

Montana Department of Justice  
Office of the Child and Family Ombudsman  
Annual Report 2015



**Office of Child &  
Family Ombudsman**

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## Executive Summary

Welcome to the 2015 annual report of the Office of the Child and Family Ombudsman. This annual report is required by Montana law and reports activities of the Office for calendar year 2015. This second annual report marks the Office's first full year in operation. We appreciate your interest in this important work.

The mission of the **Office of the Child and Family Ombudsman** is to work to prevent child abuse and neglect and increase safety, well-being, and permanency for Montana's children through fair and just **advocacy, education, outreach, and investigation.**

## Overview

The Office is guided by four principles consistent with the standards of the United States Ombudsman Association:

The Office is **independent** of the Montana Department of Public Health and Human Services (DPHHS), meaning it is separate and free from influence of the individuals the Office may investigate. The Office is part of the Montana Department of Justice. In the Department of Justice, the Office is part of the Division of Criminal Investigation and the Children's Justice Bureau.

The Office is **impartial**. The Office does not take sides in disputes, but rather works to mediate issues and seek resolution for all parties. The Office works collaboratively with all parties, including DPHHS, to improve services for the children of Montana. The Office may advocate certain recommendations which benefit the individual who requested assistance; however, advocacy from the Office is always directed at improving the services of DPHHS, and should not be construed as supporting one individual over another.

The Office is **confidential**. The information collected and shared by the Office is protected by law.

The Office is dedicated to a **credible review process** for each request received. The Office will have a solid understanding of the laws governing child welfare, systems of care, and best practices in working with children and families. The Office keeps the requestor apprised of each step of the process and takes actions that improve transparency of the child welfare system.

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***Communication with CFSD through the Office made a measurable difference in the lives of Montana’s children.***



## 2015 Office of the Child and Family Ombudsman Statute Changes

The 2015 Legislature passed House Bill 472 effective July 1, 2015. The new statute governing the Office of the Child and Family Ombudsman, hereafter the Office, is numbered MCA 41-3-1208 through MCA 41-3-1213 and MCA 41-3-209. The full statute is in **Appendix I** of this report.

The most significant change in the new statute is MCA 41-3-209, which lists the following specific circumstances the Department must report to the Office within one to five business days:

- Within one business day;
  - a death of a child who, within the last 12 months:
    - had been the subject of a report of abuse or neglect;
    - had been the subject of an investigation of alleged abuse or neglect;
    - was in out-of-home care at the time of the child's death; or
    - had received services from the department under a voluntary protective services agreement;
- Within five business days:
  - any criminal act concerning the abuse or neglect of a child;
  - any critical incident, including but not limited to elopement, a suicide attempt, rape, non-routine hospitalizations, and neglect or abuse by a substitute care provider, involving a child who is receiving services from the department pursuant to this chapter; or
  - a third report received within the last 12 months about a child at risk of or who is suspected of being abused or neglected.

As directed by law, Child and Family Services Division (CFSD) began generating the MCA 41-3-209 reports, called *Alerts*, to the Office on July 1, 2015. Electronic *Alerts* are sent to the Office daily by CFSD on the computer. The Office accesses the *Alert* screen on the CFSD database daily. Each *Alert* provides case information for review.

House Bill 472 also clarified the role and responsibilities of the Office as follows:

- The Ombudsman will work collaboratively with the Department and with county attorneys on cases under review.
- The Ombudsman's outreach and education work expanded to include a wider audience which allows the Ombudsman to be a part of Department discussions and planning in an open and transparent manner.
- The Ombudsman is able to apply for grants.
- The Ombudsman continues to report annually to the Attorney General, but in addition, reports annually to the Legislature.
- The new law gives the Ombudsman privilege, which protects the Ombudsman's independence and increases confidentiality of citizens. The Ombudsman may not be compelled to testify or

produce evidence in any judicial or administrative proceeding with respect to any matter involving the exercise of the Ombudsman's official duties.

### **2015 Office of the Child and Family Ombudsman Data and Statistics**

From December 16, 2014 - December 15, 2015, the Office received 194 total contacts. The steps followed by the Ombudsman for requests are described in **Appendix II** of this report.

