State of Indiana

Department of Child Services
Ombudsman Bureau

2016 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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STATE OF INDIANA

Eric J. Holcomb, Governor

DEPARTMENT OF ADMINSTRATION
Department of Child Services Ombudsman Bureau

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The Honorable Eric J. Holcomb, Governor
The Honorable Speaker and President Pro Tempore
Sam Criss, Interim Director, Indiana Department of Child Services
Terry Stigdon, 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 2016 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, 2016 to December 31, 2016 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 Governors Pence and Holcomb, Department of Child Services Interim Director Criss and incoming DCS Director Stigdon, 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 2016. Their commitment to Indiana's families 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 DCS Ombudsman 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

Table of Contents

Executive Summary

Introduction

The DCS Ombudsman Bureau continued to experience substantial program growth in 2016. The agency's efforts focused on ensuring the continued stability of the agency's goals of:

- effectively responding to constituent complaints in a timely manner;
- enhancing and developing program practices and guidelines;
- increasing the number of constituent responses;
- and, 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 2016, the primary activity of the office was to respond to complaints, determine findings, provide case specific and systemic recommendations, and monitor DCS responses. 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 584 Information and Referral (I & R) inquiries, conducted 101 Assists, opened 238 Cases and closed 248 Cases. A total of 384 active total cases were reviewed during 2016 (258 closed and 87 closed) which included cases from the last quarter of 2015. Three investigations were completed in 2016.

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. For the first time in three years, the DCS Ombudsman Bureau experienced no staff turnover in 2016.

Budget: The DCS Ombudsman Bureau was appropriated $313,807 in the 2016 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. This increase allowed the DCS Ombudsman Bureau to continue efforts to address staffing and outreach challenges. Continued program growth in 2016 presented opportunities for the growth of service delivery to those constituents impacted by DCS involvement. As a result, the DCS Ombudsman Bureau found it necessary to request an increase of one Full Time Equivalent (FTE) Assistant Ombudsman during 2016 to support the timely response to constituent needs. Steps were also taken to increase the Assistant Ombudsman's job title and salary in an effort to attract and retain skilled talent to the DCS Ombudsman Bureau. The proposed staffing changes will enhance current program service delivery by identifying "areas of specialty" for Assistant Ombudsman that is not available at this time. For example, each Assistant Ombudsman would be provided with staff development specific to key DCS areas such as Assessment; Permanency; Foster Care and Adoption; or Clinical Issues etc. Additionally, an increase in staff will provide an opportunity for the DCS Ombudsman Bureau to delve deeper into systemic areas of concern as well as program outreach.

Program Development

Policies and Procedures: The *Procedures and Practices Guidelines* for the DCS Ombudsman Bureau is posted on the agency's website. 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. The DCS Ombudsman Bureau's information is also linked to the Indiana DCS website (www.dcs.in.gov). The state of Indiana launched an Ombudsman website in 2016 to provide an additional opportunity for constituents to access ombudsman services and support across the state (www.Ombudsman.in.gov). Information regarding the DCS Ombudsman Bureau can be found on this page.

Tracking and Reporting: This office continues to compile quarterly reports to document complaint/case activity each quarter and to track responses to recommendations. 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 2016 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, DCS Ombudsman Bureau email, or staff. In an effort to develop public awareness among individuals and agencies working directly with children and families impacted by DCS, the DCS Ombudsman Bureau staff presented workshops, and provided information regarding the 2015 Annual Report

and DCS practices to the Indiana University School of Social Work, Auburn Indiana County Foster Care Support and Mentoring Group, Student Interns from the University of Indianapolis, the Lucas County Ohio Child Welfare Ombudsman, and various media outlets.

DCS Ombudsman Bureau brochures and posters are available to all local DCS offices, and the public. The DCS Ombudsman Bureau Director serves as 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 specific to the ombudsman role and child welfare practice. The agency is a member of the United States Ombudsman Association (USOA). The USOA provides opportunity for consultation, support and education to all members. The DCS Ombudsman Bureau staff also participates in trainings at conferences hosted by DCS, Indiana Youth Institute, IARCA, Statewide Child Fatality Review Committee, Kids Count Indiana, and a variety of webinars, books, and articles with information of interest to the agency.

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

Identified Task	Goal	2015 Metric (Average)	2016 Metric (Average)
Days From Inquiry to Response	1 day	.23 days	.44 days
Days Case Remains Open	30-60 days	29.1 days	34 days
Days Investigation Open	60-90 days	95 days	43 days

Collaboration with DCS

Communication: The Director of the DCS Ombudsman Bureau meets 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, as needed. All specific case reviews and/or investigations are initiated by contacting the Local Office Director, and Regional Manager who assists the agency by ensuring 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. The DCS Ombudsman Bureau participated in a number of Peer Reviews during 2016 and was able to provide feedback regarding system strengths and challenges.

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 *2015 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.

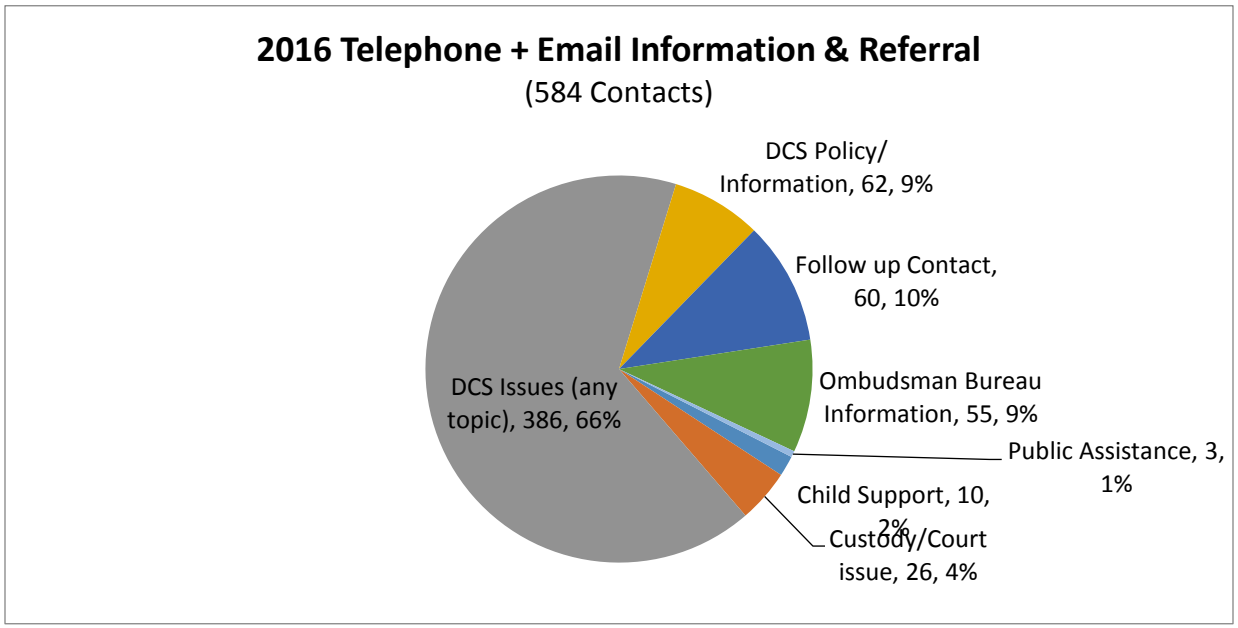
Complaints

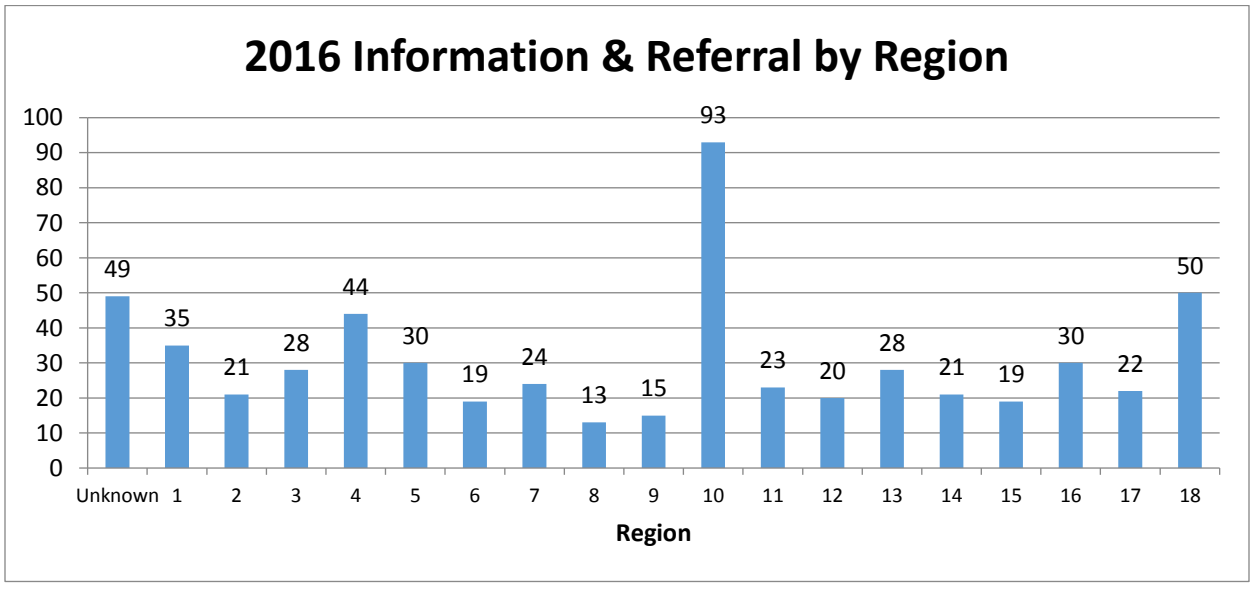
The Process Overview

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 as to the outcome. If a case is investigated, a detailed report is completed and forwarded to DCS and the 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 is 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 584 I & R Inquiries during 2016. The graphs below illustrate the topics of inquiry and the origin by DCS Region of origin.

