State of Indiana

Department of Child Services
Ombudsman Bureau

2010 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 characterizes 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.

STATE OF INDIANA

Mitchell E. Daniels Jr., Governor

DEPARTMENT OF ADMINSTRATION
Department of Child Services Ombudsman Bureau

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January 31, 2011

The Honorable Mitch Daniels, Governor
The Honorable Speaker and President Pro Tem
James W. Payne, Director, Indiana Department of Child Services
Rob Wynkoop, Commissioner, Indiana Department of Administration

In accordance with my statutory responsibility as the DCS Ombudsman, I am pleased to submit the 2010 First Annual Report for the Indiana Department of Child Services Ombudsman Bureau.

This report provides an overview of the activities of the office from December 14, 2009 to December 31, 2010 and presents information regarding program development, case activity and outcomes. Also included is a summary of recommendations and DCS responses.

The DCS Ombudsman Bureau appreciates the leadership and support of Governor Daniels, the Indiana Legislature, and the Department of Child Services. Thank you for the opportunity to serve the children of Indiana.

Respectfully,

Susan Hoppe

Susan Hoppe, Director
DCS Ombudsman Bureau

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Ombudsman's Message

In 2009 the Indiana Legislature created the Department of Child Services (DCS) Ombudsman Bureau 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 gives the ombudsman the authority to evaluate the effectiveness of policies and procedures in general and provide recommendations. The creation of the ombudsman office occurred four years after DCS was established as a separate agency during 2005.

Since 2005 DCS has implemented sweeping reforms, including a reduction in case load size to meet nationally recommended standards, a significant increase in staff, the adoption of the Practice Model which is based on the concepts of Teaming, Engaging, Assessing, Planning and Intervention (TEAPI), a tool for measuring outcomes, a 12 week training program for staff, reorganization of the number of regions from 8 to 18, and a shift from services being paid by the county to being paid by the State. Since taking the office of Indiana's first DCS ombudsman, I have had the opportunity to study and learn about the DCS initiatives and programs adopted since 2005 and to review the measured outcomes, and continue to be impressed with DCS's commitment, expertise and tireless effort to explore innovations and meet best practice standards. DCS and the DCS Ombudsman Bureau share genuine concerns about ensuring the safety, well-being and positive outcomes for the children we serve. The collaborative working relationship that has been forged between DCS and this office and the many courtesies Director Payne and his staff have extended are gratefully acknowledged.

The year 2010 for the ombudsman office was characterized by a year of "firsts", including the initial mission statement, policy/ procedural manual, investigation, investigation report, data analysis report, recommendation and the first annual report in the history of the Bureau. The establishment of priorities and standards for best practice were central considerations in all aspects of program development. During the first year of operation, the DCS Ombudsman Bureau responded to 364 telephone/email inquiries, opened 161 cases and closed 150, and provided twenty-two cases specific, and fifteen general, recommendations.

This report provides a summary of the ombudsman activity for this first year. The first section describes the operational components of the program, the second part analyzes information about the complaints, and the third section discusses ombudsman recommendations to DCS and the responses.

As I enter my second year as the DCS ombudsman, I am honored to continue to serve the citizens of Indiana in our shared goal of protecting Indiana's children. The Department of Child Services Ombudsman Bureau looks forward to the General Assembly's continued support for programs and practices that improve the lives of Indiana's most vulnerable children.

Becoming Operational

Purpose

As defined by the statute and reinforced in the mission statement, the major responsibility of the ombudsman is to respond to citizen complaints by providing strategies for resolving concerns or conducting investigations that promote safety, child-well being and permanency. Considering this charge, the primary activity of this office during 2010 consisted of responding to complaints, recording findings and providing recommendations. Upon the assumption of the office December 14, 2009 the ombudsman developed a task list for the first year of operation to serve as a guideline to ensure the implementation of the statutory responsibilities of the office. (Attachment A) The list included projects related to research/training, administration, program development, recording data, and communication with DCS. A description of the progress in each category is discussed in further detail in this section.

Research/Training

Research of other ombudsman programs was initiated to become knowledgeable about standard practices and operations. Thirty-three states have some form of statutorily enabled children's ombudsman programs. Twelve of these programs are strictly children ombudsman programs, and attention was devoted to these similar programs. Annual reports, websites, articles and commonly used forms were reviewed. Telephone interviews were conducted with other ombuds, and a site visit made to the ombudsman office in Dayton, Ohio. The book Conducting Administrative Oversight & Ombudsman Investigations by Gareth Jones, the basic ombudsman text, was studied. While this course of study was extremely helpful in providing a framework for the office, it became apparent that each office was unique and driven by the statute that created it, resulting in a wide variety of ombudsman responsibilities and scope in authority. To ensure continued education in the field, the ombudsman became a member of the United States Ombudsman Association and attended the annual conference during October 2010.

To establish a knowledge base regarding DCS policies and practices, the Child Welfare Manual was studied. Information describing the Practice Model was reviewed and the ombudsman had the opportunity to observe a Child Family Team Meeting (CFTM). Meetings were scheduled with various DCS Program Directors to learn about specific programs and DCS reports available.

Administration

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

Staff/Resources*:* The Bureau consists of the Director and a part-time assistant who is shared with the Department of Corrections ombudsman. During 2010 the position was filled from March 8, 2010 through December 20, 2010. A new assistant was hired January 3, 2011.

A Memorandum of Understanding (MOU) was entered into with the Attorney General's Office for a Deputy Attorney General (DAG) to provide legal consultation as needed. Technical assistance is provided by IDOA MIS Director.

Budget: The Bureau was appropriated $145,400 for the 2009/2010 fiscal year, which was allocated from the general fund. The majority of the expenditures were for personnel, with the remainder devoted to utilities, supplies and travel.

Program Development

Outreach: To publicize the existence of the Bureau, information about the office was submitted to the 211-Connect database, an Information and Referral hotline serving sections of the state. The DCS Ombudsman Bureau website was created and added as a link on the IDOA website. DCS also added the link to their website. A brochure was developed and disseminated through DCS and various community organizations. The ombudsman attended meetings with community groups and child advocates throughout the State to share information about the function of the office and to listen to community concerns regarding DCS issues.