**TABLE 1:** *Ombudsman actions and case status 2014 and 2015*

<b>Ombudsman Action</b>	<b>Contacts April 1, 2014- December 15, 2014</b>	<b>Contacts carried over from 2014</b>	<b>Contacts December 16, 2014-December 15, 2015</b>	<b>Total Contacts As of December 15, 2015</b>
Declined to intervene	4		9	13
Referred for other services and closed	18		51	69
Mediated and closed	15	13	14	42
*Investigated and closed	4	2		6
Closed no further contact		20	31	51
Open, being investigated		1	12	13
Open, being reviewed or mediated	32	6	43	49
Pending request form to review	10		34	34
<b>Total Open</b>		<b>7</b>		<b>96</b>
<b>Total contacts</b>	<b>83</b>		<b>194</b>	<b>277</b>

*\*Investigations are the most serious intervention by the Office. Investigations are opened only after all efforts to resolve the request are exhausted. The purpose of an Ombudsman investigation is to determine the result of specific policy and procedure questions in a case. A thorough investigation takes four to six months and is completed with a written report to the Director of DPHHS.*

The table below outlines the number and type of electronic *Alerts* received directly from CFSD.

**TABLE 2:** *Electronic Alerts from CFSD July 1, 2015-December 15, 2015*

Type of Alert	Number Received	Investigations as Result of Alert
*Child Fatality	5	5
Cross Report to Law Enforcement	282	0
Runaway	6	0
Other critical incident	1	1
Third report to Centralized Intake/ Child Abuse Hotline in 12 months	1,949**	0

\*Criminal investigation of a Child Fatality is conducted before the Ombudsman investigation of Child Fatality.

\*\* From September 30, 2015

The first priority of the Office is to respond to requestor contacts. Reviews begin upon receipt of a Request for Assistance form.

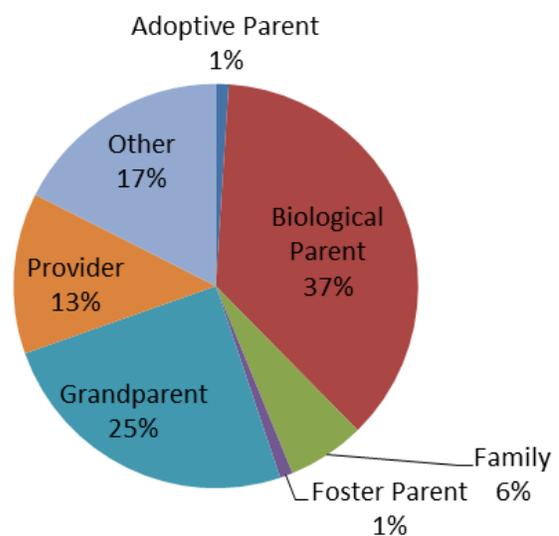
Review of electronic *Alerts* is completed as quickly as resources permit. Since July 1, 2015 the *Alerts* triggered five new investigations and additional case reviews. Three case reviews led to the removal and placement of children who were not safe at the time of the *Alert* to the Office.

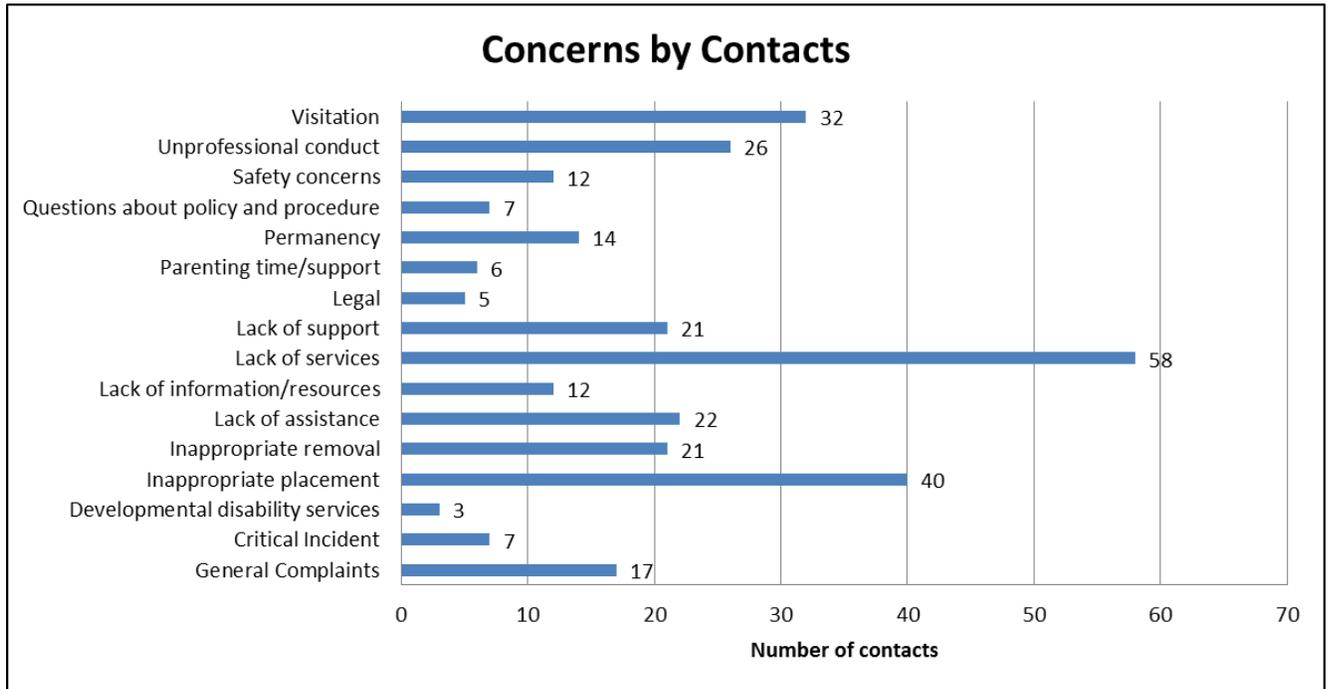
The Office received 1,949 *Alerts* due to “a third report received within the last in 12 months about a child at risk or who is suspected of being abused and neglected.” Review of each *Alert* has increased the length of time it takes for the Ombudsman to respond to requests for assistance. The high number of *Alerts* in this category is also independent evidence that current CFSD staffing resources are insufficient. CFSD field staff lack time to complete documentation in a timely fashion and there is a priority on fieldwork rather than paperwork.