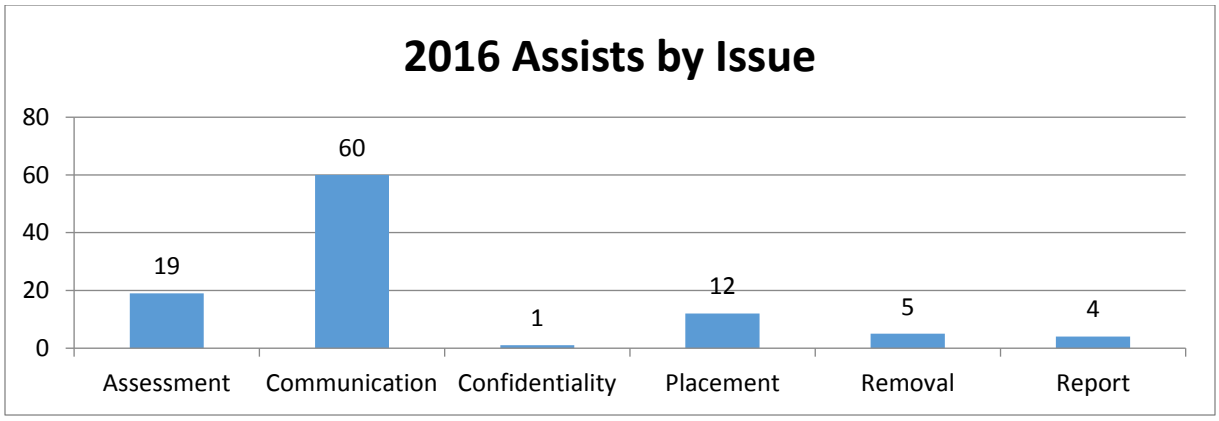


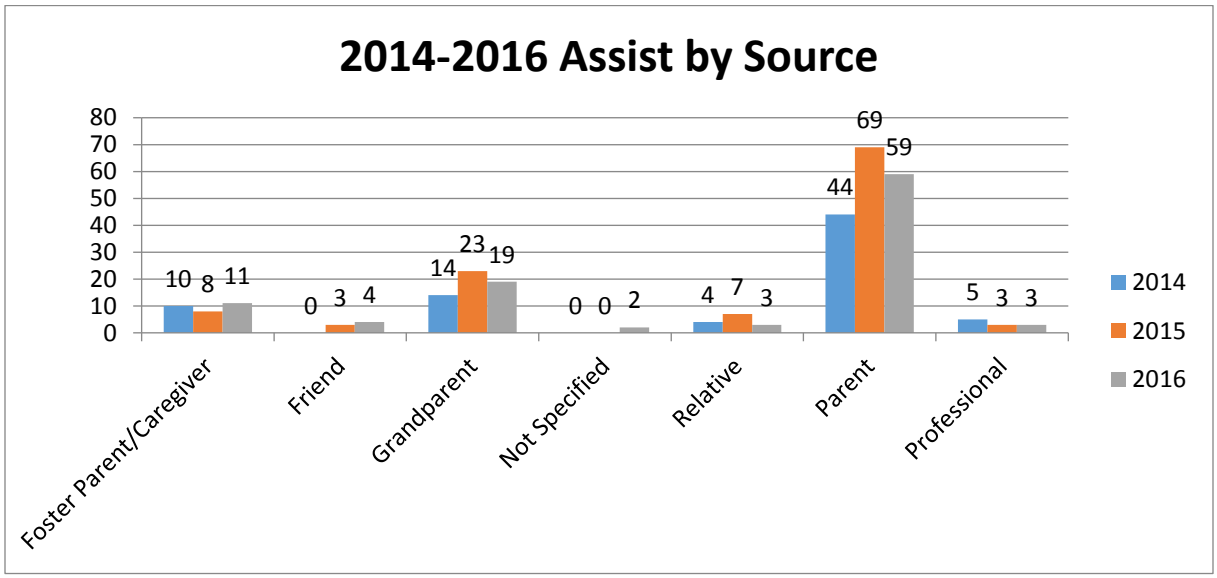


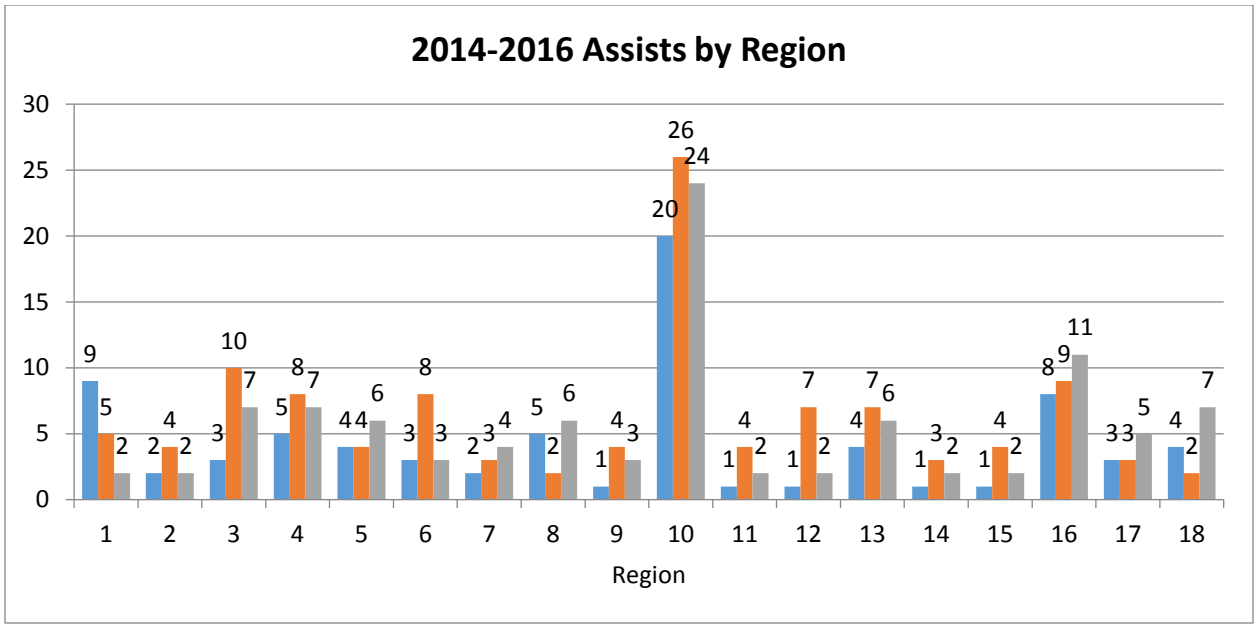
The I & R function has proven to be a valued service for constituents. Providing potential complainants with education regarding the DCS process and/or contact information for DCS staff is often the first step to a successful resolution. (See Attachment C for a Regional map.)

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. The DCS Ombudsman Bureau completed 101 Assists in 2016. The use of the Assist category continues to demonstrate that communication between complainants and DCS is key to resolving differences between stakeholders. The following graphs illustrate additional details about the Assists:





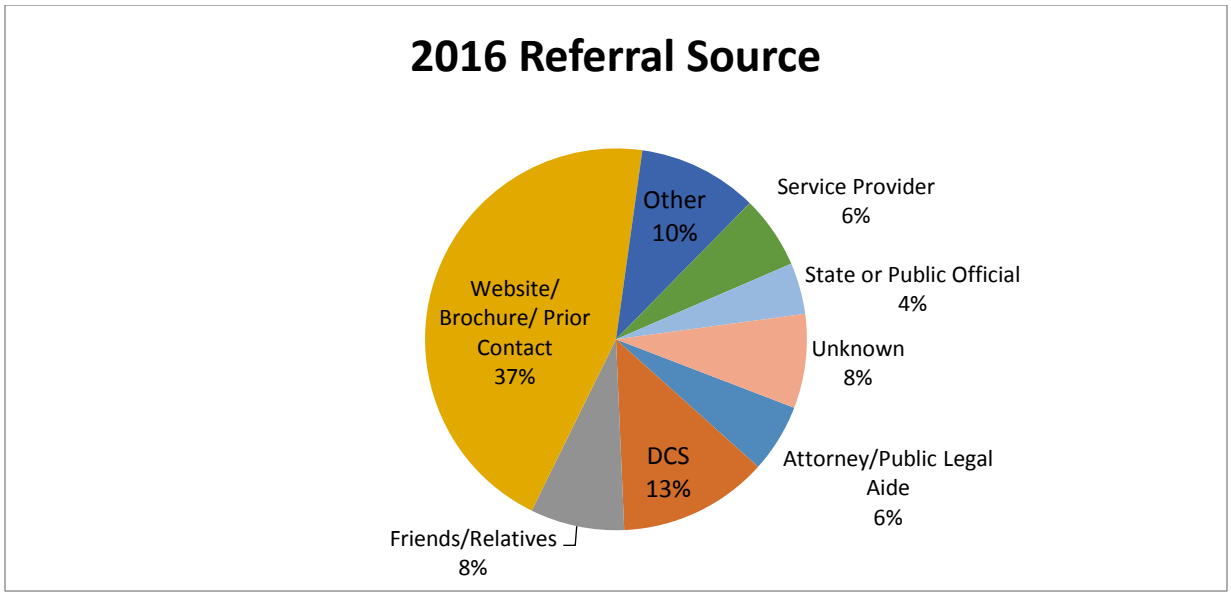


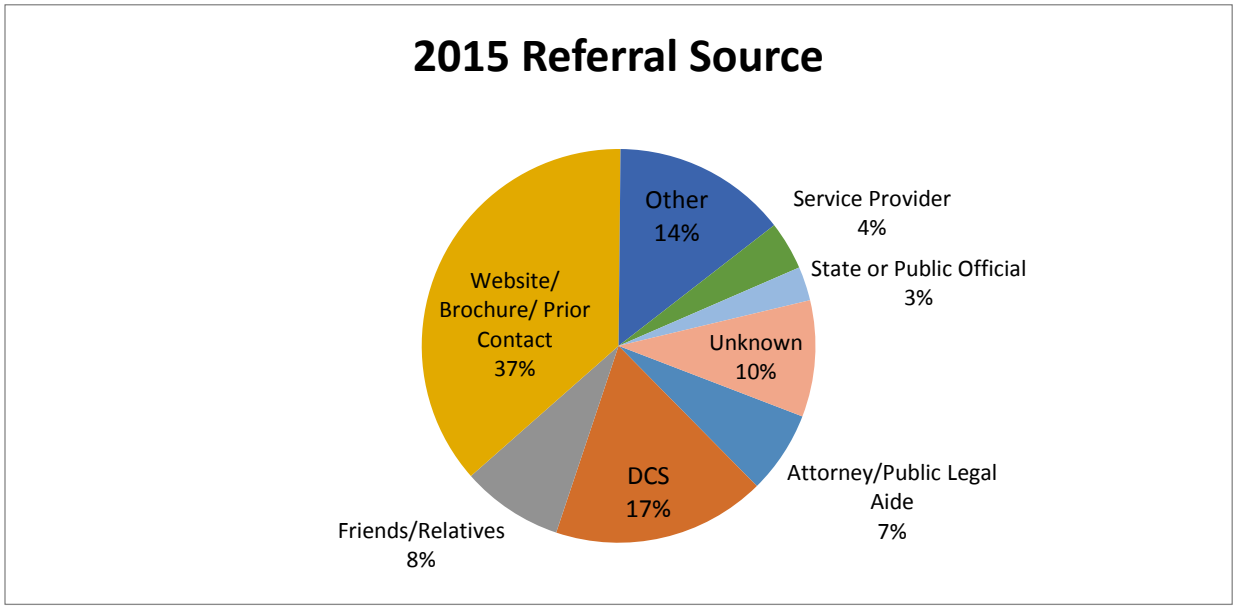
Cases

During 2016, 238 cases were opened and 248 cases were closed during the course of the year. The cases were generated following the receipt of a formal complaint. A total of 384 active total cases were reviewed during 2016 (258 closed and 87 closed) which included cases from the last quarter of 2015. Three investigations were completed in 2016. The significant number of Assists (101) suggests that the DCS Ombudsman Bureau was able to foster greater problem resolution at the onset of the inquiry by actively encouraging communication between DCS and DCS Ombudsman Bureau complainants. As a result, DCS Ombudsman Bureau staff was able to actively focus on case reviews and investigations that were more complex in nature.

Referral Source

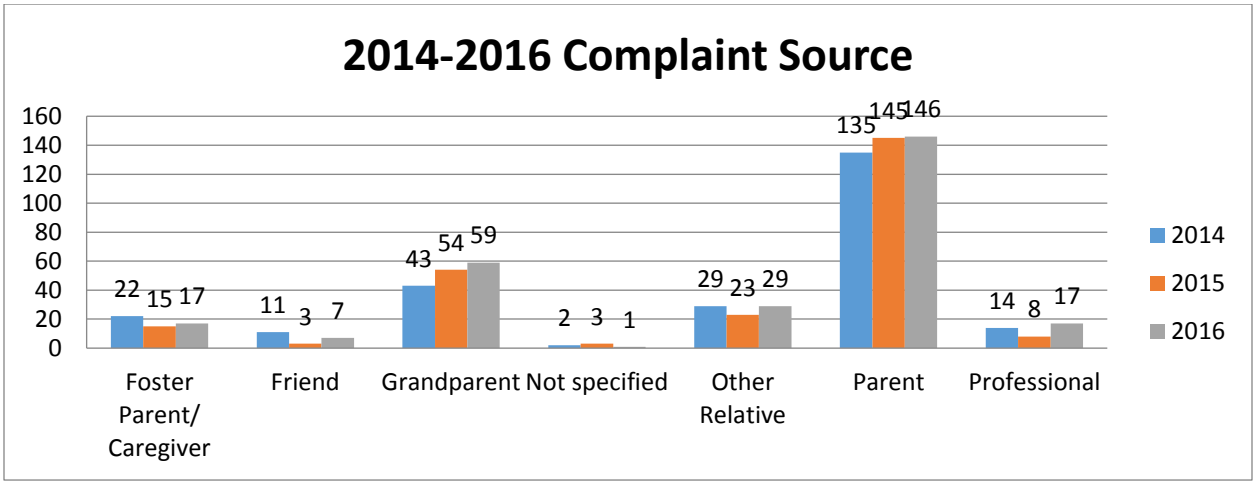
Comparison of 2015 and 2016 data suggests that Website/Brochure/Prior Contact continues to be the largest source of referrals and has remained constant at 37% of all referral sources. Other referral sources have remained constant within one to four points. Unknown reflects those individuals that chose not to identify a referral source during intake discussions with the Bureau or on complaint forms.