Policies and Procedures: The mission statement was developed within the first month, and the complaint form followed shortly. Policies and procedures were developed and a manual was written. The manual is published on the website and provides guidance on the following topics:

- The intake process
- Case acceptance guidelines
- Notification requirements
- The investigation process
- Determining validity
- Turnaround Time
- Record keeping
- Reports
- Recommendations
- Responsibilities of the DCS Ombudsman

DCS Ombudsman Bureau Information System: A case information database was developed in Access within the first month. After three months it became apparent that the Bureau received many Information and Referral Inquires that did not result in an open case, but still required a response. Another database was then developed to track the Information and Referral Activity separately from the database with the case information. DCS Ombudsman cases also have a paper file, which are retained per state record keeping policy.

DCS Information Access: The ombudsman office was given access to the Indiana Child Welfare Information System (ICWIS) and the DCS Intranet; training was provided on both systems. These resources enable the ombudsman to view DCS case records and DCS reports.

Reports

Quarterly

To ensure the program continues to serve the mission and to document accountability, accurate data about program activity is required. The DCS Ombudsman Bureau submits quarterly reports on the calendar year to serve this purpose. The quarterly report includes four components. The first part is a summary of the case activity and includes numerical counts of cases by region, major issue, type of response and outcome. The second section provides brief case summaries and outcomes for all the cases by region. The third section outlines the recommendations given and responses received during the quarter, including a section for any new general recommendations. The fourth part is a list of the Information and Referral Inquiries and responses by date. The quarterly report is distributed to DCS Director Payne and his executive staff, IDOA Commissioner Wynkoop, and the Governor's office, and has served primarily as a tool for information sharing and analysis.

Other

The ombudsman is unable to draw any conclusions about the general status of children in Indiana pursuant to IC 4-19-5-10 9 (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.

Communication with DCS

Communication with Field Staff: An introduction letter was sent to DCS Regional Managers and County Directors December 30, 2009 explaining the role of the ombudsman office and proposed process for communicating with the local DCS office when a complaint is received. Subsequently the ombudsman and DCS collaborated to develop a protocol for this process, in addition to the protocols for ombudsman referrals to Child Protection Team (CPT) and ombudsman investigations of critical incidents. Upon conclusion of a review and/or investigation in which a complaint is determined to have merit, case specific recommendations are offered, and the local office responds to the recommendations within 60 days.

Communication with Executive Staff: The ombudsman attends regularly scheduled meetings with the DCS Chief of Staff and DCS Director of Field Operations. The meetings provide the opportunity to share information, discuss cases, resolve problems and address concerns. Recommendations are also discussed, and DCS responds to all general recommendations within 60 days.

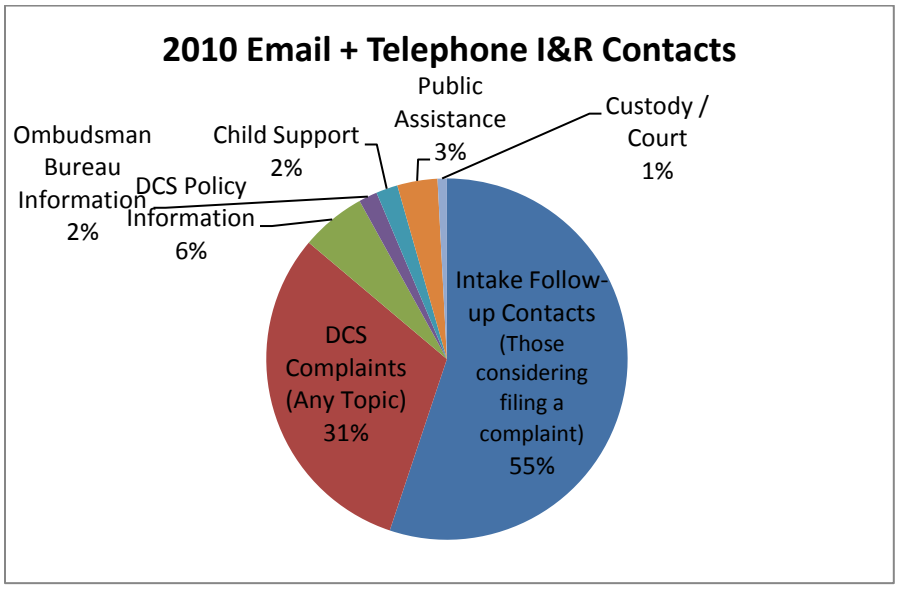
Complaints

The Process Overview

Formal complaints are required to be submitted in writing on the DCS Ombudsman Bureau complaint form. However, the Bureau also receives a number of Information and Referral (I&R) Inquiries via telephone and email that do not result in an open case, but require a response. To track this service, pertinent information about the contact is recorded in the Information and Referral (I&R) contact log database. A case is opened when a complaint form is received. The complainant and DCS are notified of the receipt of the complaint and an intake assessment is made regarding the appropriate response. After the initial assessment, a variety of responses are possible. The ombudsman 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. As mentioned previously, during the first few months of operation, cases were opened when the only response required to a complaint was Information and Referral services, but this practice was later revised. The complainant and DCS are informed in writing of the findings when a validity determination is made or of the disposition if the case did not generate a validity determination. If a case is investigated, a detailed report is completed and forwarded to DSC and complainant if they are a parent, guardian custodian or Court Appointed Special Advocate/Guardian ad Litem (GAL). Other complainants receive a general summary of the findings. If a complaint was determined to have merit, recommendations are made to address the issue, and DCS provides a response to the recommendations. Following is an analysis of the complaints received during 2010:

Information and Referral Inquiries

During 2010 the Bureau responded to 364 I&R inquiries concerning the topics below:

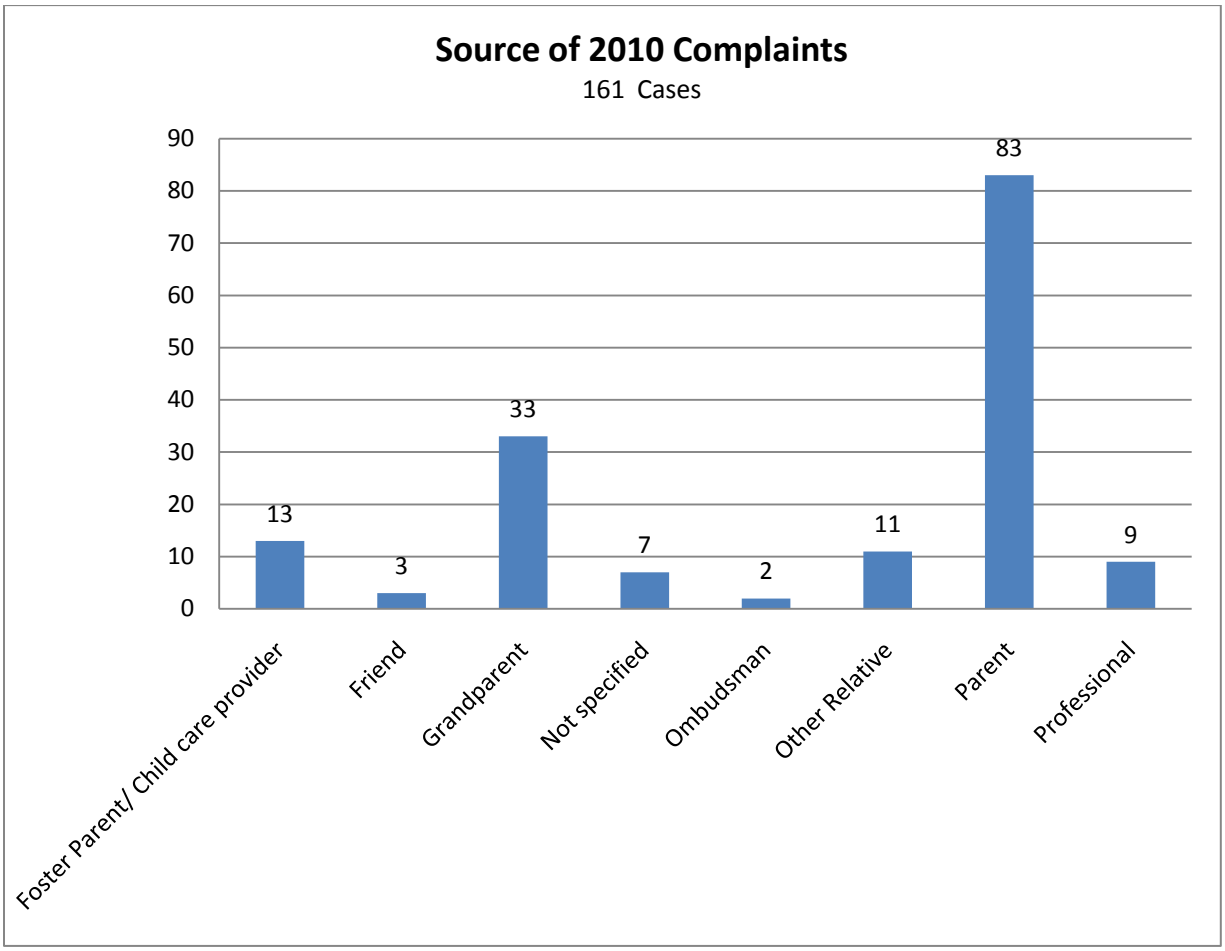


Formal Complaints

During 2010 the Bureau opened 161 cases. Following is information about those cases.

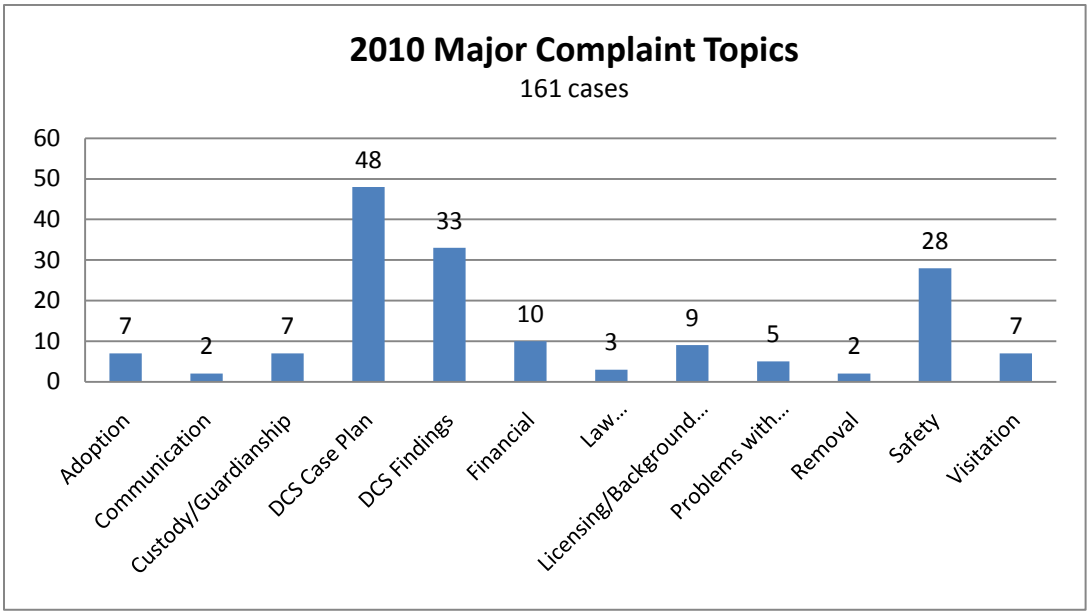
Complaint Source

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 2010 parents made up the greatest share of complainants followed by grandparents.



