Montana Department of Justice
Office of the Child and Family Ombudsman
2022 Annual Report

Contact the Ombudsman:

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Contents

Executive Summary

Welcome to the 2022 annual report of the Montana Department of Justice Office of the Child and Family Ombudsman (OCFO). This annual report is required by Montana Code 41-3-1211 and is a summary of activities for January 1 through December 31, 2022.

OCFO's work is conducted through two primary activities: First, it responds to citizen questions and concerns about Montana's child protection system by reviewing individual cases. Second, it collects and analyzes a tremendous amount of data. Both the citizens' questions and the data identify systemic issues in Montana's child welfare system, including internal Child and Family Services Division (CFSD) practices, legal and judicial system challenges, and the role of community service providers. OCFO strives for effective and positive outcomes as it continues its commitment to strengthening the child protection system for those who work in it and for those who seek its assistance.

Highlights for 2022:

- OCFO was accessible and responsive to citizens with a total of 350 contacts and 146 Requests for Assistance.
- The Department of Justice (DOJ) Missing Persons Specialist, OCFO and Department of Public Health and Human Services (DPHHS) CFSD continue to analyze and track reports of youth missing from out of home placements to reduce risk of harm and shorten the time until they are located.
- OCFO submitted 12 *Findings Reports* to the Director of DPHHS.
- As directed by the 2021 Legislature OCFO published *The First Knock on the Door: A Systemic Report*
- Outreach and education about OCFO continued with three *Meet the Ombudsman* sessions with CFSD staff.

Recommendations to DPHHS (pg. 18):

The casework and child fatality reviews in 2022 yielded two recommendations. Rationales are included later in this report.

1. The CFSD case management system and online databases should be updated and the information contained in the three separate electronic records should be consolidated.

2. DPHHS CFSD to provide notification to OCFO regarding critical incidents of neglect or abuse by a substitute caregiver pursuant to MCA 41-3-209.

Mission

The Office of the Child and Family Ombudsman responds to citizen requests to protect the rights of children and families by improving case outcomes and strengthening Montana's child welfare system.

To support its mission, OCFO follows four principles consistent with the standards of the United States Ombudsman Association.

Principles

1. OCFO is independent of the Montana Department of Public Health and Human Services (DPHHS), meaning it is separate and free from influence of the individuals whose actions OCFO reviews. It is part of the Montana Department of Justice's Division of Criminal Investigation and managed by the Special Services Bureau (SSB).

2. OCFO is impartial. OCFO treats citizens equitably and works collaboratively with all parties to improve services for the children of Montana. It may advocate certain recommendations, which benefit the individual who requested assistance; however, advocacy is always directed at improving services offered by DPHHS and should not be construed as supporting one individual over another.

3. OCFO is confidential. It adheres to Montana law.

4. OCFO provides a credible review process to each citizen contacting the Ombudsmen. OCFO keeps each requestor apprised of each step of the process and takes actions that improve transparency of the child welfare system.

To request assistance, contact our office in one of the following ways:

Telephone: 1-844-25CHILD (1-844-252-4453)

Fax: 406-444-2759

Email: DOJOMBUDSMAN@mt.gov

Office of Child and Family Ombudsman staff:

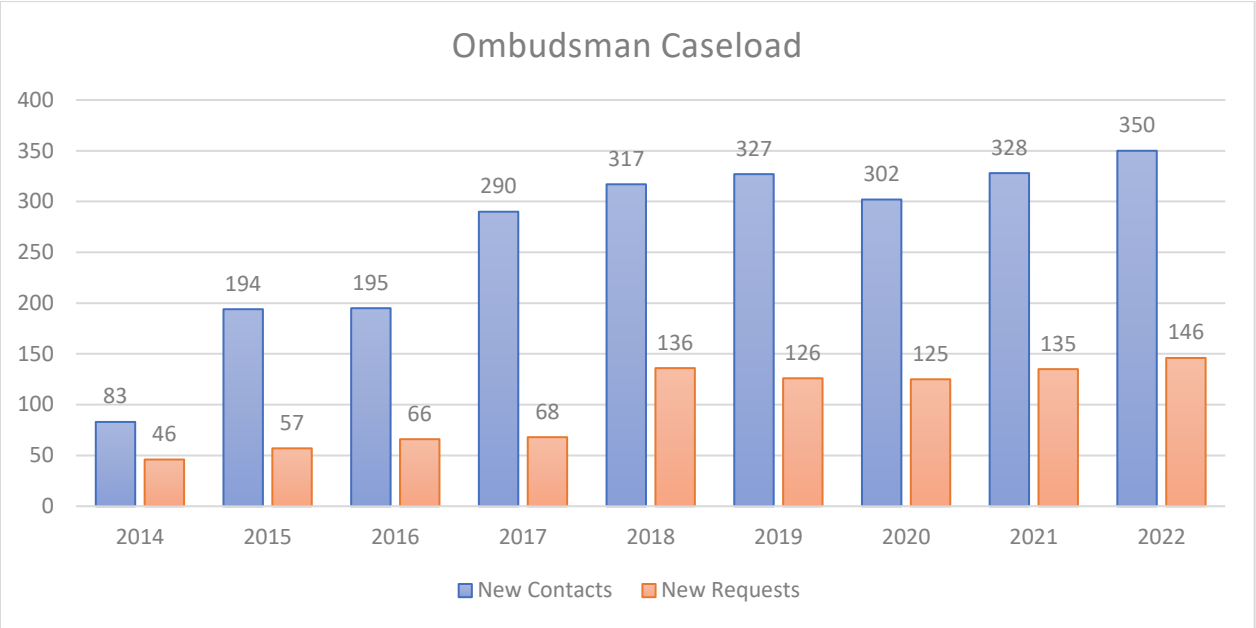
Dana Toole, LCSW – Special Services Bureau Chief
Gala Goodwin, ACSW, LCSW – Child and Family Ombudsman (grant funded FTE that ended July 1, 2022)
Marci Buckles, BSW – Child and Family Ombudsman
Kaci Gaub-Bruno, MA – Residential Investigator/Child and Family Ombudsman
Shannon Tanner – AmeriCorps Member, Justice for Montanans

Duty: Respond to Citizens' Requests

When a citizen calls, emails, or writes OCFO, they begin the Intake process as a *Contact*. If the Contact submits a Request for Assistance (RFA) form, they are then called a *Requestor*. OCFO reaches out to Contacts at least three times to assist in completing the RFA form. The number of Contacts and Requests are collected each year. At the end of each year, open Contacts and open Requests carry over to the next year.