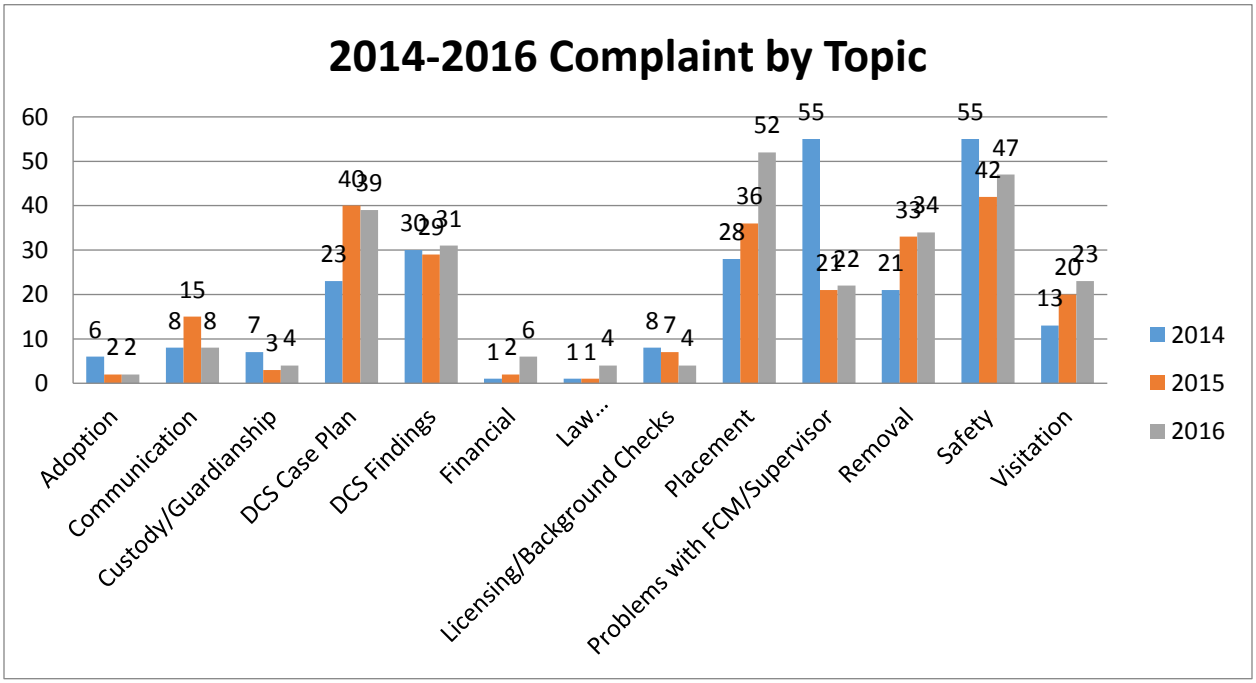
Complaint Source

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 2016, parents continued to make up the greatest share of complainants followed by grandparents, other relatives, foster/adoptive parents and professionals.



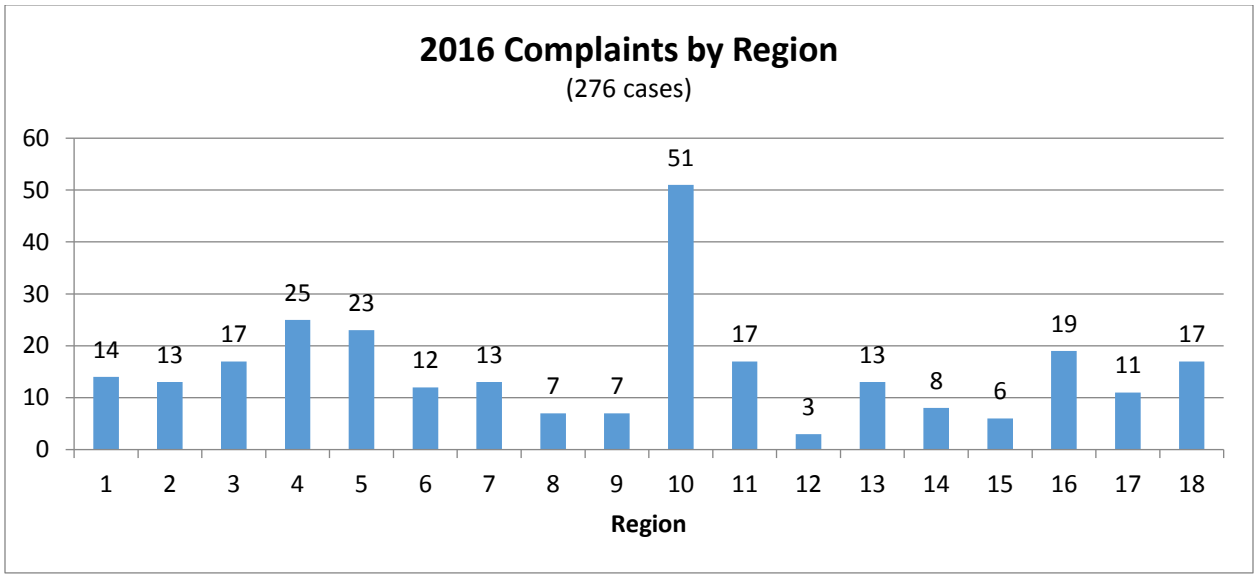
Complaint Topics

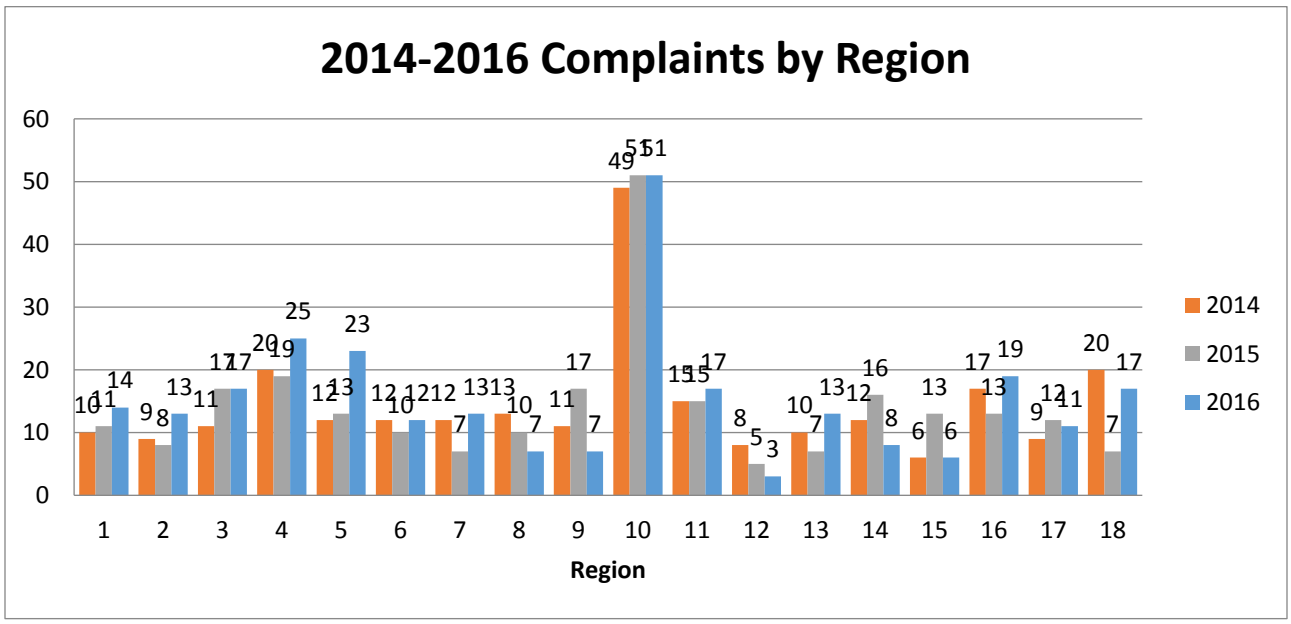
During 2016, the three major complaint topics included *Child Safety*, *DCS Case Plan*, *and Placement* There is a continued trend of complaint topics from previous years, as illustrated in the graph below.



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 2016. 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.

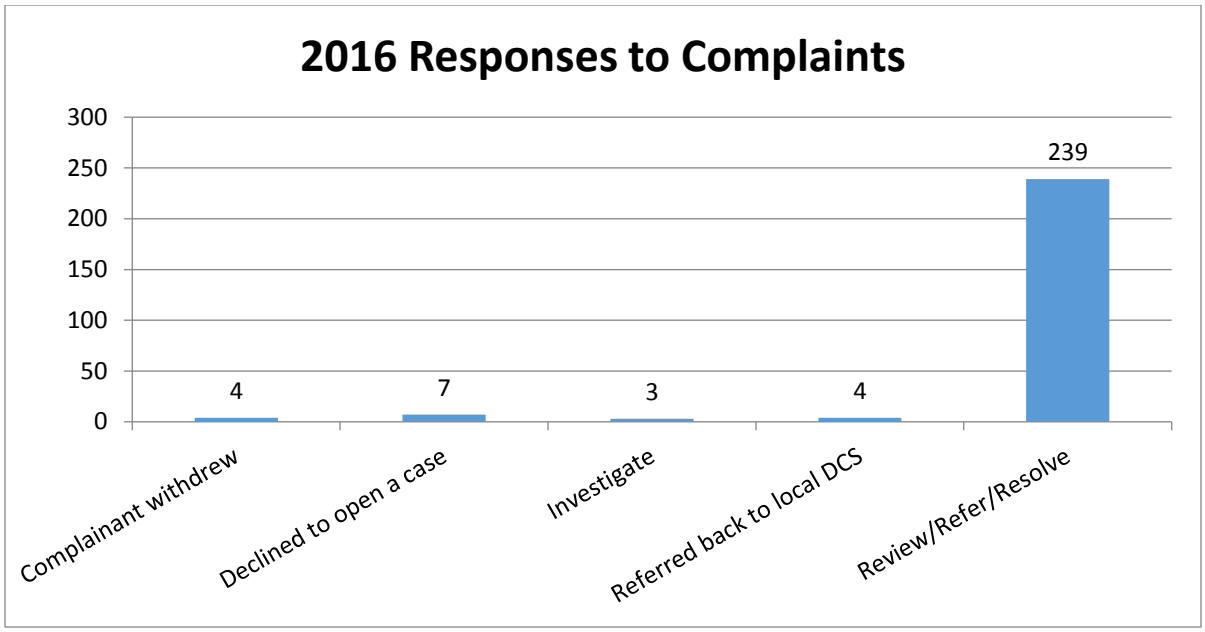
Refer Back to the Local DCS: Pursuant to statute, the DCS Ombudsman Bureau requires that complainants attempt to resolve their issues with the local DCS office through the DCS internal complaint process prior to filing a complaint with the DCS Ombudsman Bureau. On occasion, it is discovered during the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

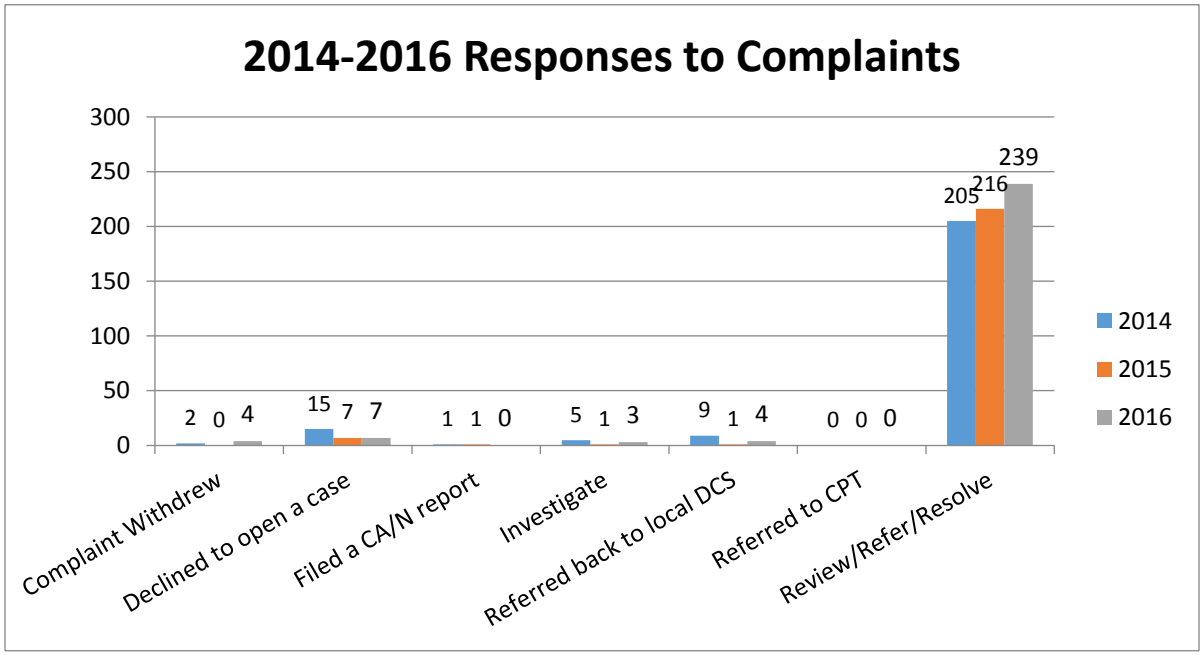
Close due to Complainant Withdrawal: Some cases have been closed prior to completion because the complainant decides to withdraw the complaint during the process.