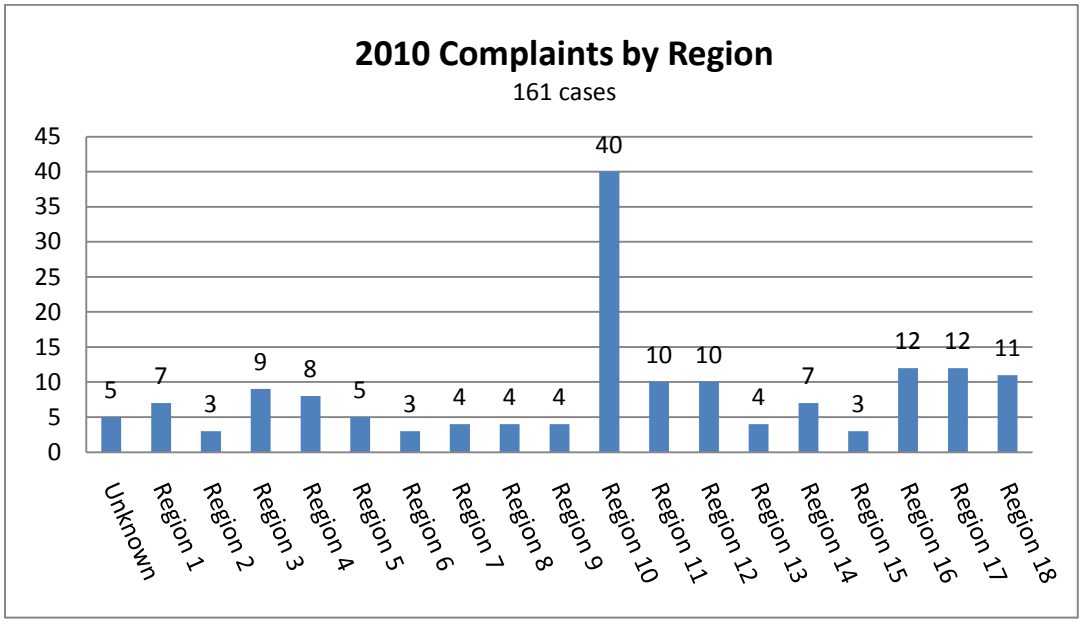
Complaint Topics

Approximately 67% of the complaints concerned the DCS case plan, DCS findings or child safety.



Complaints by Region

DCS is organized into 18 Regions. (Attachment B) Each region has a Regional Manager who supervises the local office directors in their region. As illustrated below a large number of complaints were received from Region 10, which is Marion County. The population density and awareness of the office are suspected factors for the increased number in this region.



Response Categories

When a complaint is filed with the office, a case is opened and an intake assessment 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 ombudsman questions. 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. All DCS staff involved with the case, in addition to the (CASA/GAL) and service providers, if applicable, 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 completed 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 or GAL/CASA. If the complainant is not one of the above they are provided a summary of the findings in general terms. Approximately 15% of the cases during 2010 resulted in investigations.

Refer Back to the Local DCS: The ombudsman requires that the complainant attempt to resolve their issues with the local DCS through the DCS internal complaint process prior to filing a complaint with the 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 and the complainant is instructed to file a complaint again if the matter was not resolved.

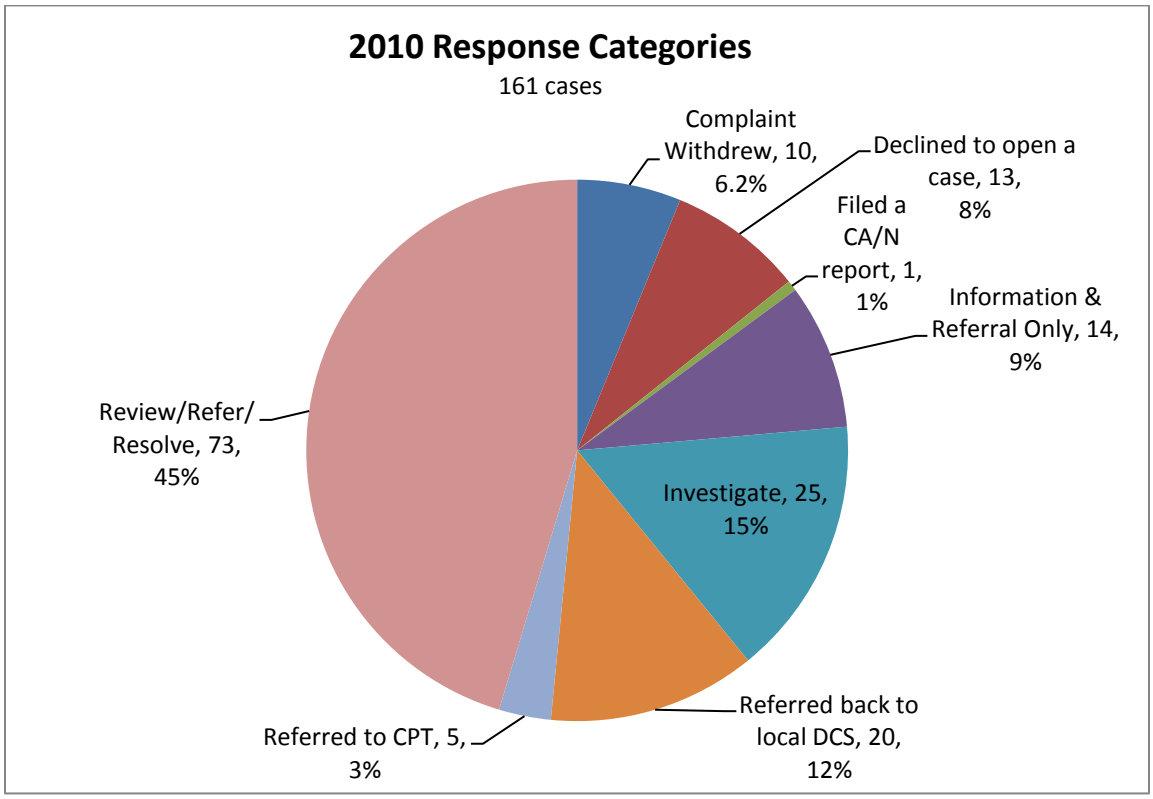
Close due to Complainant Withdrawal: Some cases have been closed prior to completion because the complainant decides to withdraw the complaint during the process.

Decline: Cases that are not within the ombudsman jurisdiction or appear vexatious in nature are declined.

Refer to Child Protection Team: The ombudsman has the option of seeking assistance from the local Child Protection Team (CPT) and 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 occurred only once during 2010.

Provide Information and/or Referrals: This type of service no longer constitutes a case, but because this response was included as a case during the first part of 2010, this category is listed here.



Complaint Validity and Outcomes

The standard for determining the validity of the complaint is mandated by 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. This component of the program will continue to be monitored and revised accordingly to ensure accurate reflection of the findings. During 2010 the Bureau recorded the findings of each case using the following designations:

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. Cases with this designation had only one allegation to be reviewed or investigated.