**GRAPH 1:** *Requestor relationship to the child.*

In 2015, individuals related by blood or adoption to the child make up 68% of the contacts in GRAPH 1. The “Other” category increased due to electronic *Alerts* from DPHHS.

## Contacts by Relationship to Child



**GRAPH 2:** *Type of Concerns by Contacts.*

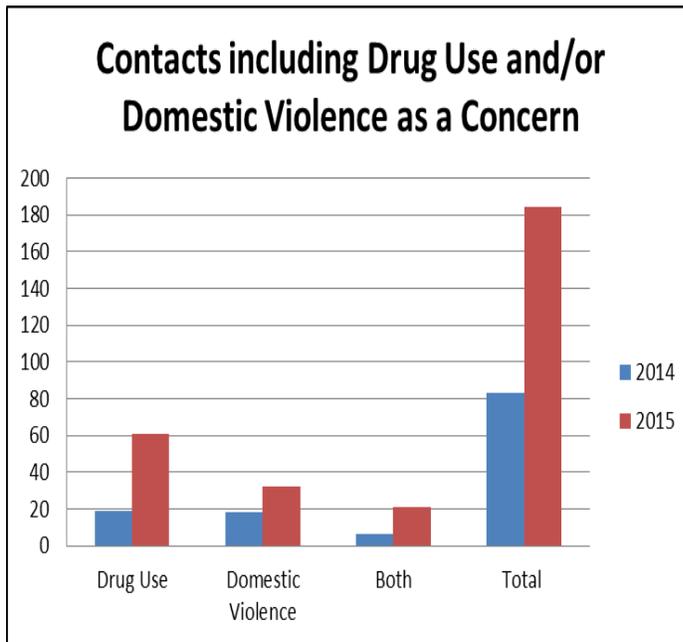
In 2014, *lack of services* and *lack of assistance* were combined. In 2015, separate data was collected as follows:

- *Lack of services:* CFSD was involved with the family in some way and the concerns include a lack of follow-through on services for parents, delayed treatment plans, delayed services for children, or delayed placement licensing process. The three most frequent identified gaps are:
  - Holding Family Engagement Meetings (FEM);
  - Setting up services recommended following evaluations;
  - Meeting with CFSD staff as scheduled.
- *Lack of assistance:* CFSD did not have enough information to investigate, closed an investigation without intervention, or completed an investigation without reviewing information the contact thought was necessary.
- *Lack of support:* CFSD services were in place, but the follow-up to either the parent or the child was inadequate and requestors did not feel involved in the case.

In 2015, the three most common concerns shared by contacts to the Office were:

- *Lack of services* - number of contacts with this concern remained the same.
- *Inappropriate placement* – concerns increased from 13% in 2014 to 21% in 2015.
- *Visitation issues* – increased from 7% in 2014 to 16% in 2015.