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 since 2016.


2016 Responses to Complaints
300
250
200
150
100
50
0
4
7
3
4
239
Complainant withdrew
Declined to open a case
Investigate
Referred back to local DCS
Review/Refer/Resolve


2014-2016 Responses to Complaints
300
250
200
150
100
50
0
2 0 4
15 7 7
1 1 0
5 1 3
9 1 4
0 0 0
205 216 239
2014
2015
2016
Complaint Withdrew
Declined to open a case
Filed a CA/N report
Investigate
Referred back to local DCS
Referred to CPT
Review/Refer/Resolve

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.

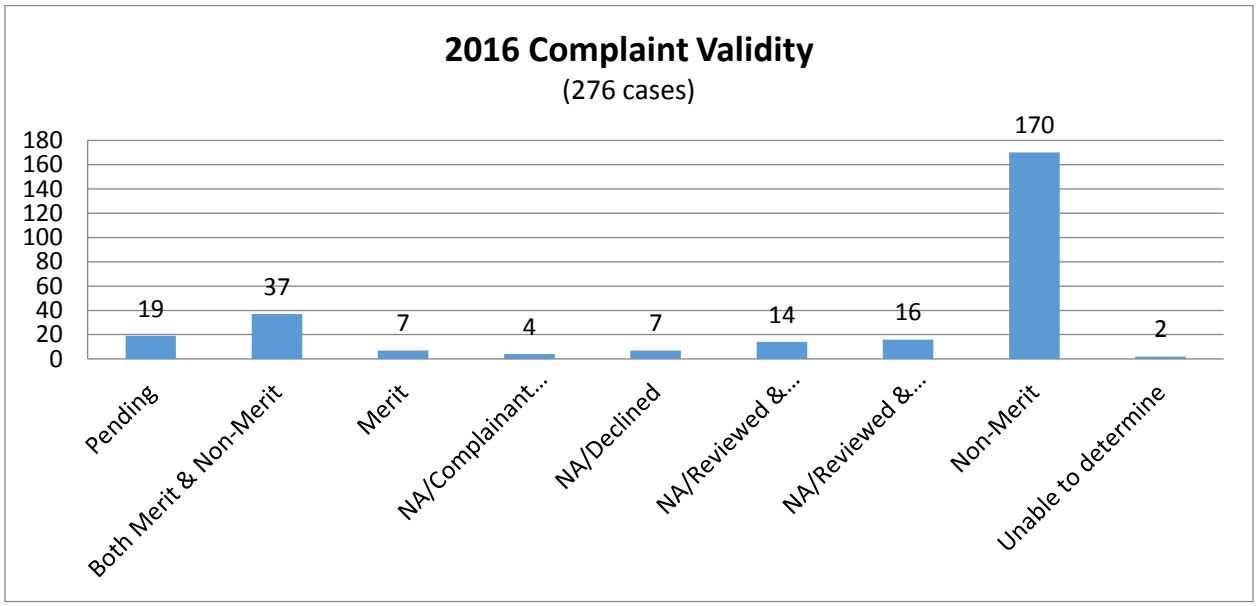
Peer Review: When the Ombudsman participates in a collaborative review with DCS a case is opened to reflect that a review is occurring. However, the peer reviews do not receive a validity determination, and the results of the review are internal and deliberative.

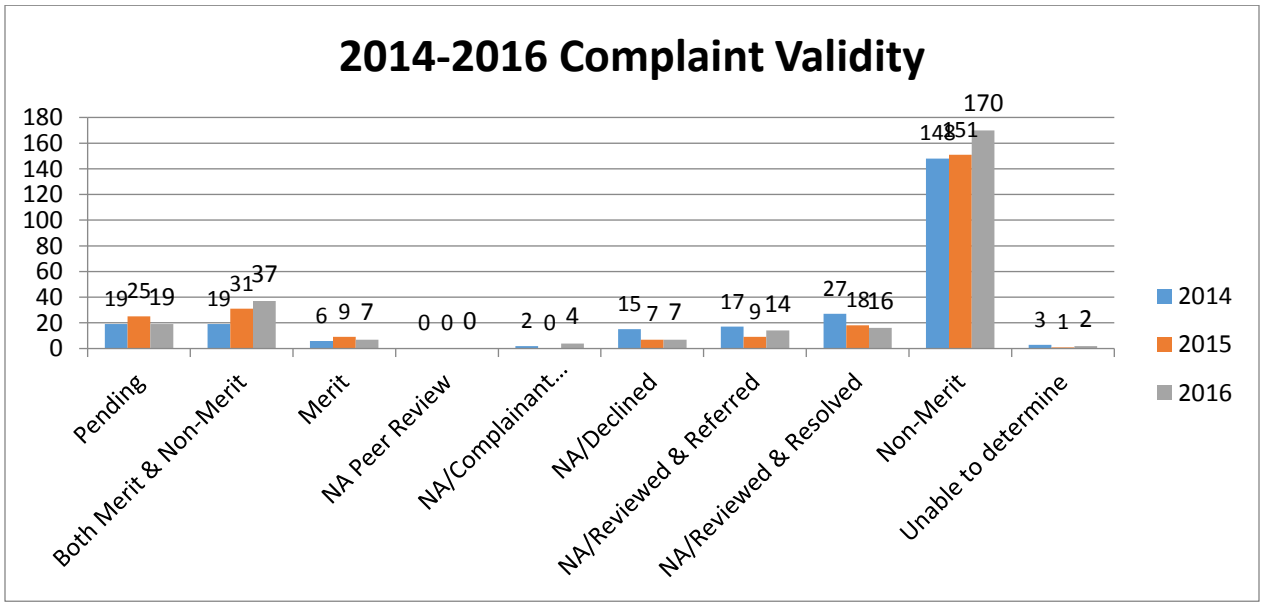
Outcomes

During 2016, validity designations were determined in 276 cases. Of these 276 cases, 7 were determined to have merit, 37 had allegations that were both merit and non-merit, and 170 were determined not to have merit. Thus 16 % of the cases with validity designations by the end of 2016 involved an allegation that was determined to have merit, and 62 % did not have merit. The remaining 22 % fell into other categories.

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 is 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 2016 as well as a comparison with prior years:





DCS Ombudsman Bureau Recommendations and DCS Responses

During 2016 the Ombudsman offered case specific recommendations on 40 cases following a review or an investigation and two 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 DCS Ombudsman Bureau has established 60 days for the response time frame. The following case examples include a sample of cases reviewed or investigated in 2016 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 DCS Ombudsman 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 are identified***.

CASE EXAMPLE #1 - CASE MANAGEMENT

The complainant alleged that DCS failed to follow policy by removing the child from the home, discriminating against the family for their religious beliefs, and placing the child with a birth parent who had a history of corporal punishment.

Findings:

Following a review of the case record, the DCS Ombudsman Bureau found no merit to the allegations. DCS removed the child from the home pursuant to policy, and the DCS Ombudsman Bureau was unable to find evidence to support the allegations that DCS actions were discriminatory based on religion. The DCS case record indicates that DCS ensured the child's safety before placing the child in the birth parent's home, and the placement was approved by the court. While the DCS Ombudsman Bureau found no merit to the complainant's allegations, there was merit specific to DCS's failure to complete monthly visits with the child. Pursuant to *Child Welfare Policy Chapter 8.10: Minimum Contact*, monthly face to face contact with the

child can occur on an alternating basis between the placement home and other locations. The case record indicates the child was not visited in the out of state placement for three consecutive months, due in part to the local office's failure to correctly process Interstate Compact for the Placement of Children documents pursuant to *Child Welfare Policy 9.3: Initial Placement/Placement Changes ICPC.*

Recommendation:

The DCS Ombudsman Bureau recommended a review of both policies by the Local Office staff.

DCS Response:

A review of the policies was completed by the Local Office staff as recommended by the DCS Ombudsman Bureau.

CASE EXAMPLE #2 - CASE MANAGEMENT

The complainant alleged that DCS failed to protect the child by failing to follow laws, rules, and written policies regarding DCS case management decisions specific to drug testing of the birth parents, petitioning the court for Termination of Parental Rights (TPR), birth parent's actions during supervised visits, failure to notify the foster parents of visitation schedule changes, monthly visits with the children in the foster home, and concerns with safety issues of child's siblings residing in the birth parent's home.

Findings:

The DCS Ombudsman Bureau's case review found no merit to the complainant's concerns regarding each of the allegations. However, there was concern that documentation in the case record did not fully reflect DCS case management actions. The DCS Ombudsman Bureau's exhaustive review of the child's record and the foster parent's record revealed concerns regarding the foster parent's struggle to remain focused on the needs of the child as opposed to the birth parent's progress or lack thereof. In fact, the foster parents had become so aggressive towards the birth parents; they were no longer invited to the Child and Family Team Meetings (CFTM) by the birth parents. There was no record in the foster parent's case file to indicate what if any follow-up, services, or support was provided to the foster parents regarding these concerns. A team meeting between involved DCS staff and the foster parents might have provided an opportunity to better align them with the permanency plan of reunification, provide case updates, and education regarding reasonable efforts, role clarification, and other policies specific to the case.

Recommendations:

The DCS Ombudsman Bureau applauded DCS's consistent management of this very difficult case while ensuring permanency for the child and support to the birth parents in an effort to achieve permanency. However, it was also advised that DCS is required to ensure that case actions are documented in the case file throughout the life of the case, pursuant to *Child Welfare Policy 5.2: Gathering Case Information*. Thus, the DCS Ombudsman Bureau recommended the Local Office provide education to staff regarding the importance of documentation in DCS case records. Additionally, the DCS Ombudsman Bureau recommended that the permanency staff assigned to this case meet with the licensing staff assigned to the foster parents to discuss concerns, identify services and support for the foster parent, and to document these and other actions in the case record.

DCS Response:

The Local Office Director indicated that in-depth discussions regarding documentation were held with DCS staff assigned to the case. The information was also shared with the Local Office staff in a group setting and examples were given when lack of sufficient documentation caused more work for the staff. The Local Office Director, assigned Family Case Manager, and Family Case Manager Supervisor also spent time discussing the specific case and developing an action plan for moving forward with a CFTM for the child's foster parents. The Local Office Director took advantage of an already scheduled foster parent training to expand the discussion to include the county's foster parents. Participants received clarity of the role of DCS and the foster parents were able to share their opinions as well.

CASE EXAMPLE #3 – PLACEMENT

The DCS Ombudsman Bureau received a complaint that DCS removed a child from relative care at the relatives request without advising the child's birth mother. The complainant also alleged that DCS placed the child in foster care without considering relatives in the same county for placement, and DCS failed to submit the Interstate Compact for the Placement of Children (ICPC) application as requested by other relatives who resided in another state.

Findings:

A review of the case record indicated that the child was removed from the relative placement at the request of the resource parent. DCS's attempts to locate the birth mother were initially unsuccessful. Once she was located, DCS advised her of the child's removal, and foster care placement. DCS contacted the in-county relative and completed the necessary background checks which revealed an unstable living arrangement. While there was no merit to the allegations regarding the above, the DCS Ombudsman Bureau did find merit that DCS failed to process the ICPC within the timeline pursuant to *Child Welfare Policy 9.1: Request to Place a Child In Another State* which states that DCS is to begin to assemble the contents of the ICPC packet within five days of identifying the placement. In this instance, DCS submitted the ICPC packet three months after the relative was identified as a possible placement.

