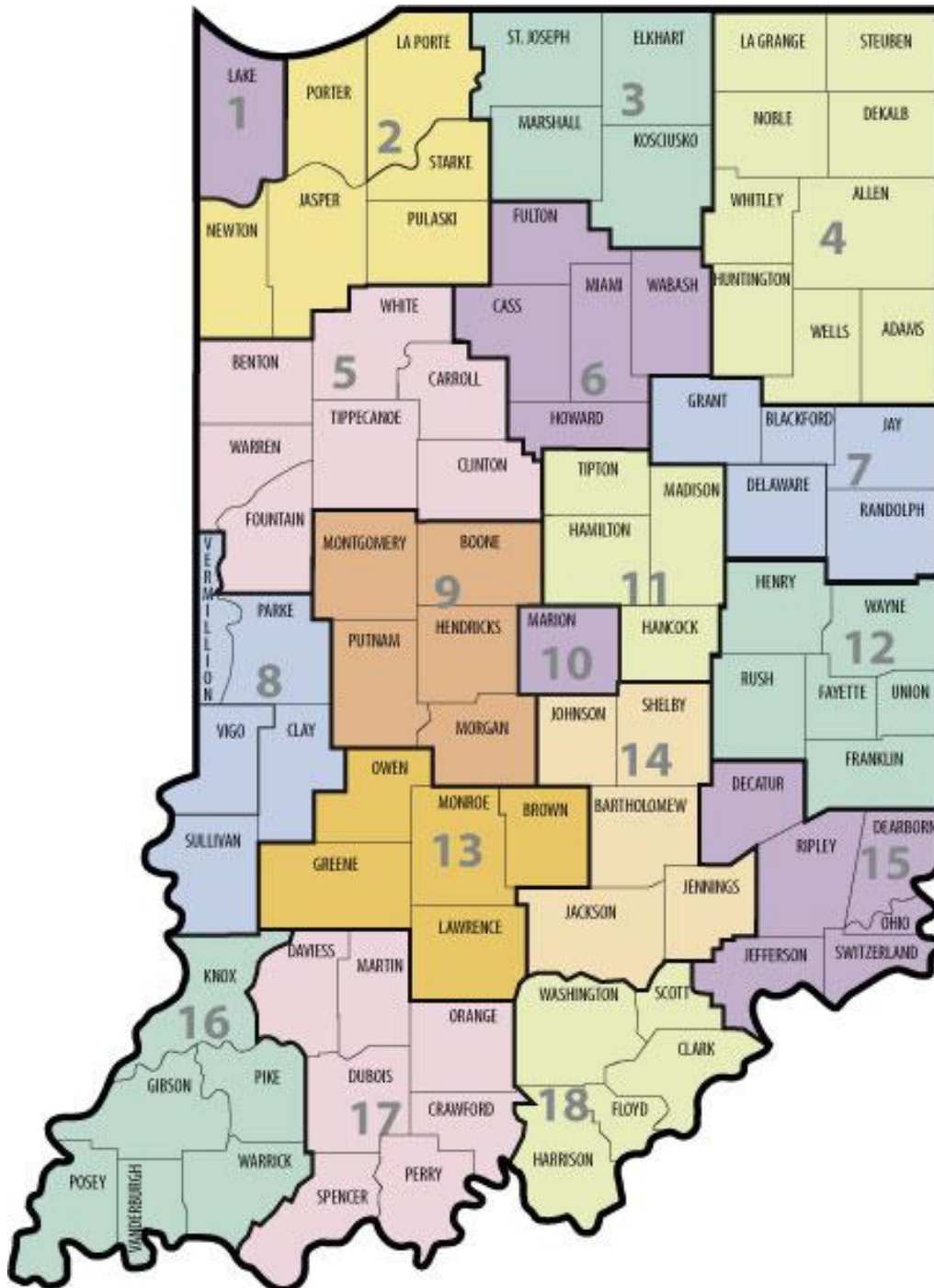
# Attachment C

## How We Work



# Attachment D

## Regional Map





# **Attachment E**

## **Contact Information**

### **DCS Ombudsman Bureau**

#### **Office Hours**

8:00 am to 4:30 pm

#### **Telephone Numbers**

Local: 317-234-7361

Toll Free: 877-682-0101

Fax: 317-232-3154

#### **Ombudsman E-mail**

[DCSOmbudsman@idoa.in.gov](mailto:DCSOmbudsman@idoa.in.gov)

#### **Ombudsman Website**

[www.in.gov/idoa/2610.htm](http://www.in.gov/idoa/2610.htm)

#### **Mailing Address**

DCS Ombudsman Bureau  
Indiana Department of Administration  
402 W Washington Room 479  
Indianapolis, Indiana 46204