**GRAPH 3:** *Contacts Reporting Drug and Alcohol Use and/or Domestic Violence.*



Of the 184 contacts in 2015:

- 61 involved drug use – an increase from 22% to 33%
- 31 domestic violence – a decrease from 22% to 17%
- 21 both domestic violence and drug use- an increase from 7% to 11%

**GRAPH 4:** *Contacts by Geographic Region.*

**Region I** –8% of the contacts originated from the counties of Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Phillips, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Treasure, Valley, and Wibaux.

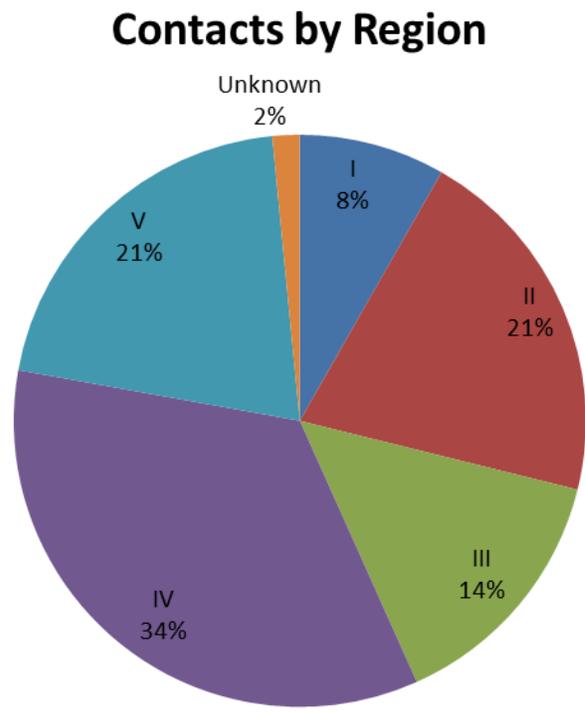
**Region II** – 21% of the contacts originated from the counties of Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole.

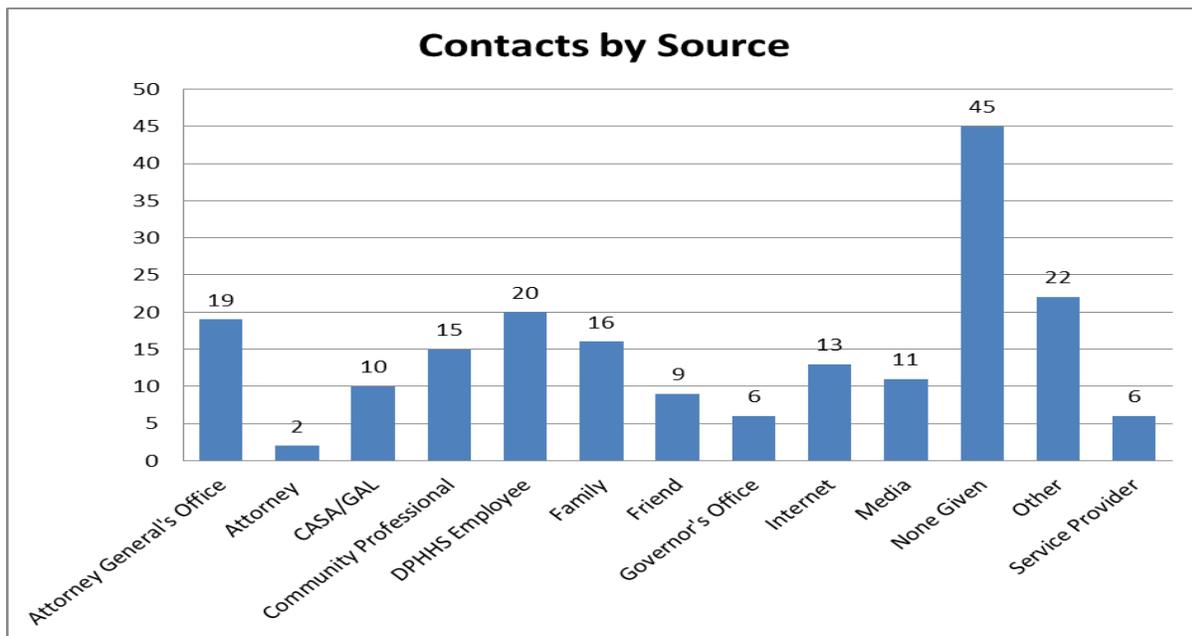
**Region III** – 14% of the contacts originated from the counties of Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Stillwater, Wheatland, and Yellowstone.

**Region IV** – 34% of the contacts originated from the counties of Beaverhead, Broadwater, Deer Lodge, Gallatin, Granite, Jefferson, Lewis & Clark, Madison, Meagher, Park, Powell, Silver Bow, Sweet Grass.