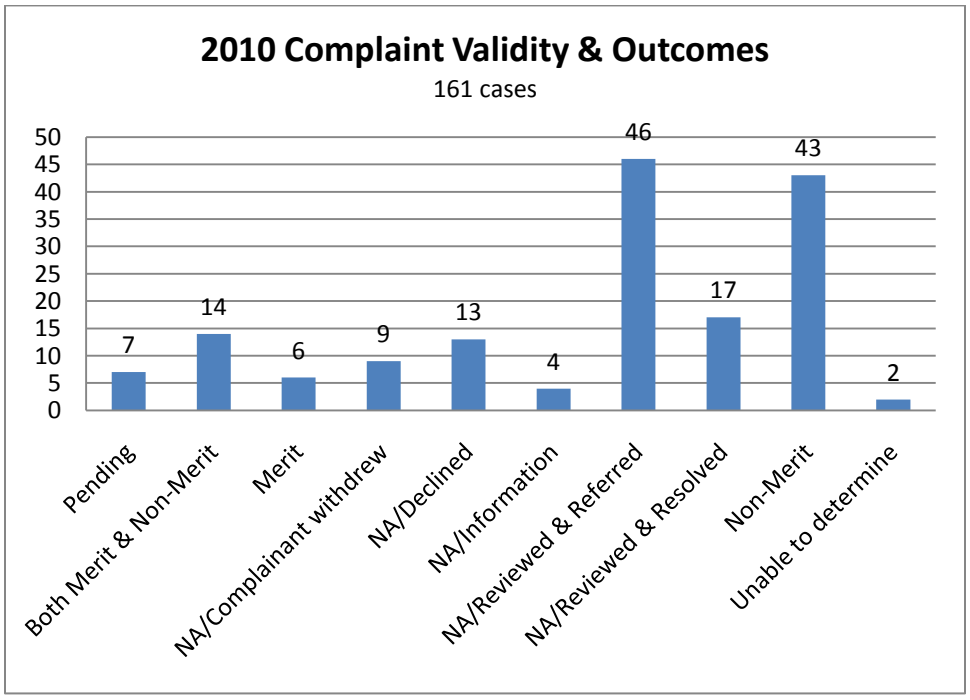
Non-Merit: When the primary allegation in the complaint is determined not to be valid following a review or investigation, the complaint is said not to have merit. Cases with this designation had only one allegation to be reviewed or considered.

Both Merit and Non-Merit: These cases involve multiple allegations, some of which were determined to have merit and others which were determined not to have merit.

Not Applicable (NA): During 2010 the Bureau received a number of cases which involved a review and/or consultation, but a validity finding was not determined. These cases are recorded in the categories below:

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

Unable to Determine: Occasionally the information uncovered is so conflicting that it is not possible to determine validity and/or the documentation to confirm or refute the allegations is not available.



Recommendations and DCS Responses

During 2010 the ombudsman offered 22 recommendations on specific cases following a review or an investigation and 15 general recommendations regarding systemic issues. All responses have been received that were due by December 31, 2010.

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

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

DCS is required to respond to the recommendations within a reasonable time, and the Bureau has established 60 days for the response time frame. The following case summaries represent a variety of issues and include cases in which the allegations were determined to have merit, the recommendations provided and DCS's response.

Case Example #1: In this case it was alleged that DCS removed the children without just cause, that the children were being abused in foster care, and that the parent was not provided visitation until 11 days after the children's removal.
Findings: The allegations regarding the removal and abuse in foster care did not have merit, but the allegation regarding visitation was true and a violation of DCS policy.
Recommendation: It was recommended the local office immediately develop a visitation plan, and provide continuing education to staff reinforcing the policy stating that face to face visitation with the parent, guardian or custodian is required within 48 hours of removal and a visitation plan is to be developed within 5 days of removal.
Response: Visitation was immediately arranged, resolving this complaint. The local office director reinforced the policy by reminding staff of the importance of parental child interaction and the policy in a local child focused publication issued to staff, providers and other community partners. The policy was reviewed at the Management meeting and Supervisors were instructed to review the policy at their monthly meeting. In addition the local office director spoke to the complainant to provide reassurance regarding the other concerns that were expressed in the complaint and determined not to have merit.

Case Example #2: The allegations in this case stated that the children, who were ordered to be with the mother on a Trial Home Visit (THV) were actually residing with other caregivers, and, that the recommended services for the parent had not been implemented.

Findings: The investigation revealed that the children's placement had not been appropriately supervised per DCS policy and that the services recommended as a result of the parenting assessment had not been implemented. It was also learned that the caregiver with whom the children were staying was the children's prior approved placement. However, during the course of this placement DCS learned that this caregiver had a prior DCS history.
Recommendation: It was recommended that the recommended services be implemented and that staff review the policies for THV preparation, supervision and minimum contact.
Response: DCS removed the children from the caregiver temporarily and returned them to the mother. The local office director reported that the parenting assessment recommendations had been implemented. In addition, a memo was sent to staff by the Director instructing staff to review Child Welfare Manual policies 8.10 and 8.39 addressing minimum contacts and the policies and procedures for beginning and maintaining Trial Home Visits. The memo stressed the importance of these polices for best practice.

Case Example #3: This complaint had multiple allegations and involved complex issues, including the mother's possible diagnosis of factitious disorder by proxy. Factitious disorder by proxy is a condition in which a person deliberately produces, feigns, or exaggerates symptoms in a person who is in their care. The complainant alleged that DCS failed to make reasonable efforts to reunify the children with their mother, changed the reunification requirements after the mother completed services, required supervised visits after having unsupervised visits, and failed to provide the mother with requested information.
Findings: The investigation revealed DCS failed to provide appropriate services in a timely manner and made changes in the requirements for reunification, resulting in delays in progress. The investigation also revealed that professionals had conflicting opinions regarding the mother's mental health diagnosis adding to the dilemma regarding the appropriate service to provide. Thus the services provided initially did not address this diagnosis. Once the diagnosis was received from a professional with knowledge of the disorder, the recommendation was made for specialized services and supervised parenting time. These services had subsequently been initiated and visits reverted to supervised. By the time the investigation was initiated, DCS had already recognized that this cases required immediate redirection and steps had been taken to correct the problem.
Recommendation: Due to the fact the circumstances responsible for the lack of direction in this case were subsequently remedied, as evidenced by a change in staff, the appropriate services being provided and a regular parenting time plan implemented, it was recommended that the local office provide the Bureau a brief description of any changes in polices/practices that were a result of this case and/or the steps taken to remedy the problems referenced in the findings.
Response: DCS attributed the mismanagement of the case to personnel issues, and noted there have been several changes in staff and management during the life of this case. Upon appointment, the new management initiated a review of the case and determined the case required immediate action to assess the status and direction. The local office director reported that since that time the case has been monitored closely to ensure existing State policies and practices are being followed. To that end, staff was educated on existing policies and the use of

the State's Practice Model was reinforced, resulting in the successful facilitation of CFTMs since March 2010. Although the local office maintains that all requested documents were provided to the mother upon request, a complete and current copy of the file was again provided to avoid any future allegations that she did not have full disclosure of all pertinent records.