Recommendations:

The Local Office cited lack of familiarity with the ICPC process as the reason for the significant delay in submission as ICPC's applications are not typical occurrences of a regular work day. While it is understandable that the ICPC process is an infrequent task for most DCS staff, implementing a system to ensure timely and accurate submission as set forth in policy is key to ensuring alignment with case management decisions. The DCS Ombudsman Bureau recommended a staff review of the aforementioned policy and a plan for ensuring timeliness and accuracy by the Local Office.

DCS Response:

The Local Office Director provided the DCS Ombudsman Bureau with a viable plan to ensure the processing of ICPC applications in an accurate and timely manner as set forth in policy, and staff planning.

CASE EXAMPLE #4 – CASE MANAGEMENT

The complainant alleged that DCS failed to seek out relative placement for a child subsequent to the child's removal from the birth mother, DCS breached confidentiality by sharing information about the child with the foster parent, DCS failed to make timely referrals for court

ordered services, DCS failed to provide services to the birth mother's boyfriend who resided in her home, DCS failed to visit the home where the birth mother was residing prior to the child's removal

Findings:

The DCS Ombudsman Bureau found no merit and determined that DCS case actions were in alignment with policy specific to complaints regarding completion of background checks, timely referrals, visitation prior to removal, and breach of confidentiality. Allegations that DCS failed to protect the child by failing to identify and place the child in relative care were found to have merit pursuant to *Child Welfare Policies 8.1: Selecting a Placement Option,* and *8:48: Relative Placement*. DCS acknowledged missed opportunities for moving forward on identifying and considering relative placement for more than five weeks due failing to utilize the DCS Investigator to assist in locating relatives. Additionally, staff received incorrect direction from the Local Office Attorney indicating that relatives could not be notified without signed releases of information from the children's birth parents. The DCS Ombudsman Bureau case review also suggested that a Child and Family Team Meeting (CFTM) between all parties shortly after the child's removal would have provided an opportunity to discuss possible placement options.

Recommendations:

The DCS Ombudsman Bureau recommended training specific to the aforementioned policies, and a change in office practice allowing staff to pursue relative placement without a signed release of information from the birth parents.

DCS Response:

The Local Office reported that staff training on the recommended policies with discussion focusing on the need to locate relatives from the time of the removal and as necessary throughout the life of the case, utilizing the services of the DCS Investigator to assist with searches, and including discussions on relative placement as a CFTM topic. Staff (including attorneys) were also reminded that DCS does not require the consents from parents to seek out potential relative placements, and they were advised on engaging relatives around the issue of placement.

CASE EXAMPLE #5 – CASE MANAGEMENT

The complainant alleged that case management decisions made by the Local Office did not protect the child. Specifically, DCS failed to inform a service provider of the birth parent's failure to meet the requirements for program participation, DCS changed the progression of the visits between the child and the birth parents despite the team's recommendations, DCS failed to hold timely Child and Family Team Meetings (CFTM), DCS failed to provide accurate information to the court regarding the birth mother's lack of compliance with services, DCS failed to file for Termination of Parental Rights (TPR) pursuant to policy, and DCS put the Resource Parents at risk by failing to maintain their confidentiality in documents presented to the court.

Findings:

The complainant was advised that the DCS Ombudsman Bureau had no jurisdiction regarding concerns that DCS failed to address the parameters under which the birth mother was allowed to participate in the specified program as the services were provided by an entity separate from DCS, and the court approved the birth mother's participation. Neither DCS nor the DCS

Ombudsman Bureau has the authority to overrule the court's order. No merit was found to allegations that DCS changed the level of visit supervision without the team's approval. On the contrary, the case review indicated that the DCS changed the visitation plan due to the birth mother's compliance and with the team's approval to allow the introduction of therapeutic visits designed to support parent and child bonding. Allegations that DCS failed to hold timely CFTMs were without merit as the case review indicated that DCS did in fact hold timely meetings to support the case progression. The case review also supports the finding of no merit specific to the allegations that DCS failed to provide accurate information to the court. The Family Case Manager submitted court reports including available information. Updated information received after the submission of the court report was provided to the court during the hearing. The DCS Ombudsman Bureau found merit to allegations that DCS failed to petition the court timely pursuant to *Child Welfare Policy 6.2: Involuntary Termination of Parental Rights*. Merit was also found regarding allegations that the Resource Parent's confidential information was provided to the birth parents. DCS acknowledged that DCS case management actions in this area were not in alignment with *Child Welfare Policy 2.6: Sharing Confidential Information* because the Family Case Manager failed to fully redact information regarding the Resource Parent that was submitted to the court and made available to the birth parents.

Recommendation:

The DCS Ombudsman Bureau recommended staff training specific to the identified child welfare policies.

DCS Response:

The Local Office Director advised that all staff were presented with copies of the policies and received training regarding same.

CASE EXAMPLE #5 – RELATIVE PLACEMENT / LICENSING

The DCS Ombudsman Bureau responded to the complainant's allegations that DCS failed to ensure the safety of a child in foster care by failing to pursue relative placement with the child's paternal grandparents.

Findings:

The DCS Ombudsman Bureau found no merit to complaints regarding the child's safety in foster care. The case review indicated that DCS and the foster placement took proper steps to provide medical care to the child. The foster parents were found to be very appropriate in the care and management of the child's health concerns. The DCS Ombudsman Bureau's case review found no merit to complaints that DCS failed to place the child in relative placement. The case notes indicated that placement was not possible due to the criminal history, and the birth parent's objections to placement. However, the DCS Ombudsman Bureau found merit to concerns regarding DCS's failure to process the licensing waiver specific to the relative's criminal history in a timely manner.

Recommendations:

The DCS Ombudsman Bureau recommended the Local Office receive training from DCS Central Licensing regarding *Child Welfare Policies 12.18: Licensing Denials, 12:19: Waivers, and 12.22: Licensing File Requirements* relative to the licensing of relatives. Additionally, the Local Office was advised that close attention should also be paid to documentation in the licensing file.

DCS Response:

Central Licensing staff held a two-hour training retreat for Local Office licensing and placement staff regarding the aforementioned policies. Education regarding *Child Welfare Policy 12.10: Evaluating Background Checks for Foster Family Licensing* was also presented.

CASE EXAMPLE #6 – ASSESSMENT

The complainant alleged that DCS failed to advise the birth parents of the allegations in an assessment, put undue stress on the family by advising them that a Child in Need of Services (CHINS) case had been filed, and refused to notify the parents of the findings of the Administrative Review.

Findings:

A report filed with DCS alleged medical neglect by the birth parents. When approached by DCS, the birth parents refused to participate in the assessments, and DCS advised that allegations would be substantiated. Once the birth parents began to comply with services, the substantiated assessment was reversed through the Administrative Review process, and a CHINS was not pursued. During the course of the case review, DCS acknowledged that the *Notice of DCS Decision to Unsubstantiate Allegations of Child Abuse and Neglect* was not sent to all of the appropriate parties. Thus, the DCS Ombudsman Bureau found merit to allegations specific to timely completions of assessment and failure to advise parties of the outcome of the Administrative Review.

Recommendations:

The DCS Ombudsman Bureau recommended that Local Office provide staff with training on *Child Welfare Policy 2.2: Administrative Review Process*.

DCS Response:

The Local Office advised that the local office received training on the aforementioned process.

CASE EXAMPLES #7 – ASSESSMENT

This complainant alleged that DCS failed to protect the children by failing to complete two assessments specific to lack of supervision, inappropriate discipline, and conflict of interest pursuant to DCS policy.

Findings:

The DCS Ombudsman Bureau found merit to allegations that DCS failed to interview all individuals pursuant to *Child Welfare Policy 4.4: Required Interviews.* No merit was found to allegations regarding lack of supervision, inappropriate discipline, and conflict of interest.

Recommendations:

The Local Office was advised to provide training to DCS staff regarding the policy to ensure their knowledge of required interviews during assessments.

DCS Response:

Copies of the policy were provided to all local office staff for individual review and sign-off at staff meetings.

CASE EXAMPLE #8 – VISITATION

The complainant alleged that DCS failed to provide court ordered visits to the birth mother who had previously signed voluntary adoption consents. DCS was to provide 3 hour weekly visits for the birth mother and her children until the adoption was finalized and thereafter, the birth

mother and adoptive parents were to develop a plan for 3 visits per year. At the time of the complaint, the birth mother had not received visits for three weeks.

FINDINGS:

The DCS Ombudsman Bureau's case review found merit to the complainant's allegations. DCS failed to provide four visits to the birth mother per the court order. One visit was cancelled due to a provider scheduling conflict and the remaining three visits were cancelled due to the prospective adoptive parents and the private licensing agency's hesitancy to transport one of the children due to behavioral outbreaks. The case record indicates that DCS and service providers made the decision to suspend the visits based on directives from the child's Guardian ad Litem (GAL) that the visits were not necessary. The case record did not indicate that the GAL had the authority via a court order to make the decision regarding the visits or direct the service providers regarding the matter. No documentation or explanation was presented to the DCS Ombudsman Bureau to indicate that DCS questioned the GAL's decision. The case record indicates that DCS requested the change in the court's order regarding visitation through a motion after the first missed visit. The record also indicates that *"current hours will need to be retained until the court has authorized the plan…"* Despite this statement, the birth mother's visits were restricted for an additional three weeks. The court ordered the birth mother's visitation resume for three additional weeks to allow for the missed visits. The court's order also stated that visits would resume after the adoption was finalized with visitation to be determined between the birth mother and the adoptive parents.

Specific to concerns regarding the safety of one of the children, the case notes indicate that meetings were held to address concerns with the child's safety during transport to visits and around the community in general. There is no indication that DCS and service providers developed a short term plan or process to address child safety issues with transportation specific to visitation. In the long term, DCS made a referral for home based services to assist the prospective adoptive parents in addressing long term, post adoption concerns with the child. While visits may have been a contributing factor to the child's anxiety and acting out behavior, evidence in the case record indicated that the child's medication may have also contributed to the transporting issues as the medication was changed on or around the same time as the changes in the visits. There is no documentation in the case record to support DCS's consideration of either or both factors. Suggestions posed by the birth mother to ensure the child's safety were ignored, and there is no indication that suggestions from service providers (additional transporters, child safety harnesses, etc.) were attempted by the licensing agency.

DCS also acknowledged that alternatives to visitations were not offered to the birth mother. Pursuant to *Child Welfare Policy 8.12: Developing the Visitation Plan, 8.13: Implementing the Visitation Plan, and 8.11: Parental Interaction and Involvement*, 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.

Recommendations:

The DCS Ombudsman Bureau recommended training for DCS staff regarding the DCS policies mentioned above. Additionally, DCS was advised to stress the importance of DCS staff

management of the DCS case and guidelines for working with the Guardian ad Litem/Court Appointed Special Advocates.

DCS Response:

The Local Office completed the review of the identified policies and stressed role relationships with the GAL and service providers.

CASE EXAMPLE #9 – CASE MANAGEMENT

In this case, the complainant voiced concerns that decisions to close the case put the children at risk because the family had not received appropriate therapy and visitation services. The complainant also states that the children had not been prepared guardianship/adoption and case closure because the children believed they were being reunified with their parents.

Findings:

No merit was found to allegations that the case was closing prematurely. The DCS Ombudsman Bureau's case review indicated that the permanency plan for the children was reunification concurrent with guardianship/adoption. DCS acknowledged that a placement for the latter permanency plan had not yet been identified as the children's current relative placement had not voiced a desire to take guardianship of or adopt the children. DCS had identified therapists to address the permanency plan and other issue through the children's therapists. There was no indication that DCS failed to provide appropriate visitation services to the family.

Upon further review of the case, the DCS Ombudsman Bureau identified missed opportunities to hold Child and Family Team Meetings (CFTM) that would have been beneficial during critical case junctures (e.g., changes in permanency plan changes, birth mother's sentencing) throughout the course of the case pursuant to *Child Welfare Manual Policy 5.7: Child and Family Meetings.* Additionally, the DCS Ombudsman Bureau found that DCS failed to complete the Case Plans for the children pursuant to *Child Welfare Manual Policy 5: 8: Developing the Case Plan*. DCS failed to hold a case conference with the required attendees, the case plan was not signed, and the case plan was not updated at times of significant change.