**Region V** – 21% of the contacts originated from the counties of Flathead, Lake, Lincoln, Mineral, Missoula, Ravalli, and Sanders.

**Unknown** – 2% of the contacts did not identify their geographic location.



**GRAPH 5:** *Contacts by referral source.*

- 'None Given' – Request for Assistance form pending; single contact with minimal information.
- 'Other' - includes Legislators; relationship not identified.

## **2015 Summary**

### **2014 Trends Update**

In 2014, the Office notified DPHHS about trends in types of requests and concerns. The following section discusses the initial trends and updates from information received during 2015.

**2014 Trend #1: Grandparents are the second largest source of contacts and consistently express concerns that their rights or their grandchildren's rights are being violated.**

**2015 Update #1: Grandparents continue to voice confusion and concern as the second most frequent contact to the Office.**

Grandparents' legal rights under Montana law are confusing.

Montana law allows grandparents to request a court to grant the right to visit grandchildren; it does not state that grandparents have visitation rights automatically. More can be done to include grandparents at all steps of the process and to explain options for accessing legal assistance at the onset of cases. Discussions with DPHHS are ongoing.

**2014 Trend #2: Parent/child visitation during out-of-home placements is inconsistent.**

**2015 Update #2: Contacts to the Office regarding visitation concerns grew by 9%.**

*"I now understand why they are involved and I can even support it!"*

*-Parent*

Visitation policies are limited and resources stretched. More can be done to facilitate visitation more consistently and in accordance with best practices.

**2014 Trend #3: Obtaining legal representation for parents and children was difficult due to the lack of financial resources, overworked public defenders, lack of communication between CFSD and attorneys, lack of representation of the children in care, conflicting Guardian ad Litem statutes, and untrained volunteers serving as Guardians ad Litem.**

**2015 Update #3: Concerns about legal representation continue at the same level of urgency.**

This concern is shared by CFSD and the court system. Prehearing conferences, special treatment courts, and pilot projects to resolve safety concerns before court involvement are underway.

### **2015 Trends**

In 2015, the data identified three new trends. These trends will be monitored over the next year. The Office notified DPHHS of the following concerns:

**2015 Trend #1: MCA 41-3-209 reporting requirements indicate insufficient resources to meet policy requirements.**

By September 1, 2015 it was clear that the *Alerts* of “a third report received within the last 12 months about a child at risk or who is suspected of being abused and neglected” were significant.

### **2015 Trend #2: Family Engagement Meetings**

Family Engagement Meetings (FEM) are designed to provide an environment appropriate to discuss concerns and strengths for each family to create an individualized effort to protect and care for children at risk or in out-of-home placement. In 2015, FEMs improved communication, increased visitation, increased family placement options, enhanced identification of safety issues, and resulted in more positive case outcomes. Currently, just seven funded FEM facilitators cover the state, which creates a challenge for CFSD to comply with FEM policy and best practice recommendations.

**2015 Trend #3: Inconsistent CFSD field office use of the following tools:**

- **In-home safety plans;**
- **Out-of-home safety plans;**
- **In-home/reunification services;**
- **Voluntary protection services agreements.**

CFSD policy and procedure allow use of the four tools listed above to reduce safety risks and prevent removal of children from parents or guardians as well as to plan reunification. In reviewing cases, the Office identified that each of these safety and planning tools are used in different ways. Standardization through policy and training would be helpful to families and to CFSD workers.

## **2015 Recommendations to DPHHS**

In 2015, the Office made both policy and procedure recommendations through completed investigations to the Department. CPS stands for Child Protection Specialist and CPSS stands for Child Protection Specialist Supervisor.

1. Policy Recommendations. The Ombudsman recommended that CFSD review and enhance training or directives on the following policies or procedures:
  - a. CFSD review policies and procedures related to investigations and opening a case. Clarify expectations for communication between CPSs and CPSSs who may be involved in investigating the same family. Set expectations for staffing cases with supervisors and making sure appropriate follow-up occurs.
  - b. CFSD review policies and procedures on in-home/ reunification services and train CPSs when they are appropriate to implement, how to take responsibility for monitoring services, and how to continuously evaluate services as stated in policy.
  - c. CFSD review policies and procedures on in-home safety plans and train CPSs when they are appropriate to implement, how to take responsibility for monitoring plans, and how to continuously evaluate plans.
  - d. CFSD review training to ensure it includes Child Protection Service Alerts and use of law enforcement when families abscond during an investigation.
  - e. CFSD create policy on Voluntary Protective Services Agreements to assist CPSs in implementing voluntary services and assessing the success of voluntary services. Include objective measurements of success where possible. Distinguish the difference between in-home/reunification services, in-home safety plans, and voluntary protective service agreements.
  - f. CFSD create policy on medically vulnerable children to assist CPSs in assessing the needs of those children in relation to present and impending dangers. Include collection of documentation specific to the diagnosis, treatment, and prognosis of any medical conditions.
  - g. CFSD review policies and procedures related to adoption and the process of securing adoption. Update policy and procedures to reflect how to address when it is appropriate to put an adoption on hold.
  - h. CFSD review policies and procedures on monthly face to face contact and documentation of contact with children in care.
  - i. CFSD continue to utilize Family Group Decision Making meetings for issues related to visitation. Refer back to meeting notes upon requests for changes to visitation.
  - j. CFSD create policy to assist CPSs in assessing individuals requesting visitation with children in foster care. Create expectations that allow for consideration of the needs of the children and the foster family whether kin or not.
  