Case Example #4: The ombudsman initiated this investigation as a result of another investigation regarding Medicaid eligibility issues that brought to attention children who may not have been receiving needed medical care while under DCS jurisdiction.
Findings: It was confirmed that the children had not received any medical care during their six month stay in foster care. One child's dental needs were significant. These actions not only deprived the children of needed medical care, but also were a violation of policy for ensuring all children in DCS's care have a medical exam within a certain time frame.
Recommendation: DCS corrected the urgent issue of providing the necessary medical care for the children upon awareness. Therefore, the recommendation was for the county to develop and implement a plan to avoid any future occurrences.
Response: The local office management staff embarked upon a review of Child Welfare Manual Chapter 8, Out of Home Services, with a special emphasis on health care policies, in addition to a study of the case transfer and Medicaid eligibility determination processes. Management staff focused on accountability and initiated actions steps to correct the problem. The local office director reported each child's case was being reviewed to ensure every child's health care needs were being met. The completion date for this review was October 15, 2010.

Case Example #5: This case was opened when a complaint was received alleging that DCS was violating policy by failing to respond to an out of state relative who expressed an interest in becoming a caregiver for children in the care of DCS.
Findings: It is DCS's policy to consider the possibility of relatives as placement options before considering other placement options. Upon review it was discovered that there was very little documentation in the contact logs to track the activity in this case. The local office director concurred and reported this was unacceptable. Per the director, an Interstate Compact on the Placement of Children (ICPC) had been initiated but was stopped because the father had not yet established paternity. In addition, the FCM suspected the father was residing with the relative and that the relative would not comply with DCS requirements regarding parental contact. Nevertheless, once paternity had been established, the relative needed to be considered to be compliant with policy, and the complaint was found to have merit based on the lack of follow through on the relative placement and the lack of documentation regarding the details of interactions with the relative.
Recommendation and Response: A frequent outcome of an ombudsman review is the correction of the problem by the local office when attention is called to the matter, prior to the receipt of the ombudsman recommendations. In this case communication was established with the relative and the ICPC was initiated, which is what would have been recommended. The local office director counseled staff regarding the appropriate response to relative inquires and expected documentation.

Case Example #6: The ombudsman received a complaint that the child abuse hotline screened out a report that should have been assigned.
Findings: The report was reviewed and appeared to be appropriate for assignment.
Recommendation: The hotline director was contacted and asked to review the screen out to either assign if appropriate or explain further the decision to screen out.
Response: The hotline director reviewed the screen out and determined the complaint had legal sufficiency. Staff was instructed to assign the Assessment and the complainant was contacted with this information. Intake Specialists and Supervisors were provided additional education regarding this decision.

Case Example #7: This case was referred for a CPT review. In this complaint it was alleged that DCS's plan to place the child with father presented a safety risk, and the mother had completed all requested services and her visits were still supervised.
Findings: The allegation to place the child with the father became moot when the father was arrested. While mother had completed services, she had not successfully completed them. However, specialized mental health services were recommended during March 2010 and June 2010, and a referral was not implemented until October 2010 at the recommendation of CPT. DCS policy states referrals for services are to be made within 10 business days of the identified need.
Recommendation: It was recommended that the local office director send a reminder to staff of the time requirements for service referrals.
Response: The local office director sent a memo to all staff reinforcing the importance of connecting families and children to the services that can assist with their needs, and advised staff to review Child Welfare Manual, Chapter 5, Section 10. Staff feedback on the issue was also invited. It is noted that DCS Central Office recently acquired the capability of tracking the timeliness of referrals, which will assist in providing information that can improve the process.

General Recommendations

Pursuant to IC 13-19-5 (2) (4) and (6), the ombudsman may also review relevant policies and procedures with a view toward the safety and welfare of children, recommend changes in procedures for investigating reports of abuse and neglect and overseeing the welfare of children who are under the jurisdiction of a juvenile court, and examine policies and procedures and evaluate the effectiveness of the child protection system. Each quarter general recommendations are provided to DCS regarding systemic issues. During 2010 fifteen such recommendations were offered. Following is a summary of these recommendations and responses. The recommendations are based on information derived from the volumes of information reviewed in the course of case reviews and investigations, in addition to information gleaned from various DCS reports and discussions with community partners.

Recommendation #1: Timely visitation appeared to be an issue in a number of complaints, particularly with regard to ensuring face-to-face contact with the parent, guardian or custodian within 48 hours of removal and developing a visitation plan within 5 days. It was recommended DCS explore the barriers to compliance with this policy and develop a plan to address them.
Response: In response to the ombudsman inquiry about visitation occurring within 48 hours of removal, DCS researched this and determined this was occurring in 62.7% of the cases. To remedy this the Quality Assurance Review (QAR) tool was revised to include monitoring for this practice. This was also addressed at the Regional Managers Meeting. A recent status check on this revealed there is still no improvement, and this will continue to be monitored.

Recommendation #2: Many cases brought to the attention of the ombudsman involved high conflict between the parents. This high conflict was not only not in the children's best interest, but also interfered with case planning when the parents were unclear about which parent DCS was considering for reunification if the parents were separated. It was recommended Family Case Managers (FCMs) be provided with resources for supporting positive co-parenting and that staff be given more direction when developing a reunification plan in cases in which custody is an issue.
Response: DCS indicated they would consider reviewing the recommended resources available to staff to support positive co-parenting. They reported the Concurrent Planning policy was recently updated which would serve to clarify the issue of reunification when both parents are seeking custody. Furthermore, DCS has proposed legislation to combine the Child In Need of Services (CHINS) and Custody cases during the life of a CHINS, which would result in more timely resolution of contested custody and less conflict for the children.