Graph 1: Caseload per year

There were 350 total contacts of which 41.7%, or 146 contacts, returned a RFA form to open a case review.



2022 Contact Data

The Child and Family Services Division's statewide structure is based on six regions, each with a Regional Administrator. The number of counties and offices in each region varies. Each region has a main office and field offices, the regional map is attached in Appendix I.

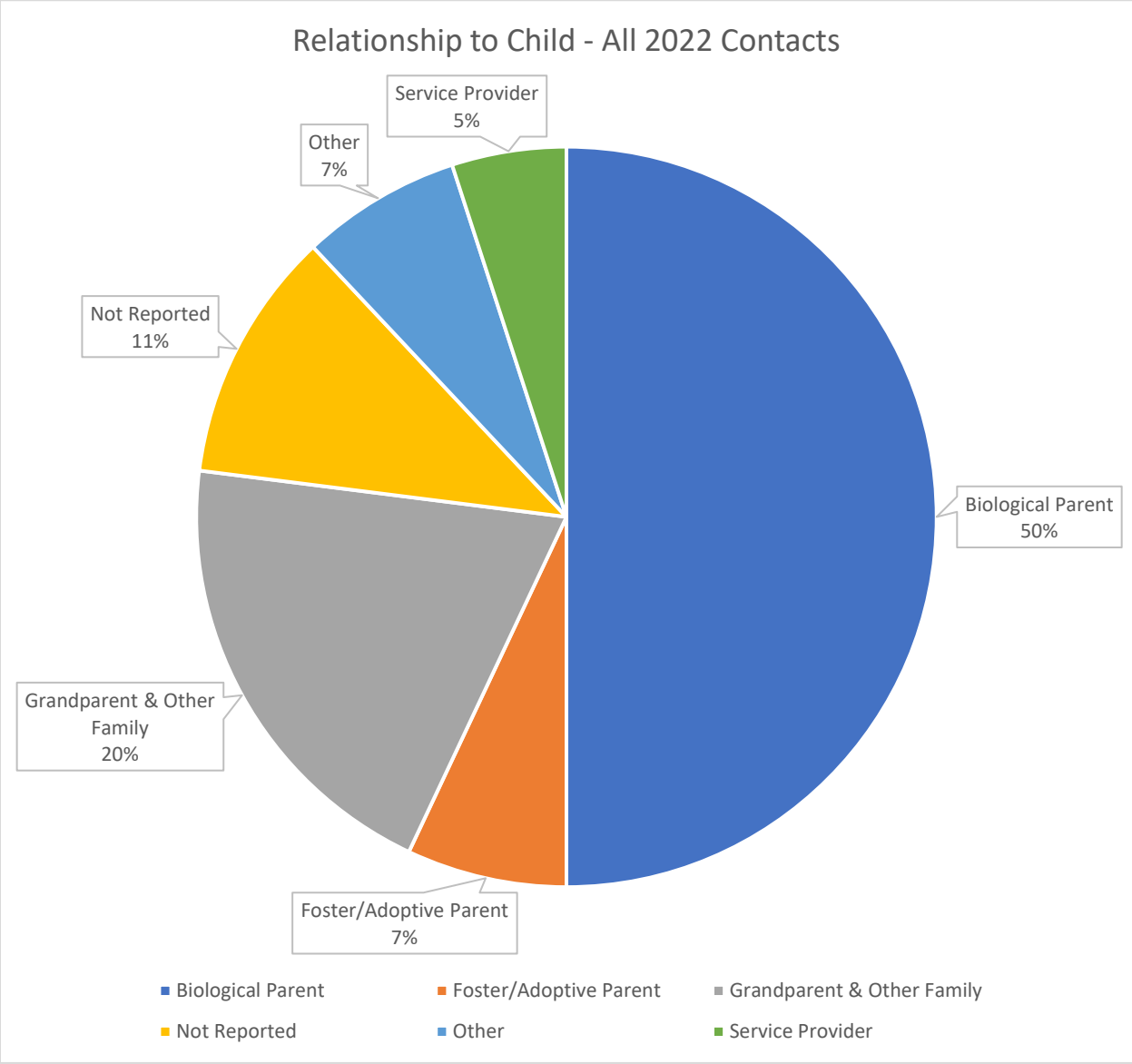
Table 1: Percentage of Contacts by Region for 2022

Region I	8%
Region II	7%
Region III	21%
Region IV	23%
Region V	9%
Region VI	11%
Tribal	<1%
Unknown/Not Provided	21%

Graph 2: Contacts by Relationship to the Child

OCFO tracks the relationship between the Contact and the child, or children, identified in the concern about CFSD action.

Biological Parents were the largest category of contacts to OCFO at 50% followed by Grandparents and Other Family at 20%.



Contacts often report more than one concern. OCFO identifies and documents up to three main concerns per contact and works with citizens to address each concern or question in the most effective manner.