2. Non-policy recommendations.
 

Where sufficient evidence existed, the Ombudsman also made recommendations for addressing case specific concerns, including:

  - a. Discontinue hold on adoption process.

***“The United States Ombudsman Association was founded in 1977 to foster the establishment and professional development of public sector ombudsman offices in the United States and the World.”***

***-United States Ombudsman Association***

- b. Reconsider classification of Centralized Intake call based on new information.
- c. Return children home.
- d. Change visitation to outside agency and offer alternative environments for supervision.

DPHHS responded positively to recommendations received and plans to work collaboratively with the Office in addressing concerns.

### **2015 Research and Outreach**

Montana law requires the Ombudsman to understand and recommend evidence-based practices to the Department. 2015 topics include:

- Trauma informed practices in child welfare;
- Parenting assessments and programs;
- Rights of developmentally disabled parents.

The Request for Assistance form, annual reports, and general information about the Office is available online at <https://dojmt.gov/enforcement/childrenjustice/>.

Outreach efforts by the Office are required by statute and included:

- Printing and distributing brochures to the 15 local Court Appointed Special Advocate (CASA) offices;
- “Meet the Ombudsman” presentations for CASA staff and volunteers in Anaconda, Billings, Bozeman, Livingston, Helena, Kalispell, and Miles City;
- Ongoing brochure mailings to service providers;
- Information packets to 43 mental health centers statewide;
- Panel participation to Governor Bullock’s Protect Montana Kids Commission.

### **2015 Staff and Support**

In January 2015, the Office received a full time AmeriCorps VISTA Volunteer. Another VISTA is approved and begins in January 2016.

The 2015 Legislature approved funds for an Assistant Ombudsman position. This improves the Office resources and timeliness of response to contacts and requests.

## **2015 Challenges and Successes**

In 2014, the Office identified two significant challenges and three major successes. The following section describes updates on the challenges from 2014 and outlines the challenges and successes from 2015.

### **2014 Challenges**

#### **2014 Challenge #1: Timely Response to the Public**

**2015 Update #1:** In 2014, the Office received two to four contacts per week. In 2015, contacts to the office rose to a consistent four per week. In July 2015, implementation of the CFSD *Alerts* increased the demand on the Office. Timely response to citizens is an important goal of the Office. The Assistant Ombudsman position and new case management system will improve response time to citizens.

#### **2014 Challenge #2: Immunity for the Ombudsman**

**2015 Update #2:** The 2015 statute MCA 41-3-1213 provided privilege for the Ombudsman, which improves the Ombudsman's ability to maintain confidentiality, but also to maintain impartiality and independence in addressing concerns.

### **2015 Challenges**

#### **2015 Challenge #1: Timely Response to the Public**

Responding to citizens contacts remains the priority of the Office. The Ombudsman continues to assess and streamline processes and procedures for efficiency. In 2015, initiation of a new case management system will improve efficiency.

#### **2015 Challenge #2: Expectations of the Office**

In the two years since the Office opened to the public, a number of misperceptions, even myths, have developed about the role of the Office. Citizen contacts to the Office involving the safety and well-being of children and families are the first priority; however, the Office is not an emergency first responder in Montana's child protection system.

The Office gives '*Meet the Ombudsman*' presentations frequently. In addition, brochures, rack cards, and posters have been widely distributed in an effort to provide uniform and accurate information statewide.

In 2015, the Office initiated program evaluation by surveying contacts to the Office. In addition, the Office is working with DOJ on a new case management system to increase data collection, which will provide direction for continued program development.