Recommendation #3: The ombudsman reviewed several cases that were being prepared for case closure which generated a concern about case closure sustainability. The issues that brought the children into care in the first place and the extent to which they have been remedied appeared to be secondary to the standard of minimal compliance. It was recommended staff receive additional training on the assessment skills required at the time of closure and how to incorporate this into Child Family Team Meeting (CFTM) process.
Response: DCS reported effective July 1, 2010 a new Quality Performance Tool, the Reflective Practice Survey is being required to provide an analysis of case management services and a format for the Supervisor to evaluate FCM strengths and needs. Sustainable case closure is one aspect to be analyzed in this process.

Recommendation #4: DCS substantiates AB/N allegations based on the preponderance of evidence standard; however how the FCM arrived at this conclusion was frequently unclear in the Assessment reports (311's). Preponderance of evidence has been described as just enough evidence to make it more likely than not that the allegation is true. A standardized format was recommended to ensure clarity of the reasoning for the findings. This would serve to increase the FCM's clarity and confidence regarding the determination and be beneficial in cases with Administrative Reviews.

Response: DCS provided additional guidance to assist staff in providing a better explanation of how they reached the status determination based on a preponderance of the evidence standard.

Recommendation #5: When complainants alleged to have been treated "rudely" or "unprofessionally" by DCS staff, it was discovered that there was no code of conduct to reference. A policy on DCS professional code of conduct was recommended.
Response: The DCS Code of Conduct was released May 1, 2010 and Computer Assisted (CAT) required training was provided during June 2010.

Recommendation #6: While reviewing home based provider reports during case reviews, it was apparent that not all provider reports provided the same documentation. In one case the provider failed to record the date, place and the length of time spent with the parent, contributing to an inaccurate account of the supervision provided. It was recommended DCS develop standard report items required in the monthly reports submitted by the home based providers to include the date, place and length of time spent with the parent.
Response: DCS reported that with a new Medicaid Initiative recognizing Community Mental Health Centers (CMHC) as the preferred providers for home based services, new reporting requirements have been developed. These reports include the date, method, and manner in which the parent was contacted along with the duration of the contact. DCS reported they would revise the template to include location and investigate the use of these forms with private non-CMHC providers.

Recommendation #7: Based on case reviews and voiced concerns from consumers and community partners, the quality of case management services appears to be compromised when cases are transferred multiple times during the life of a case. It was recommended DCS endorse procedures that minimize case transfers and a standard process for sharing information when a change in FCM is necessary.
Response: While DCS has existing policy that addresses case transfers between counties, transfers between assessment and on-going workers, and completing child and family team meetings at critical junctures such as worker transitions, there is currently no policy to formalize the process of the transition of a case due to a change in worker because of turnover, long-term medical leave. Etc. DCS policy will begin the process of determining policy, practice and procedure for such internal transfers. Updated information indicates this policy is in draft form and had not yet been released. DCS recognizes the impact that worker turnover has on permanency for children, and this is addressed in a standing meeting that analyzes turnover data and examines strategies to minimize turnover.

Recommendation #8: The DCS Ombudsman Bureau requests that complainants attempt to resolve their concerns with DCS through the DCS internal complaint process prior to filing a complaint with the Bureau. This office suggests the complainant begin with the FCM, and if unresolved, to continue with the Supervisor, Division Manager, Local Office Director and Regional Manager. While there is administrative policy regarding complaints to the DCS constituent services representative, there is no policy for the process a complainant should use

when attempting to resolve their problems directly with the agency via telephone. It was recommended DCS develop a policy for this process. This would streamline the process for all if there was a formal procedure to reference.
Response: DCS reported the constituent complaint policy was in the process of being revised to clarify the escalation of telephone complaints, as well as providing additional clarifications to the complaint process. The draft policy was anticipated for September 30, 2010, but updated information indicates this work is still in process.

Recommendation #9: It was recommended DCS explore the possibility of minimizing involvement in some cases involving sexual abuse allegations between two minors. Unless there is an issue of parental neglect/supervision, there appears to be little role for DCS in these cases, particularly if law enforcement is involved. Any adjustments, of course, would have to be made in accordance with DCSs statutory responsibilities.
Response: DCS agreed with this recommendation and is exploring this issue as well as others where the child does not appear to be seriously impaired or seriously endangered and does not require coercive intervention. DCS has established a new protocol for working with law enforcement on these cases. As it pertains to sexual abuse with young children and the practice of identifying young children as perpetrators, the hotline has revised the focus. Intake staff now focuses on the specifics of the behaviors being reported and developmental implications. If lack of supervision is an issue or the behavior appears aggressive or out of the age development behavior, the assessment will be assigned.

Recommendation #10: It was recommended DCS consider referring to parental visitation as "parenting time" rather than "visitation". This term appeared to be supportive of DCS's practice to engage and empower families and is consistent with the language used in custody proceedings.
Response: DCS reported this language change has been submitted to Policy for analysis.

Recommendation #11: The delay in Medicaid eligibility processing for a certain population of children was brought to the ombudsman's attention. While it was apparent DCS had been working diligently to improve this process, there was no instant solution to these complex issues. It was recommended DCS continue to work on improving this process with the Department of Family Resources (DFR) and to provide guidance to FCMs on troubleshooting when there is a problem.
Response: To resolve this issue DCS had already created a Medicaid Eligibility Unit (MEU) to serve as a Medicaid enrollment center for this population. The applications and verifications are filtered through the MEU and sent to DFR for processing. This compact process and the MEU's expertise are expected to improve efficiency. DCS reported they will continue to work with DFR to refine the process and shorten timeframes. There is an email box for staff to forward questions to the MEU. This guidance will be re-issued to the field so that proper staff can be apprised any enrollment issues. It is noted the ombudsman has received positive feedback recently about the effectiveness and responsiveness of the MEU unit, and there were no complaints concerning Medicaid in the fourth quarter.