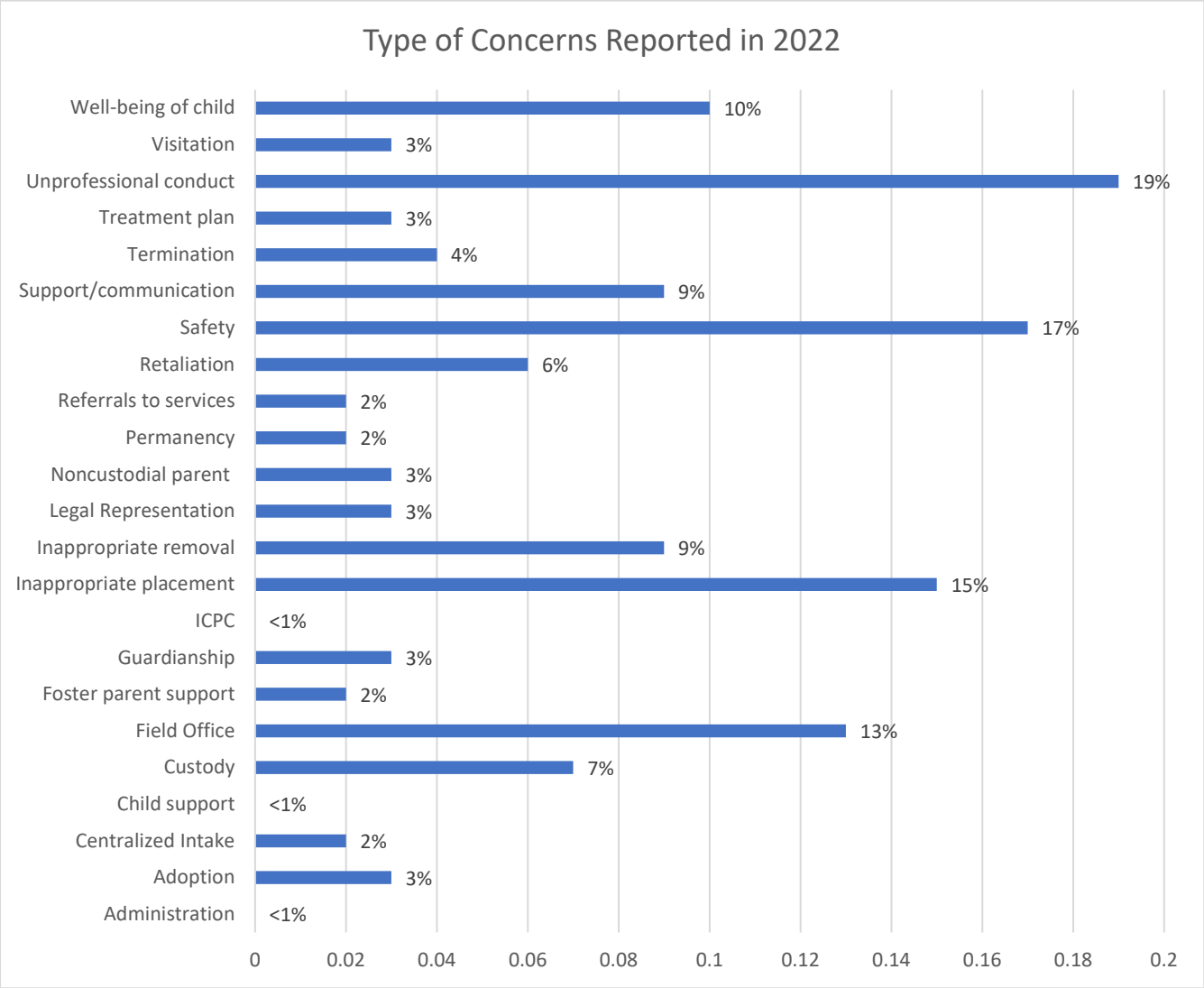
The most prevalent citizen concerns in 2022 about children and families were:

Unprofessional conduct: This indicates the citizen's belief that the Child Protection Specialists (CPS), Child Protection Specialist Supervisors (CPSS), Regional Administrators (RA) or other staff persons' behavior in interactions was disrespectful, unreasonable, unhelpful, or unethical. Last year, 19% of citizens identified this as a concern. When OCFO was able to verify this allegation, it was reported to the appropriate supervisor.

Child Safety: This included concerns that reports to CFSD were not being fully investigated or safety plans were not sufficient. Seventeen percent (17%) of citizen contacts identified a safety concern for one or more children. This category also includes concerns that range from reports to CFSD not being fully investigated to safety plans that were not sufficient.

Inappropriate placement: Fifteen percent (15%) of contacts identified a concern about a child being placed in an environment that the contact believed was inappropriate.

Graph 3: Type of Concerns Reported by Contacts to OCFO



Duty: Investigate Findings

2022 Outcomes

OCFO received 350 contacts. Of the contacts within OCFO jurisdiction to investigate, 146 submitted Request for Assistance forms by the close of the year. Per Montana Code, every request must be investigated by OCFO unless it meets one of four statutory reasons per MCA 4-3-1212 to decline. Those reasons include:

- OCFO investigated previously.
- The request is vexatious or not made in good faith.
- The requestor is not personally aggrieved.
- The case is too old to justify an investigation.

It is OCFO's practice to make three attempts to obtain a request form from a contact before closing it as a "no further contact."

Review Process

An OCFO case review is an investigation of all the CFSD actions or omissions for a specific case. Each CFSD case may include records located in three different electronic databases:

- Child and Adult Protective Services or *CAPS*
- Montana Family Safety Information Systems or *MFSIS*
- Document Generator or *Doc Gen*

Additional case specific records may also be maintained in a hard file at the CFSD local office.

The range of intervention provided by OCFO includes referral to services; mediating concerns directly with the requestor and CFSD; addressing concerns directly with legally mandated stakeholders; and in some cases, preparing a Findings Report which is submitted to DPHHS and to the citizen requestor's who fit within MCA 41-3-205's Confidentiality - disclosure exceptions. OCFO conducts an accurate and comprehensive case review for each citizen requestor. The Ombudsmen frequently provide resources to citizens even when the case is not appropriate for OCFO services or must be declined.

Table 2 describes in more detail the outcomes of individual contacts.

Table 2: Status of contacts to OCFO for 2018—2022.