### **2015 Successes**

#### **2015 Success #1: Communications with CFSD**

Communications between the Office and CFSD were streamlined in 2015, improving responses to Ombudsman inquiries. The new reporting requirement, the *Alert* system, was in place on time and continues in a transparent fashion. Regular meetings ensure that citizen concerns are addressed as quickly as possible. Communication with CFSD through the Office made a measurable difference in the lives of Montana's children.

#### **2015 Success #2: Citizen Feedback**

The Office's first priority is responding to citizens. A survey for collecting and addressing stakeholder feedback started in December 2015 and will be used regularly throughout 2016. Continued effective

development of the Office will be based on information and suggestions from citizens and stakeholders. Plans are in place for ongoing program evaluation of the Office.

### **2015 Success #3: Permanent Presence**

The 2015 Legislature made the Office of the Child and Family Ombudsman permanent. Citizens may count on the continued presence and availability of the Office to respond to requests. Policies and procedures can be finalized and posted online for public information in 2016. The Office will continue program development to support the Office duties of **advocacy, education, outreach, and investigation.**



## **Appendix I: Current Montana Statute**

**41-3-1208.** Office of child and family ombudsman established. (1) There is an office of the child and family ombudsman within the department of justice provided for in 2-15-2001. (2) The attorney general shall appoint a person who is a resident of this state and is qualified by training and experience to perform the duties of the ombudsman.

**41-3-1209. Purpose and intent.** The legislature finds that an independent, impartial, and confidential ombudsman serves:

- (1) to protect the interests and rights of Montana's children and families; and
- (2) to strengthen child and family services by working in collaboration with the department and with appropriate county attorneys in cases under review.

**41-3-1210. Definitions.** For the purposes of this part, the following definitions apply:

- (1) "Administrative act" means a department action, omission, decision, rule, interpretation, recommendation, policy, practice, or procedure relating to child and family services.
- (2) "Child and family services" means services provided by the department under this chapter.
- (3) "Ombudsman" means the person holding the position of the child and family ombudsman.
- (4) "Request for assistance" means a request by a person asking the ombudsman for assistance in protecting the rights or interests of a child or family in this state.

**41-3-1211. Powers and duties.** The powers and duties of the ombudsman are:

- (1) to respond to requests for assistance regarding administrative acts and to investigate administrative acts;
- (2) to investigate circumstances surrounding reports that are provided to the ombudsman pursuant to [41-3-209](#);
- (3) to inspect, copy, or subpoena records as needed to perform the ombudsman's duties under this part;
- (4) to take appropriate steps to ensure that persons are made aware of the purpose, services, and procedures of the ombudsman and how to contact the ombudsman;
- (5) to share relevant findings related to an investigation, subject to disclosure restrictions and confidentiality requirements, with individuals or entities legally authorized to receive, inspect, or investigate reports of child abuse or neglect;
- (6) to periodically review department procedures and promote best practices and effective programs by working collaboratively with the department to improve procedures, practices, and programs;
- (7) to undertake, participate in, and cooperate with persons and the department in activities, including but not limited to conferences, inquiries, panels, meetings, or studies, that serve to improve the manner in which the department functions;
- (8) to provide education on the legal rights of children;
- (9) to apply for and accept grants, gifts, contributions, and bequests of funds for the purpose of carrying out the ombudsman's responsibilities; and
- (10) to report annually to the attorney general and the children, families, health, and human services interim committee. The report must be public and may contain recommendations from the ombudsman regarding systematic improvements for the department.

**41-3-209. Reports to office of child and family ombudsman.** The department shall report to the office of the child and family ombudsman:

- (1) within 1 business day, a death of a child who, within the last 12 months:
  - (a) had been the subject of a report of abuse or neglect;
  - (b) had been the subject of an investigation of alleged abuse or neglect;

- (c) was in out-of-home care at the time of the child's death; or
- (d) had received services from the department under a voluntary protective services agreement;
- (2) within 5 business days:
  - (a) any criminal act concerning the abuse or neglect of a child;
  - (b) any critical incident, including but not limited to elopement, a suicide attempt, rape, nonroutine hospitalizations, and neglect or abuse by a substitute care provider, involving a child who is receiving services from the department pursuant to this chapter; or
  - (c) a third report received within the last 12 months about a child at risk of or who is suspected of being abused or neglected.