Recommendations:

The DCS Ombudsman Bureau recommended DCS schedule a CFTM for the case, hold a case plan conference to bring the current case plan up to date, and provide staff training specific to CFTMs and case plans.

DCS Response:

The Local DCS office provided policy training for all staff, and the Family Case Manager Supervisor and Family Case Manager met to discuss the missed opportunities and importance of documentation. A CFTM was held to plan with the team, create a new case plan, and obtain the appropriate signatures pursuant to policy. It should be noted that DCS had difficulty completing the CFTM and case plans due to the relative placements refusal to participate in the process and the parents request to only communicate with DCS via their attorney. *Note: Despite the case management barriers, the case record indicates that the birth father successfully completed services and the permanency plan of reunification was expected to occur.*

CASE EXAMPLE #10 – PLACEMENT/ASSESSMENT/DOCUMENTATION

The DCS Ombudsman Bureau received a complaint alleging the DCS failed to protect the children by allowing them to be placed on a trial home visit with the birth mother even though there was an open assessment alleging abuse by the birth mother, and DCS failed to speak with the victim and the relative caregiver regarding the allegations of abuse.

Findings:

No merit was found regarding allegations that DCS failed to protect the children by allowing a trial home visit placement with their birth mother even though there was an open assessment alleging abuse by the birth mother. The case review indicated that the child received a minor scratch while the birth mother was attempting to remove the child from a bunk bed during a visit. DCS unsubstantiated physical abuse and put a safety plan in place to assist the birth mother in setting behavioral boundaries for the child. The court approved the trial home visit subsequent to the completion of the assessment. The DCS Ombudsman Bureau's case review also found no merit to allegations that DCS failed to complete required interviews pursuant to policy as DCS interviewed the child victim as well as the relative caregiver during the course of the assessment. The DCS Ombudsman Bureau found merit in that DCS failed to properly document DCS case management actions regarding the assessment pursuant to *Child Welfare Policy 5.2: Gathering Case Information*. Furthermore, several relevant contacts pertaining to the assessment were not documented in the MaGIK electronic case file. Pursuant to *Child Welfare Policy 4.25: Completing the Assessment Report*, the Family Case Manager (FCM) will provide a summary of the evidence gained during the assessment and review the *Assessment of Alleged Abuse or Neglect Report (SF 113/CWO311)* for accuracy and completeness, and the Family Case Manager Supervisor (FCMS) will review the report for accuracy and completeness before approval.

Recommendations:

The DCS Ombudsman Bureau recommended training for the Local Office staff regarding the related child welfare policies to ensure understanding and the importance of the policies.

DCS Response:

The Local Office provided training and implemented steps to ensure best practice in the area of assessments. These steps included, developing a checklist to use as a guide when closing assessments, implementing a Quality Assurance process which included a monthly review to identify strengths or opportunities, and training on documentation and general guidelines for completing assessment reports. Copies of all processes were provided to the DCS Ombudsman Bureau to document steps taken by the Local Office.

CASE EXAMPLE #11 – ASSESSMENT/DOCUMENTATION

The complainant alleged that DCS failed to make a timely finding in an assessment, and DCS did not have sufficient evidence to substantiate allegations of neglect. Additionally the complainant indicated that the DCS Family Case Manager (FCM) was unprepared for a subsequent Child and Family Team Meeting (CFTM) and was unable to communicate service requirements to the birth parent.

Findings:

The DCS Ombudsman Bureau found no merit to allegations that DCS had insufficient evidence to substantiate the allegations and file a Child in Need of Services (CHINS) petition. The case

record indicates that the birth parents failed to ensure all medications in the home were secure from the child. The child was placed in residential psychiatric treatment during the course of the assessment. DCS was concerned that the child could be at risk during future home visits without the coercive intervention of the court to ensure the parent's adherence to safety plans put in place by the hospital.

The DCS Ombudsman Bureau found merit to the allegations that DCS failed to complete the assessment timely pursuant to *Child Welfare Policy 4.22: Making an Assessment Finding*. While it was noted that communication barriers existed between DCS and the psychiatric hospital, DCS is required to initiate an assessment for allegations of neglect within five days of receiving the report pursuant to *Child Welfare Policy 4.38: Assessment Initiation*. Contact between the child and DCS took place one month after the filing of the hotline report which raised concern that the safety of the child was in question for a month after the report was received. DCS failed to take steps to contact another person (other than the alleged perpetrator), who could provide information on the allegations and condition of the child, in order to initiate the assessment as set forth in policy. There was also concern that significant contacts were not documented and/or there was again no contact with anyone regarding the case from the time DCS finally initiated contact with the child for another month. At the time the DCS Ombudsman Bureau gained access to the case, DCS had entered only two contact notes in the electronic case file even though there were at least ten contacts made during the month. In total, DCS failed to document engagement with the child, and providers consistently for a period of two and a half months. The DCS Ombudsman Bureau found that case management actions specific to documentation were not in alignment with *Child Welfare Policy 5.2: Gathering Case Information*.

Recommendations:

Recommendations were made suggesting training specific to the aforementioned policies be made for Local Office staff to ensure case management actions and policy alignment.

DCS Response

The Local Office advised that training was provided to staff in the identified policies at a staff meeting.

CASE EXAMPLE #12 – CHILD SAFETY/REMOVAL

The DCS Ombudsman Bureau received a complaint alleging that DCS failed to protect two children determined to be Child in Need of Services (CHINS) in their decision to allow them to remain in the home with her birth mother despite several allegations of abuse and neglect. The complainant went on to state that the birth mother made no progress in the case, had denied domestic violence and child abuse by the children's step-father, failed to comply with services, and allowed several people unknown to DCS to move in and out of the home during the life of the case. The oldest child (Child A) went to go live with her father for three months before choosing to return to her mother's care. DCS was preparing to close the CHINS case when Child A was killed in a car accident. At the time of the accident, Child A was riding in the car with the birth mother's friend. Questions regarding the specifics of the car accident were pending at the time of the DCS Ombudsman Bureau's investigation. The complainant stated that despite allegations of neglect, and pending law enforcement charges against the birth mother, the

younger daughter (Child B) remained in the birth mother's care following the death of Child A. Initially, the DCS Ombudsman Bureau found the allegations to be without merit as the Local Office had ensured the safety of Child B and was providing and monitoring services to support the family. However, due to the return of positive drug screens taken by the birth mother at the time of Child A's death, the DCS Ombudsman Bureau re-opened the complaint and determined that an investigation was necessary specific to the following allegations:
Allegation 1: DCS failed to protect the physical or mental health or safety of Child A and Child B by failing to follow specific laws, rules or written policies in the case management decisions related to both children.

Allegation 2: DCS failed to protect Child B by failing to remove the child from the home of the birth mother following the death of Child A.

Findings:
The DCS Ombudsman Bureau found merit to both allegations. The investigation indicated that drug screens administered to the birth mother after the death of Child A tested positive for drugs. Additionally, the birth mother admitted to allegations which included providing alcohol to minors, selling prescription medication, mixing medication with alcohol on the night of Child A's death, and domestic violence between the birth mother and visitors to the home. It was also noted that the birth mother denied some of the allegations in previous assessments. Child A was removed from her birth mother's home and placed in the care of her birth father subsequent to the positive drug screens and birth mother's admission of the allegations of abuse and neglect. Child A received services to address the death of her sister and repair her relationship with her father.

There was grave concern that the case in question was managed outside the realm of DCS policies/directives that define and guide child welfare practice as stated in *Child Welfare Policy 1.0: Introduction to the Child Services (DCS) Manual.* The DCS Ombudsman Bureau investigative review indicates that DCS failed to manage the case pursuant to the following policies:
4.18 Initial Safety Assessment –DCS failed to complete initial and subsequent safety assessments during the life of the case.
4.23 Initial Family Risk Assessment - DCS failed to complete additional Risk Reassessments at critical case junctures pursuant to policy.
5.1 Transitioning a Case – DCS failed to transition the case from the Assessment Family Case Manager to the Permanency Case Manager pursuant to policy.
5.2 Gathering Case Information – Documentation of certain DCS efforts were not present in MaGIK (electronic case record) at the time of the DCS Ombudsman Bureau's case review.
5.3 Engaging the Family – While Birth Father maintained contact with DCS throughout the life of the case, DCS's engagement focused primarily on engagement with Birth Mother and the children despite Birth Father's willing participation in the case from the onset of DCS' involvement.
5.7 Child and Family Team Meetings – DCS failed to hold CFTMs to promote engagement and the on-going participation with either birth parent during the assessment phase, or at any of the numerous critical case junctures.

5.8 Developing the Case Plan – DCS failed to hold Case Conferences for the purposes of developing the case plans. The DCS Ombudsman Bureau was not able to determine what if any role the birth parents played in the development of the case plan or if the case plans were presented to them for signatures.
7.4 Parental Interaction and Involvement – DCS failed to assess through a partnership with the CFTM, the interactions of the parent/guardian/custodian and the children who were identified as candidates at imminent risk of placement, to determine whether they were accomplishing the goals and objectives outlined in current case plans or activities. DCS also failed to complete on-going assessments of safety and risk at critical case junctures. Case plans were not completed pursuant to policy and there is no indication that they were updated at critical case junctures.
7.11 Safety and Risk Assessments – DCS failed to complete Safety and Risk Assessments pursuant to policy.

Recommendation 1

While it is impossible for the DCS Ombudsman Bureau to determine what effect if any DCS's failure to follow the aforementioned policies in part or in the whole would have had on the trajectory of the case specific to the death of Child A and the continued safety of Child B, DCS is required to follow all specific laws, rules or written policies in the case management decisions related to families and children. Failure to do so is not in alignment with Values and Principles set forth in *Child Welfare Policy 1.0: Introduction to the Department of Child Services (DCS) Manual* or the *Indiana Child Welfare Practice Model*.

Thus, the DCS Ombudsman Bureau recommends the Local Office complete a review of the aforementioned policies with all Local Office staff with a close attention to a review of *Child Welfare Policy 1.0* and the *Indiana Child Welfare Practice Model*. Further, DCS is recommended to submit a plan for ensuring that Child and Family Team Meetings, Case Conferences, Safety Assessments and Risk Assessments are held and completed pursuant to DCS Child Welfare Policies and the Indiana Child Welfare Practice Model, with special attention to services for Father Engagement.

Recommendation 2

The Job Description of the Family Case Manager states that it is the responsibility of the Family Case Manager Supervisor to ensure that the practice of DCS staff is in alignment with DCS policy, regulations and operating procedures at all times.

The DCS Ombudsman Bureau recommends the Local Office review the job descriptions for Family Case Manger (Assessor and Permanency) and Family Case Manager Supervisor with DCS staff and develop a plan to ensure that Family Case Manager Supervisors are managing and monitoring staff and cases pursuant to job descriptions, policy, rules, laws and best practice.

Recommendation 3

There is great concern regarding the appearance of bias against the Birth Father by DCS. DCS staff report that Birth Father participated minimally in services prior to the death of Child A and argued with the Family Case Manager and the Family Case Manager Supervisor at times. Additionally, the Family Case Managers reported Birth Mother and children describing Birth Father's involvement with the children as sporadic and only occurring between his many relationships. However, a review of the case record paints a contrasting picture of Birth Father's

involvement. Birth Father appeared at the Initial Hearing while Birth Mother did not. Birth Father maintained consistent contact with Local Office staff throughout the case while Birth Mother was consistently evasive and avoided contact with DCS and service providers. Birth Father participated in counseling with Child A when the child resided in his home, while Child A and Child B failed to participate in any counseling while residing in the home of the Birth Mother. Birth Mother's compliance in services was minimal and remained as such prior to the death of Child A. The argument between the FCM and Birth Father appears to stem from his concerns regarding DCS's handling of the DCS case. Given Birth Mother's eventual admission of activities that placed the children at risk, Birth Father's frustration with DCS is viewed as understandable by the DCS Ombudsman Bureau when placed in the context of events that took place during the life of the case.