Outcome Measures	2018 Outcomes	2019 Outcomes	2020 Outcomes	2021 Outcomes	2022 Outcomes
Closed, no further contact.	53	64	101	126	128
Declined to intervene.	6	9	5	7	20
No citizen response after review opened	N/A	N/A	N/A	N/A	6
Referred and closed.	81	77	51	55	49
Closed – Concerns fully resolved.	14	15	24	14	16
Closed – Plan established.	10	20	35	45	13
Closed – Questions answered.	18	13	74	83	104
Findings Report to DPHHS Director	15	7	6	12	12
Open from previous year's contacts.	82	73	25	71	38
Pending review at end of year	51	54	43	11	33

OCFO maintained 2.5 employees and an AmeriCorps member .8 FTE to manage intake for half of the year. The 1.0 grant funded FTE ended on July 1, 2022. With 1.5 FTE Ombudsmen dedicated to case reviews a requestor's wait time increased from eight to ten weeks.

Duty: Share Findings

2022 Findings Reports and Recommendations

OCFO submitted twelve *Findings Reports* to DPHHS. *Findings Reports* document case specific violations of law, policy and procedure and are sent to the Director of DPHHS. The reports make recommendations to improve practices.

There were a total of 32 recommendations to DPHHS within the twelve *Findings Reports*. DPHHS agreed with 28 of the recommendations (87.5%) and disagreed with four of the recommendations (12.5%). MCA 41-3-1212 requires DPHHS to respond to all *Findings Reports and Recommendations* within 60 days. DPHHS complied within the required time for all twelve reports.

All *Findings Reports* recommendations made to DPHHS and the written responses, can be found in Appendix IV of this report. The responses which differ from the OCFO recommendation are in orange font.

Child Fatalities

Montana Code Annotated (MCA) 41-3-209 requires the DPHHS CFSD to provide critical incident notifications to OCFO, including child fatalities.
MCA 41-3-209 directs CFSD to notify OCFO:

1) Within one business day: The 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 service agreement.

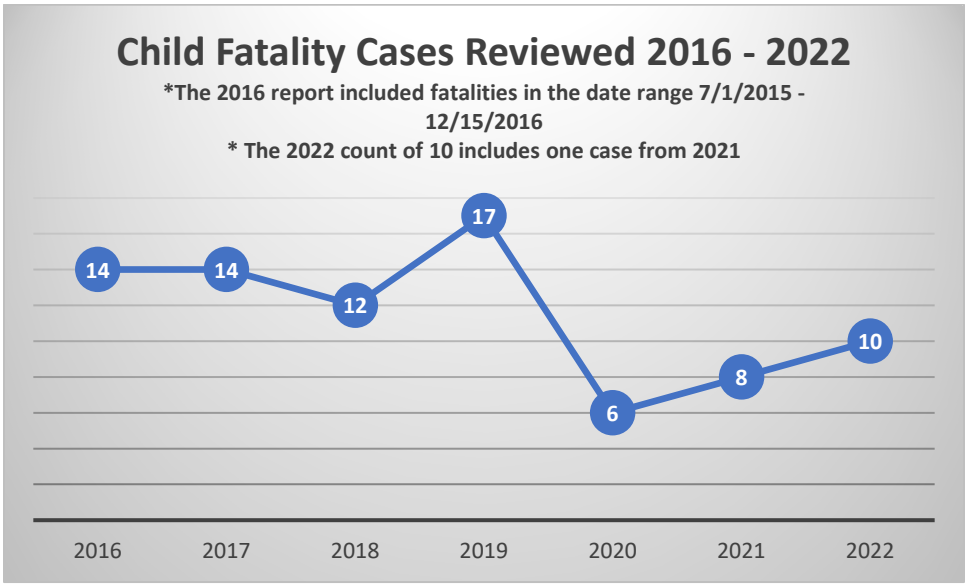
OCFO reviewed ten child fatalities. Seven of the fatalities were reported by CFSD to OCFO. Three fatalities were found by OCFO staff by online newspaper articles, one of which occurred in 2021.

OCFO's Child Fatality Review Process

DPHHS provides notification of a child fatality via email to OCFO. OCFO reviews all reported child fatalities. In every case, OCFO uses CFSD's electronic case management systems and/or requests all CFSD documentation for each child and family member included in the report of the fatality. All documentation available in the case management systems or provided by CFSD is reviewed. OCFO conducts an accurate and comprehensive case review for each child fatality, however OCFO's authority is limited to review only CFSD records and does not include all

medical, law enforcement, criminal history, educational, mental health, medical examiner or coroner findings, or other sources of documentation about the deceased child or his/her family. To provide a comprehensive, neutral review, the child fatality review team includes the Special Services Bureau (SSB) staff from other related programs. Data points from each case were identified and recorded in the review process.
OCFO reviews are initiated separate from a criminal investigation. No actions are taken to interfere with a criminal or judicial process.

The following sections summarize the SSB Child Fatality Review Team's findings.

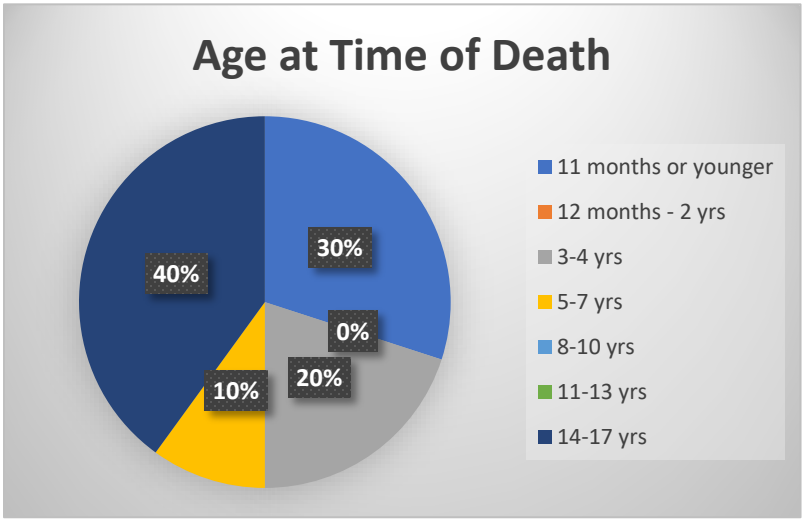


Child fatality cases have been reviewed by OCFO since July 1, 2015. The 2016 OCFO Child Fatality Report reviewed 14 fatalities dated between July 1, 2015, and December 15, 2016, an eighteen-month date range.