Recommendation #12: The CFTM is an integral part of the case management and case planning process. The team meetings have set agenda items that build on each other and are designed to serve a specific purpose in the case planning process. After reviewing a great number of CFTM notes during 2010, it was observed that the "What can go wrong?" agenda item was frequently overlooked or minimized. Failing to address this has the potential to create problems when things do not go as planned and have resulted in complaints to this office. It was recommended FCMs be reminded as to the importance of this section and to be sure to include it in the meetings. If DCS learns that for any reason, FCMs are uncomfortable facilitating this section, an appropriate plan to address this is recommended.
Response: DCS agreed that this section of the CFTM is an important part of the agenda and was recently reinforced with the Regional Managers and subsequently with local management staff and FCMs. DCS has received reports that some strength based FCMs stress the likelihood of a successful plan, and down play this section. DCS believes this is a critical component to the process and must be addressed. DCS forwarded this recommendation to the Policy Director to see if existing quality review tools can be enhanced to further improve this area.

Recommendations #13: It was recommended DCS provide further guidance to staff regarding the role/responsibility of DCS when the family develops a plan during the CFTM process that, according to best practice and/or the training and expertise of DCS professionals, does not appear to be in the child's best interest or sustainable. While this office recognizes the family's role in decision making is central to the Practice Model, DCS's guidance to ensure the plan is the best plan to meet the child's needs and to ensure safe, sustainable case closure is also an important role.
This was a fourth quarter recommendation and the response is pending.

Recommendation #14 A significant amount of cases reviewed involved substance abuse issues. Among those cases a wide variety of DCS responses were observed with regard to the degree of sobriety and participation in services that was required prior to recommending unsupervised parenting time, a THV, an Informal Adjustment (IA) and/or reunification. It was recommended DCS evaluate the appropriateness of Informal Adjustments (IA's) in cases of serious substance abuse, and consider the question of at what point in recovery can parents be expected to provide a safe environment and appropriate parenting. Following discussion and resolution of these questions policy should be developed and training provided to staff.
This was a fourth quarter recommendation and the response is pending.

Recommendation #15: Per policy parental and the local office director's consent is required before DCS can administer psychotropic medications to children in care. Furthermore, DCS Policy states that DCS should seek a second opinion when a physician prescribes more than 5 psychotropic medications, antidepressants for children under four and/or psycho stimulants for children under 3. These cases should also be considered for additional review. Based on a variety of practices observed with regard to this issue, DCS staff appeared to be confused about this policy. It was recommended DCS issue a reminder to staff of the policy in Chapter 8, Section 30 and reinforce compliance.
This was a fourth quarter recommendation and the response is pending.

Child Fatalities

State Fatality Review Team

The Indiana State Fatality Review Team was created by statute and organized during 2004. During 2009 the statute was amended to include representation from the office of the ombudsman, and the ombudsman participates in the monthly meetings reviewing selected cases. During 2009/2010 the State Fatality Review Team reviewed child deaths caused by drowning and child deaths caused by ingestion.

The 2010 State Fatality Review Report on drowning can be viewed at: www.childdeathreview.org/reports/IN_DrowiningRpt_2010.pdf.

Notification

Since June 2010 DCS has made arrangements to have the Call Center (Centralized Child Abuse Hotline) include the ombudsman on the list for immediate notice all fatality/near fatality reports that have had any DCS history. The ombudsman reviews all of the reports and notes questions for follow up on certain cases.

Future Considerations

The performance metrics for the DCS Ombudsman Bureau are to respond to all inquiries within 24 hours, to complete case reviews between 30 and 60 days, and to complete investigations between 60 and 90 days. During 2010 The DCS Ombudsman Bureau averaged 26.33 days for the completion of reviews, and 46.53 days for the completion of investigations. Statistics for response time to inquiries were only available for the last quarter during 2010, and average response time was less than 24 hours. The plan for the next year is to continue to meet these performance goals, refine the process for responding to individual complaints, record data and ensure that the resources are devoted to those complaints that have the biggest impact on child safety and well-being.

Attachments

Attachment A

DCS Ombudsman Bureau Task List for First Year of Operation

	Completed	In Process	Target Date
Research and Training			
Web Review of other programs and websites	12/16/09		
Identify similar programs and review forms and reports	12/17/09		
Visit other programs and network with like offices	1/11/10		
Join USOA and utilize consultation as needed	12/23/09		
Attend Ombudsman training scheduled for October 2010	10/2010		
Complete/study Conducting Administrative, Oversight & Ombudsman Investigations by Gareth Jones	2/2010		
Learn ICWIS program	12/29/09		
Obtain access to DCS intranet and learn how to use	5/2010	X	
Study and Attend CFTM	4/2010		
Program Development			
Create Mission Statement and Guiding Principles	12/23/09		
Develop draft procedures for receiving & investigating complaints	12/15/09		
Finalize procedures for receiving & investigating complaints	8/2010		
Develop complaint form	12/20/0		
Develop investigation report format	2/14/10		
Develop & install data base for tracking cases	12/30/09		
Develop website and links	1/6/10		
Introduce DCS Ombudsman Program to County Directors	1/6/10		
Identify liaisons within DCS & arrange for regular meetings	3/1/10		
Begin receiving inquiries and complaints, resolving and investigating	1/6/10		
Develop data base for Information & Referral inquiries	3/1/2010		
Develop procedure for monitoring fatalities/critical cases		X	
Administrative			
Set up operations (office, printer, computer etc.)	12/15/09		
Hire Assistance	3/18/10		

Attachment A

	Completed	In Process	Target Date
Reporting Activity & Progress			
Develop and Finalize Quarterly report format; submit first QR 3/2010	3/2010	X	
Develop and Implement procedure for providing DCS recommendations and receiving responses	9/2010	X	
Submit initial report	1/18/10		
Prepare and submit annual report			1/30/11
Outreach			
Schedule meetings with Community Partners		X	
Participate in State Fatality Review		X	
Submit information for 211 Connect database	6/2010		
Design , print and distribute brochure	8/2010	X	
Future			
Fine-tune reporting format and develop enhanced data base report capability			2011/2012
Continue to fine-tune and develop program content, procedures and standards			2011/2012
Continue to track fatalities/near fatalities and develop criterion for selecting any to review if appropriate			2011/2012
Update website as needed			2011/2012
Develop process for identifying trends based on data as well as ombudsman cases			2011/2012

Attachment B

DCS Ombudsman Bureau Contact Information

Office Hours

8:00 am to 4:30 pm

Telephone Numbers

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