**41-3-1212. Investigations -- discretion -- procedure.** (1) The ombudsman shall investigate a request for assistance unless:

- (a) the request for assistance could reasonably be addressed by another remedy or channel;
  - (b) the request for assistance is trivial, frivolous, vexatious, or not made in good faith;
  - (c) the request for assistance is too delayed to justify an investigation;
  - (d) the person requesting assistance is not personally aggrieved by the subject matter of the request; or
  - (e) the request for assistance has been previously investigated by the ombudsman.
- (2) (a) After an investigation is completed, the ombudsman shall provide to the department any findings, conclusions, and recommendations.
- (b) At the ombudsman's request, the department shall inform the ombudsman in a timely manner about any action taken to address or any reasons for not addressing the ombudsman's findings, conclusions, and recommendations.

**41-3-1213. Privilege.** The ombudsman may not be compelled to testify or produce evidence in any judicial or administrative proceeding with respect to any matter involving the exercise of the ombudsman's official duties, except as necessary to enforce the provisions of this part.

## **Appendix II**

### **Responding to Requests and Contacts:**

When the Ombudsman receives a request for assistance, the Ombudsman reviews and organizes each request according to the following categories:

- Decline to intervene – The request will be declined if it can be addressed by another remedy; is trivial, frivolous, or not made in good faith; is too delayed to justify an investigation; the requestor is not personally aggrieved by the subject matter of the request; or the request was previously investigated by the Ombudsman. (MCA 41-2-1313)
- Referral to other services - The Ombudsman will be able to assist by finding the right person or service to address the request. The Ombudsman will provide the requestor information on whom to contact. The Ombudsman may follow-up with the individual.
- Informal Mediation/Conflict Resolution - The Ombudsman, after following up with the referral source and the individual, may offer to mediate the concern with the parties involved. Resolving conflicts may involve phone calls to clarify needs, meetings to address concerns, and assistance with resource identification. Where a conflict can be resolved to improve communication and improve the outcome for the child or children involved, the Ombudsman will engage the Department.
  - 1) Investigation and Report -In other cases, a request will come to the Ombudsman with serious and complex concerns and significant attempts to resolve the issue. The Ombudsman will open an investigation if the following criteria are met: The intake process identifies an action or omission by DPHHS;

- 2) The action or omission involves a child served by DPHHS or a child with safety, permanency, or well-being needs;
- 3) The action or omission places a child, parent, or other caregiver at risk of harm or is a violation of law, policy, or procedure with respect to a child or family receiving or in need of services from department DPHHS
- 4) The individual requesting assistance has also sought help through DPHHS employees or procedures.

An investigation may include collection of all case documentation, interviews of involved parties, and attendance at meetings and court hearings about the case. An investigation may include a meeting of the parties involved. All investigations will conclude with a written report delivered to the Director of DPHHS and include recommendations for future action. In the updated statute, DPHHS shall inform the Ombudsman in a timely manner about any actions taken or not taken to address the report findings and recommendations. (MCA 41-3-1212)

The Ombudsman also reviews each request and will classify it as Emergent or Non-Emergent.

- **Emergent** – when the Ombudsman determines the information provided suggests that *an action or omission by DPHHS has placed a child or parent in imminent substantial risk of harm*. An Emergent response will commence upon receipt of the information or within 24 hours. Emergent responses may include calling 911 and a report to the statewide Child Abuse Hotline, which is administered by DPHHS. It may also include a direct call to the CFSD Administrator.
- **Non-Emergent** - Non-Emergent investigations will be processed by the Ombudsman based on the information provided and as required for a timely response.

## **Appendix III**

### **Glossary of Acronyms**

<b>AG</b>	Attorney General	<b>MGM</b>	Maternal Grandmother
<b>BCBA</b>	Board Certified Behavioral Analyst	<b>MGF</b>	Maternal Grandfather
<b>BMR/BFR</b>	Biological Mother/ Biological Father	<b>MPA</b>	Masters of Public Administration
<b>CASA</b>	Court Appointed Special Advocate	<b>PGM</b>	Paternal Grandmother
<b>CFSD</b>	Child and Family Services Division	<b>PGF</b>	Paternal Grandfather
<b>CJB</b>	Children’s Justice Bureau	<b>RA</b>	Regional Administrator for Child and Family Services
<b>CPS</b>	Child Protection Specialist	<b>USOA</b>	United States Ombudsman Association
<b>CPSS</b>	Child Protection Specialist Supervisor		
<b>DCI</b>	Division of Criminal Investigation		
<b>DOJ</b>	Department of Justice		
<b>DPHHS</b>	Department of Public Health and Human Services		
<b>DV</b>	Domestic Violence		
<b>FEM</b>	Family Engagement Meeting		
<b>FP</b>	Foster Parent		
<b>GAL</b>	Guardian ad Litem		
<b>LCSW</b>	Licensed Clinical Social Worker		
<b>MCAN</b>	Montana Child Abuse Neglect Training		