Child Fatality Review Findings:

Finding 1: Age at Time of Death

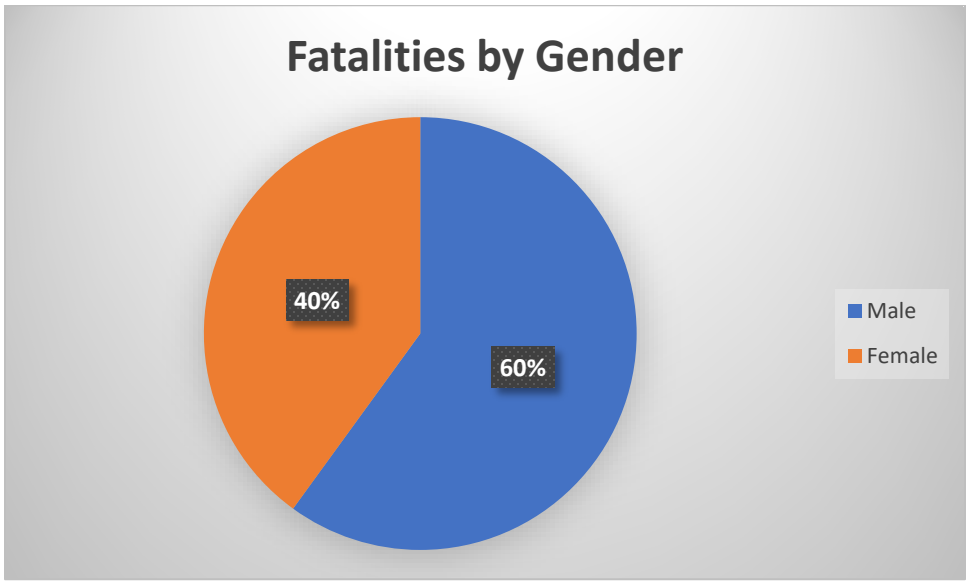
There were more fatalities involving children between the ages of 14 and 17 years than in 2021. The second largest group of fatalities were among children who were 11 months or younger.



Finding 2: Age Under One Year

Half of the children were eleven months or younger on the date of the fatality. Of the 10 fatalities, six cases involved a child 5 years old or younger. The four fatalities that involved youth over the age of 14 were accidental or a crime that did not involve caregiver abuse or neglect.

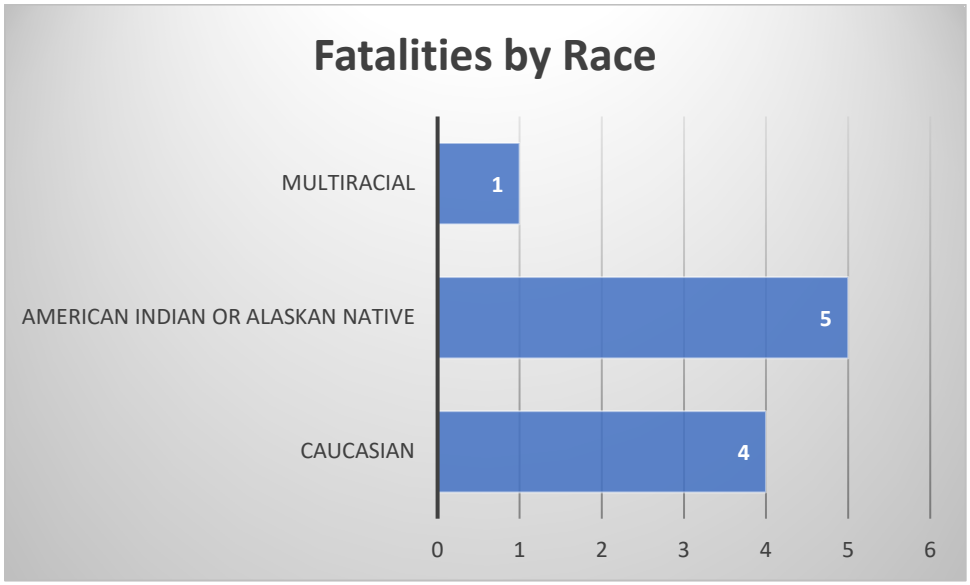
Finding 3: Gender



About two thirds of the fatalities were male children and about one third were female children.

Finding 4: Race

DPHHS CFSD identified the race of each child.

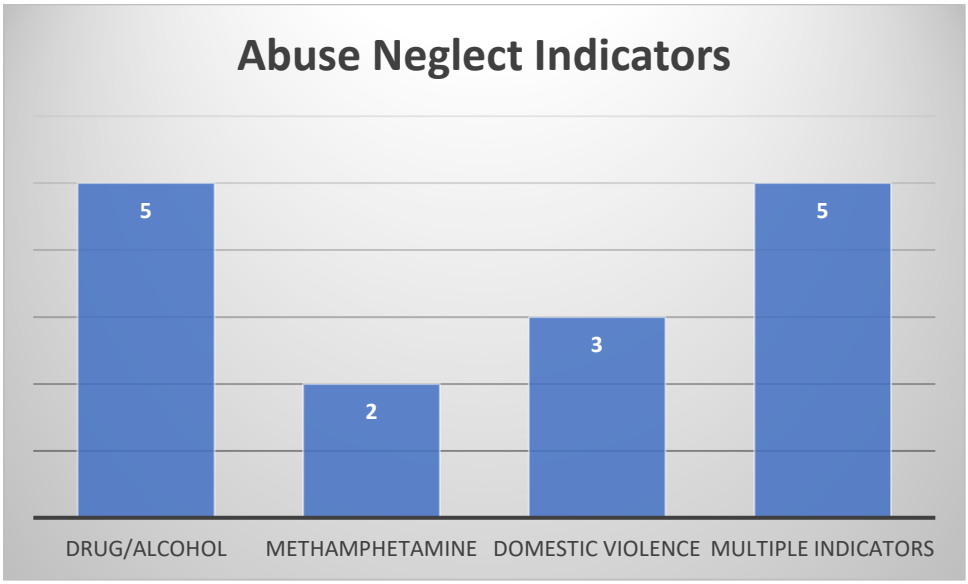


Finding 5: Criminal Charges

For the 2022 fatalities, four cases resulted in criminal charges.