The case records indicate that Birth Father advised DCS of his willingness to participate in the CHINS process and services to support the children. While he is referred to services at the onset of the case, there is no indication from the case record that DCS encouraged Birth Father to participate. Rather, the focus of DCS's communication with Birth Father centered on his seeking and attaining custody of the children. The birth father was pursuing custody until Child A decided to return to her mother's care. It is significant to note that while DCS acknowledged the child's return to the birth mother's home, the agency was unable to explain the exact reason for the child's decision to return, and there is no indication of discussions to determine if the change was in the child's best interest. The DCS Ombudsman Bureau finds that DCS missed significant opportunities to engage Birth Father to fully participate in services that would nurture and support his relationship with his children and ensure their safety.

The DCS Ombudsman Bureau recommends that Local Office staff receive training in Father Engagement services from DCS staff trained in the fundamentals of father engagement or from a DCS Father Engagement service provider contracted in the region.

DCS Response

The Local Office Director advised that the staff reviewed the indicated policies, and received information regarding the Child Welfare Practice Model and completed a team activity to support the training. Additionally, Father Engagement Services training was provided to staff by a privately contracted agency.

CASE EXAMPLE #13 – ASSESSMENTS

The complainant alleged that DCS's failure to complete assessments pursuant to policy placed three siblings at risk. The complainant stated that the children were adopted several years ago, and the adoptive mother allowed the birth mother to have extended contact with them. The complainant states that the children were dirty when they came to visit and they disclosed that they were physically abused by their adoptive mother and others since their adoption.

Findings:

After an exhaustive review of the case record, the DCS Ombudsman Bureau found merit to the complainant's allegations that assessments were not completed pursuant to policy. Missed opportunities were identified in two assessments involving the children. In the first assessment, DCS failed to initiate contact with the children within the five days outlined in policy. The

second assessment was reopened during the DCS Ombudsman Bureau's case review and resulted in substantiated physical abuse against the adoptive mother and her daughter and the removal of one of the children from the home for the purposes of receiving more intense services. The adoptive mother was ordered out of the home with services, and the other two children remained in the home under the care of their adoptive grandmother. The third assessment of neglect against the adoptive mother was unsubstantiated by DCS. Again, the DCS Ombudsman Bureau's case review revealed DCS's failure to use exigent circumstances to interview the children, and also failed to use investigative tools available to DCS to locate the adults in the case.

Recommendations:

The DCS Ombudsman Bureau voiced grave concerns regarding DCS's failure to follow policies in the completion of the assessments. The case review revealed evidence of failure of the Family Case Manager Supervisors to monitor the case management of the allegations and ensure that these action were in alignment with Child Welfare Policy. The DCS Ombudsman Bureau recommended a thorough review of the following policies:

4.0: Diligent Search
4.3: Conducting the Assessment – Overview
4.4: Required Interviews
4.5: Consent to Interview Children
4.6: Exigent Circumstances
4.7: Locating the Subjects
4.9: Interviewing Children
4.20: Good Faith Efforts
4.22: Making an Assessment Finding
4:25: Completing the Assessment Report and 4.B Tool on Writing Assessments
5.2: Gathering Case Information - inconsistent documentation

DCS Response:

The Local Office provided training specific to the DCS Ombudsman Bureau's recommendations.

CASE EXAMPLE #14 – ASSESSMENT/PLACEMENT

The DCS Ombudsman Bureau received a complaint alleging that DCS failed to take action regarding reports of abuse. DCS failed to interview all required parties in two of the assessments. DCS failed to interview the children in a neutral location and failed to notify the children's mother of an open assessment.

Findings:

Following a review of the DCS case record, the DCS Ombudsman Bureau found no merit to allegations that DCS failed to take actions on reports of abuse. DCS records indicate that DCS completed an assessment on every report that was screened in by the hotline. Decisions to screen out reports were made pursuant to *Child Welfare Policy 3.6: Recommending CA/N Reports for Screen-Out*. No merit was found to the allegation that DCS failed to interview the children in a neutral location as the interviews with the children were conducted as directed in *Child Welfare Policy 4.9: Interviewing Children*. The DCS Ombudsman Bureau found merit to the allegation that DCS failed to interview all required parties (children, parents, and report sources) in certain assessments pursuant to *Child Welfare Policy 4.4: Required Interviews*.

Pursuant to *Child Welfare Policy 4.25: Completing the Assessment Report*, the Family Case Manager Supervisor failed to ensure the completion and accuracy of certain assessments. Merit was also found to the allegation that DCS failed to notify the birth mother of an assessment through the Notification of Assessment form as set forth in *Child Welfare Policy 4.3 Conducting the Assessment – Overview*. Though not included on the original complaint, the DCS Ombudsman Bureau completed a thorough review of all assessments and found that documentation was lacking throughout the assessments. As a result, the DCS Ombudsman Bureau found merit in DCS's failure to complete certain assessments, and ensure thorough documentation pursuant to *Child Welfare Policy Chapter 4: Assessments and 5.2: Gathering Case Information*.

Recommended:

The DCS Ombudsman Bureau recommended that the Local Office staff be provided with additional education regarding ensuring thorough assessments as set forth in *Chapter 4, Section 4* of the *Indiana Child Welfare Manual*. It is also recommended that the Local Office staff review *Chapter 5, Section 2* to ensure understanding of the importance of complete, thorough, and accurate documentation throughout the life of the case beginning at the assessment phase. Lastly, it is recommended that the local office Family Case Manager Supervisors (FCMS) review *Child Welfare Policy 4.3: Conducting the Assessment – Overview* to ensure this policy has been applied when guiding and reviewing assessments, as the FCMS provides the initial level of quality assurance within the system.

DCS Response:

The Local Office Director held training to address the DCS Ombudsman Bureau's recommendations. Staff received training and support in the identified areas, and steps were taken by Leadership to implement processes to support ongoing management of assessments to ensure timeliness and accuracy.

CASE EXAMPLE #15 – CHILD SAFETY

The DCS Ombudsman Bureau received a complaint alleging that DCS failed to protect a sibling group of six by failing to follow specific laws, rules, or written policies in case management decisions related to the children. The complainant stated that the Family Case Manger (FCM) was unprofessional, unprepared, and unresponsive to service providers responsible for the children despite numerous requests for meetings to discuss the concerns regarding safety in the children's foster home, the foster home's inability to meet the children's extensive special needs, and concerns that the DCS permanency plan for adoption of the children by their foster parent was not in their best interest due to medication used by the foster parent to address extensive physical and mental health needs. Based on the written complaint, telephone interviews and the jurisdiction of the DCS Ombudsman Bureau, an investigation was opened into the following allegations:

Allegation 1: DCS failed to protect the children's physical or mental health or safety by failing to follow specific laws, rules, or written policies in the case management decisions related to the children.

Allegation 2: DCS failed to protect the children by placing them in a foster home that could not meet their extensive special needs, and that the DCS permanency plan of adoption by Foster Parent was not in their best interest.

Findings:

According to case records, service providers began to voice concerns to DCS regarding the care of the children early in 2015. These concerns centered on questions regarding the Foster Parent's ability to care for the children due to prescribed medication. Service providers advised the DCS FCM that the Foster Parent had developed a pattern of failing to return calls from the school regarding the children's hygiene and behavior. It is noted that the Foster Parent affirmed that the medication left the Foster Parent unresponsive to care for the children until mid-day. Foster Parent's adult children residing in the home were responsible for getting the children ready for school in the morning. However, as both of them were involved in their own activities outside of the home during the remainder of the day, they were unavailable to respond to emergencies regarding the children.

There is limited documentation in the case record to support the DCS assertion that DCS was responsive to the concerns of the service providers. While the children were receiving therapeutic and educational services to support their special needs, family services to support Foster Parent A's transition through a recent divorce and toward the permanency plan of adoption of six special needs children as a single parent were not in place. Additionally, DCS had failed to initiate adoption preparation services for the children. It is noted that the Guardian Ad Litem requested that plans for Termination of Parental Rights (TPR) be delayed until such times that DCS was able to work with school personnel to ensure the educational needs of the children were being met. The case notes do not reflect DCS progress in working with school personnel.

Both allegations were determined to have merit. DCS asserted that myriad concerns voiced over a significant period of time by services providers and organizations working with the children and the family were addressed. However, an extensive review of case records and interviews with DCS staff indicated that DCS failed to document their efforts in this regard. While service provider emails and letters were entered into the DCS case record, the DCS response to service provider's concerns and requests for meetings were not. It is noted that a significant amount of the information in the electronic case file was entered after the initial review by the DCS Ombudsman Bureau. DCS acknowledged that meetings requested by the service providers to address concerns regarding the safety of the children and the permanency plan for adoption by the foster parents was not held for two months due to circumstances beyond the FCM's control. It should also be noted that the DCS Ombudsman Bureau's investigation indicated that the Family Case Manager Supervisor (FCMS) was unaware of the missed meetings and service provider concerns until they were brought to DCS's attention by the DCS Ombudsman Bureau.

Recommendation 1:
Review *Child Welfare Policy 5.2, Gathering Case Information* with staff and discuss the importance of documentation in the case as a means of documenting case activities and events.

Recommendation 2:
Review *Child Welfare Policy 5.7 Child and Family Team Meetings* with staff and develop an agency plan for ensuring that CFTM are held and documented in the case file. Schedule a CFTM (see *Recommendation 5*) to assess and address current needs of the children and foster parent.

Recommendation 3:
Review *Child Welfare Policy 8.15 Services for Resource Families* which states that the Indiana Department of Child Services (DCS) will offer services to the resource parent(s) to care for the child, support the resource parent's care for the child, assure the child's needs are being met, and address issues that may lead to placement disruption.

Review *Child Welfare Policy 5.10 Family Services* which indicates that Family Preservation Services in the form of home based case work is also available to pre adoption and post adoption services for adoptive families at risk or in crises.

Recommendation 4:
The Job Description for DCS Family Case Managers states that it is the responsibility of the Family Case Manager Supervisor to ensure that Family Case Managers and other staff are following policies, regulations and operating procedures, and assures that contacts between staff and people receiving services as well as between staff and all other involved social service providers and the public are conducted in a professional and ethical manner. During the course of the investigation, it was determined and acknowledged by the FCMS that the FCMS was unaware of the significant concerns brought to the attention of the FCM by service providers. Case notes indicate regular staffing between the FCMS and the FCM however, it was determined that the FCMS relied heavily upon the FCM to advise FCMS of concerns with the case. It was discussed that while this is the expectation in managing staff and caseloads, a more active approach to staffing provides a necessary balance to supervision. This can be achieved by utilizing tools and training available to support appropriate supervision.

Review the job description for Family Case Manager (FCM) and Family Case Manger Supervisors (FCMS) with DCS staff and develop a plan to ensure that FCMS are managing and monitoring staff and cases pursuant to policy.

Recommendation 5:
The DCS Ombudsman Bureau received the original complaint in May 2015. Due to the complex nature of the case, the investigative review remained open until February 2016 for the purposes of monitoring DCS case actions specific to the complainant's concerns. During the course of the DCS Ombudsman Bureau's involvement, the children were removed from the foster care placement for a period of time and returned to the foster parent following an assessment involving a separate case. The case record indicates licensing staff and permanency

staff met in September 2015 to address licensing issues and to develop a plan for supporting the foster parent from a licensing standpoint. The Family Case Manager and the licensing staff continued to monitor the progress of the children in the home of the foster parent by visiting the home pursuant to policy. Case notes regarding licensing staff interactions with the foster parent were consistently entered into the case file. However, concerns regarding the documentation of efforts made by permanency staff (FCM/FCMS) to rectify the needs of the children remained. The DCS Ombudsman Bureau recommended that DCS hold a CFTM with all parties to address the aforementioned concerns and develop a plan for supporting the foster parent and the children toward the permanency plan of adoption. The DCS Ombudsman Bureau's investigation closed in February 2016. Update: the permanency plan of adoption was changed to reunification and DCS began efforts to support the plan.

DCS Response:
The Local Office response indicated that DCS reviewed the policies recommended by the DCS Ombudsman Bureau. DCS provided additional oversight for staff to ensure the completion of Child and Family Team Meetings (CFTM), and shared that practice indicator reports showed a significant increase in completing CFTM and documentation of same on a monthly basis. Resource Parents were sent information regarding available resources and services through the county's monthly Resource Family Newsletter, and efforts to ensure Family Case Managers (FCM) visitation with children within five days of placement were closely monitored. DCS also states that CFTM meetings were held with attendance by service providers.

GENERAL RECOMMENDATIONS TO SYSTEMIC ISSUES

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. DCS responds to systemic recommendations made by the DCS Ombudsman Bureau. During 2016, two recommendations were offered. 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.