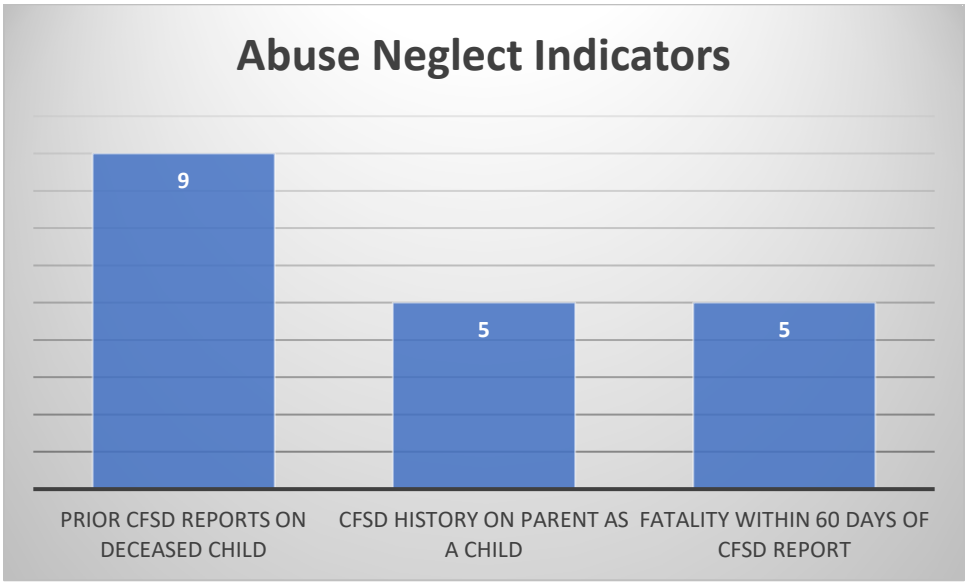
Child fatality case reviews count specific detailed facts related to the child's history and to family dynamics identified in the CFSD records. Family dynamics include behaviors and indicators that are known to increase the risk of child abuse. A case with one or more of these is considered a case with multiple risk indicators such as:

Finding 6: Multiple Risk Factors



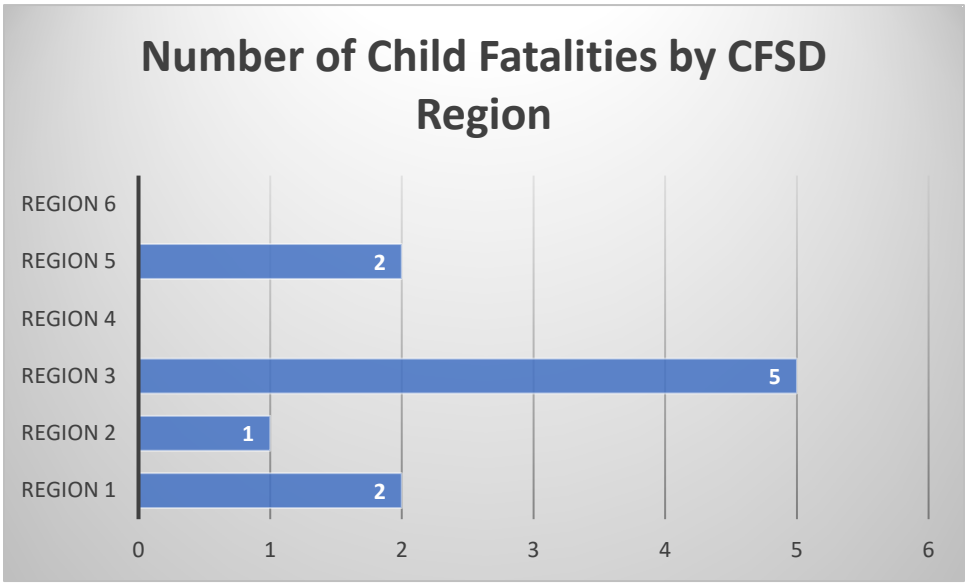
Finding 7: History of reports to CFSD.

There were historical reports alleging abuse or neglect for nine of the ten children.



Finding 8: CFSD Regions

Child fatalities occurred in four of the six CFSD regions.



2022 Notifications Data

Child fatalities are not the only statutorily required notification OCFO receives from DPHHS. MCA 41-3-209 also directs CFSD to notify OCFO:

2) Within five 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;
(c) 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;
(d) a third report received within the last 12 months about a child at risk of or who is suspected of being abused or neglected.

Cross Reports:

Notifications received under 2) (a) or "any criminal act concerning the abuse or neglect of a child" are called *Cross Reports*. A Cross Report occurs when law enforcement makes a report to CFSD Centralized Intake (CI) of suspected child abuse or when a CFSD Centralized Intake Specialist (CIS) reports a possible crime against a child to a local law enforcement agency. OCFO receives an email for each Cross Report statewide. OCFO received 5,092 Cross Reports in 2022, which is more than any prior years.

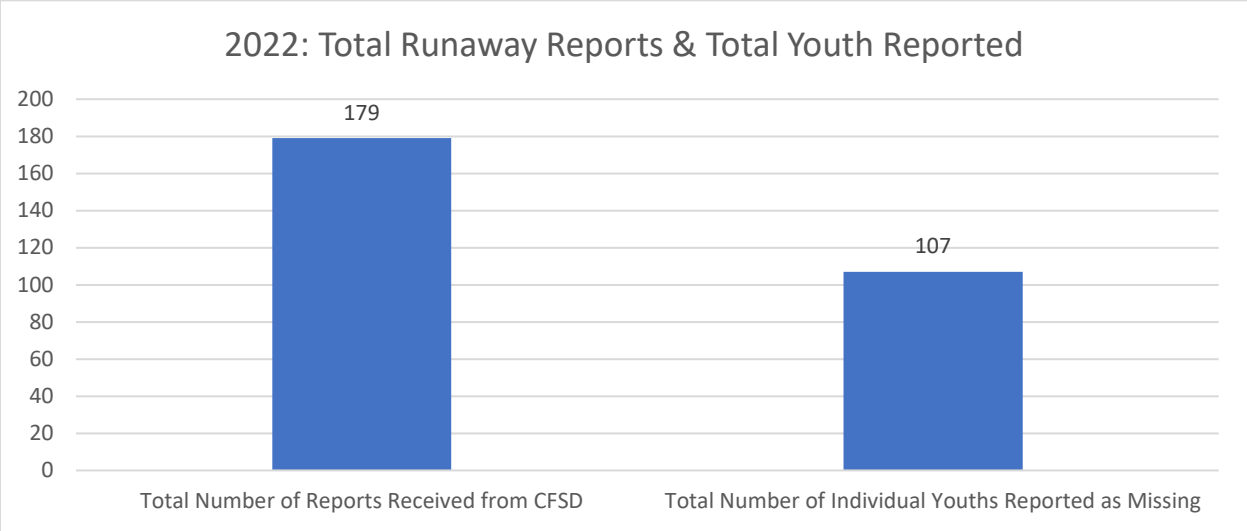
Critical Incidents:

Runaways & Missing Youth: OCFO works closely with DPHHS CFSD and the DOJ Missing Persons Specialist to track any youth who is missing from an out of home placement, or who has been receiving services from CFSD. DOJ hosts a global email for reports of missing youth which assures that law enforcement is notified each time a youth is missing, and CFSD also notifies DOJ when the youth is located.

As outlined in OCFO's 2021 Annual Report, OCFO hosted coordinated meetings with CFSD staff and the DOJ Missing Persons Specialist. The meetings were held monthly via Zoom and the graphs below captures how many reports were sent to OCFO in 2022 and other relevant data.

Last year, OCFO received 179 reports from CFSD about a youth reported as missing. From this recorded data, OCFO found that there were some youths who were repeatedly reported as missing thus the 179 reports represent 107 individual youth. OCFO records each report as a separate event. It is important to understand that there are some youths who are recurrently reported as missing throughout a month and year and that the numbers presented reflect that.

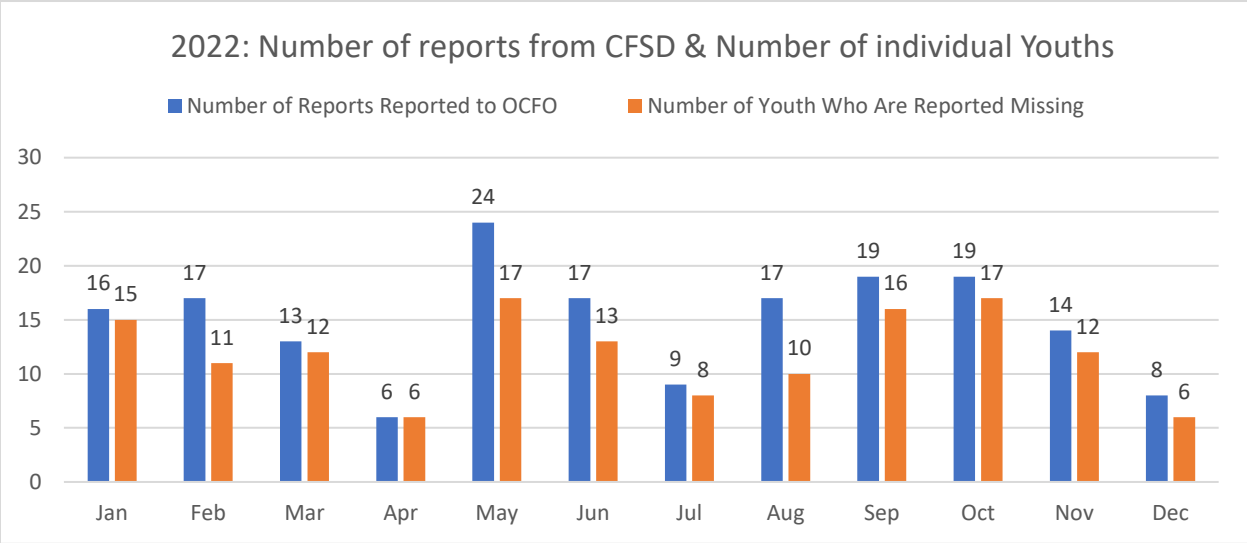
Runaway Youth Graph 1:



From the data collected from 2022, OCFO was also able to conclude that the average age of a youth who is reported missing is 15 years old.

The following graph shows the difference between how many report*s* were received in a month versus how many individuals were reported as missing.