Recommendation #1 – Staffing and Caseload Size Barriers to Child Welfare Best Practice
In 2016, the DCS Ombudsman Bureau continued to identify DCS staffing needs and caseload size as impediments to policies specific to the provision of child welfare services including but not limited to the completion of assessments, holding Child and Family Team Meetings and case plan conferences, family engagement (specifically fathers), case record documentation, development and implementation of visitation plans, support to relative/kinship caregivers, and services to resource parents. DCS Local Offices responded to recommendations to address

these concerns while DCS leadership worked to identify solutions to remedy systemic challenges in these areas. In an effort to identify, develop and implement approaches to enhance existing child welfare practice, DCS also presented plans to address systemic concerns to the State Budget Committee in November 2014. One such effort included commissioning Deloitte Consulting, LLP *"to identify process and practice improvements that DCS could implement to ultimately enhance child safety"* (*Bonaventura, March 18, 2015*). The resulting ***Casework and Workload Analysis – Final Recommendations*** report completed by Deloitte Consulting, LLP during the first quarter of 2015 acknowledged DCS's continued efforts to better protect children and identified steps to improve agency operations. DCS prioritized the study recommendations into four priorities:

1. Hiring additional field staff
2. Improving organizational efficiencies
3. Enhancing staff training of use of technologies
4. Improving data driven decision making

The DCS Ombudsman Bureau is supportive of DCS efforts to address systemic challenges to the provision of quality services and support to families and children and requests an update on DCS activities in the four priority areas identified by DCS.
DCS Response: Pending

Recommendation #2 – Documentation
Thorough and consistent documentation is the cornerstone of DCS best practice efforts. The charge to document events and activities are included throughout DCS policy and specifically in *Child Welfare Policy 5.2: Gathering Case Information* which advises that documentation begins at assessment and continues throughout the life of the case. The DCS Ombudsman Bureau case reviews completed in 2015 revealed a significant number of instances where the bureau had difficulty reviewing complainant concerns due to the lack of sufficient documentation in the case file. This became particularly challenging in situations where DCS staff was no longer employed by the agency. While the DCS Ombudsman Bureau acknowledges that case load size and staffing needs greatly impact DCS's ability to consistently address practice issues, it is imperative that DCS actions align with DCS policy, laws and written rules. The DCS Ombudsman Bureau recommends DCS respond regarding agency efforts to address documentation concerns.
DCS Response: Pending

DCS Ombudsman Bureau Reflections and Future Initiatives

Agency Response
In 2016, 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. Services and supports have been delivered to DCS Ombudsman Bureau constituents in a timely, efficient and effective manner. 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. The use of Assists as a viable tool to foster communication and resolve concerns between complainants and the Local Offices continue to allow DCS Ombudsman Bureau staff to focus on more complex case reviews and investigations.

DCS Ombudsman Bureau Initiatives

The responsibilities of the DCS Ombudsman Bureau require experienced staff proficient in the areas of child welfare and criminal justice issues; problem resolution; research; 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.

The DCS Ombudsman Bureau currently employs two Assistants with the responsibility of responding to constituent concerns. In 2015, the DCS Ombudsman Bureau began discussions with the State Personnel Department to identify strategies to better align the Assistant Ombudsman job description with the actual tasks performed. 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 for additional staff and/or an increase in staff salaries 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 to restructure the agency to support better work flow. A request for funding to increase outreach efforts and staff development was also made.
The budget requests were approved during the 2015 Legislative Session. The DCS Ombudsman Bureau was appropriated $313,807 in 2015, which was an increase of $98,132 from the previous fiscal year. Efforts to address staff retention and outreach efforts continued in 2016. Effective April 2017, The Assistant Ombudsman status classification was changed from an Administrative Assistant 2 to a Program Director 2 with a 4.5% increase in salary. While funding efforts for outreach and training efforts increased, the DCS Ombudsman Bureau was able to hold the costs consistent with previous years by participating in opportunities at low to no cost.

The request for additional staff was not approved in 2016. The DCS Ombudsman Bureau continued to pursue approval for an additional Assistant Ombudsman Position to support the agency's efforts.

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.

Particular appreciation goes to Assistant Ombudsman Jessica Stier and Assistant Ombudsman Jamie Anderson. They are invaluable assets to the success of the DCS Ombudsman Bureau and the diligent efforts they bring to the agency are greatly appreciated.

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 Stier 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:

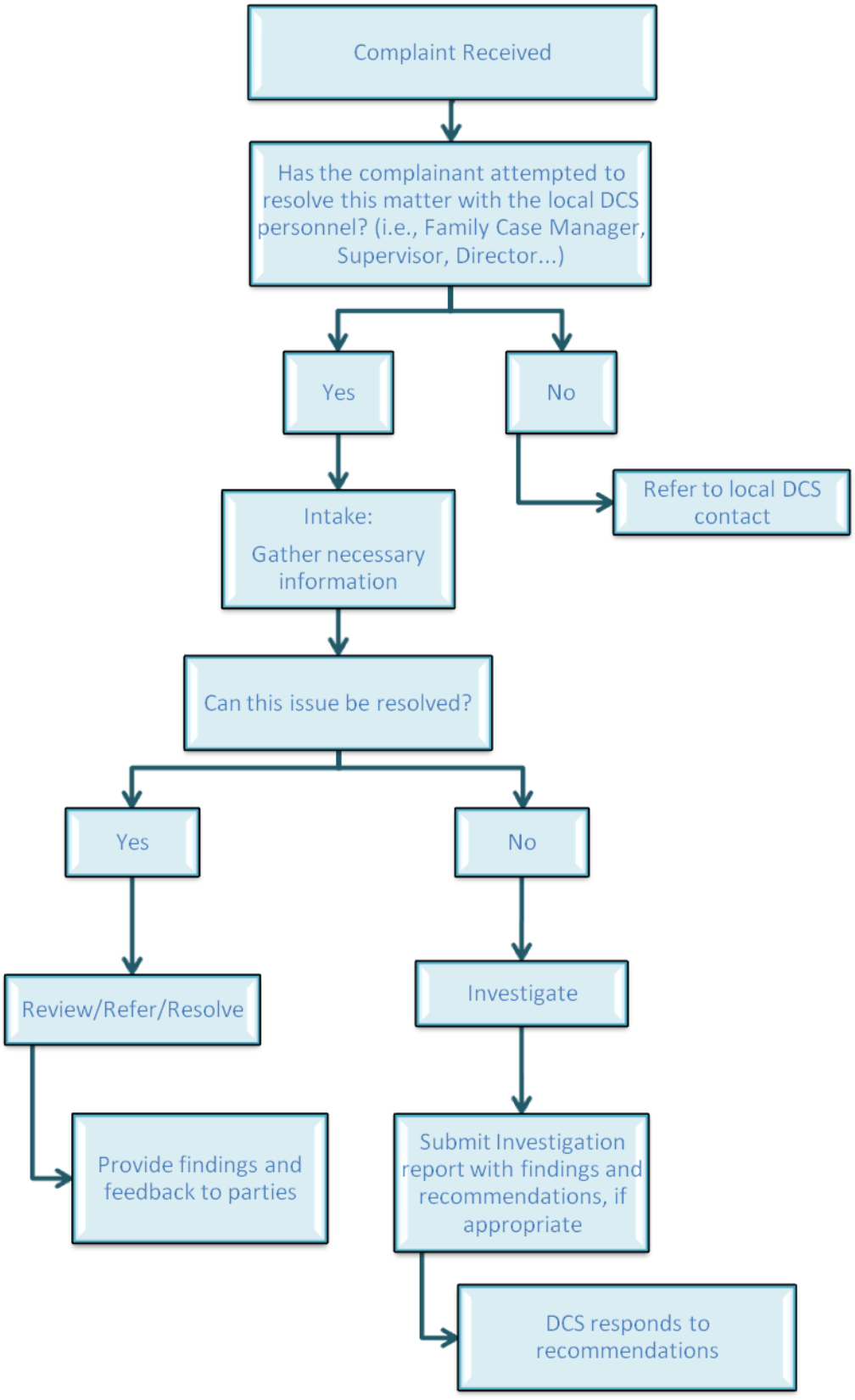
- Decline to accept a complaint that does not fall within the jurisdiction of the Bureau.
- Determine the level of review, the documentation and interviews necessary for gathering the information required to determine findings.
- Expect the complainant to provide any additional information requested.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

DCS Ombudsman Bureau Responsibilities

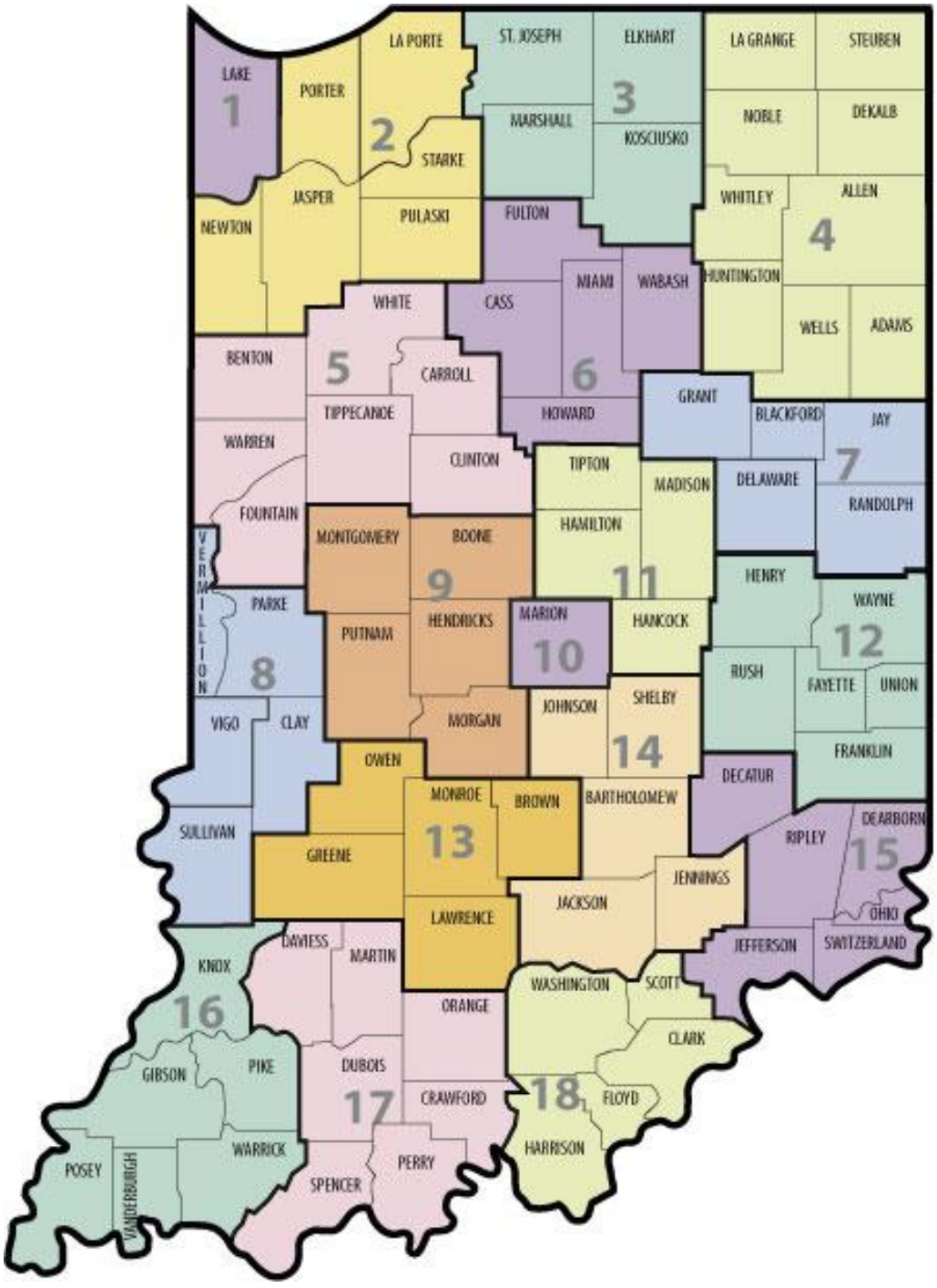
The Bureau shall:

- 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



DCS Ombudsman Bureau

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