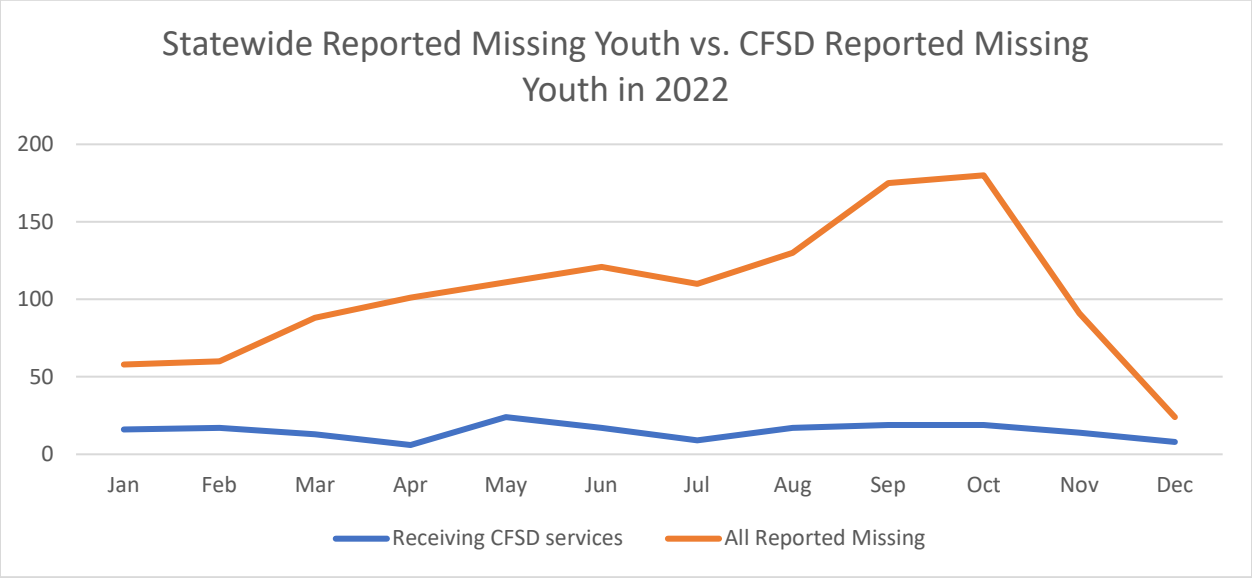
Runaway Youth Graph 2:



In addition to the reported missing youth notifications from CFSD, OCFO receives data from the DOJ Missing Persons Specialist every month. The data shared lists all the reported missing youth in Montana to law enforcement who have been located. Not all the names shared by the DOJ Missing Persons Specialist are youths receiving services from CFSD, but there are some who overlap.

The graph below shows two groups: reported missing youth who are receiving services from CFSD and reported missing youth who are not.

Runaway Youth Graph 3:

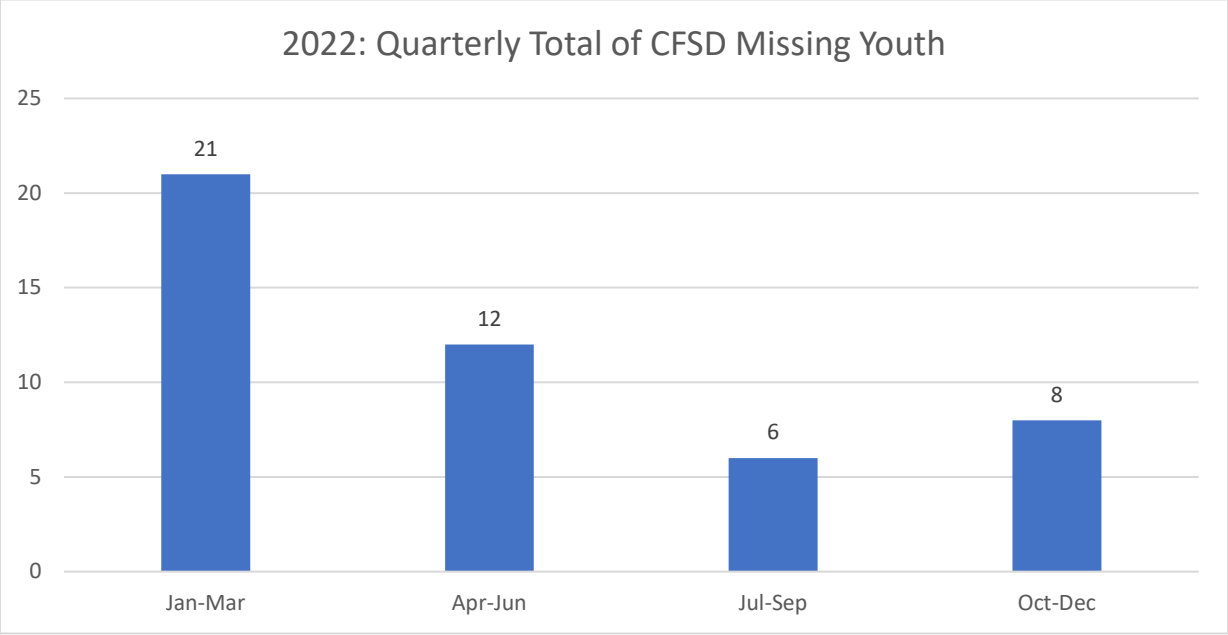


OCFO, in conjunction with the DOJ Missing Persons Clearinghouse, have begun to compare clearinghouse missing youth with those receiving services through CFSD on a monthly basis. This protocol has produced a more accurate number of identified runaways.

Every month, OCFO reviews all the names listed on the DOJ Missing Persons Clearinghouse and filters out which youths are receiving services through CFSD. Once those youths are identified, OCFO creates a list that is then shared at the monthly meetings which allows a collaboration between CFSD, OCFO and DOJ Missing Persons Specialist. The outcomes from this meeting are shared with local law enforcement jurisdictions and county level CFSD offices, thus closing a gap of information that a youth has been located but law enforcement has not notified to remove the name from the Missing Persons Clearinghouse

Through OCFO's facilitation between CFSD and DOJ, the amount of unaccounted reported missing youths who are receiving CFSD services decreased over time in 2022. The graph below shows how many reported missing youths remained missing after a DOJ and CFSD meeting for every quarter of 2022.

Runaway Youth Graph 4:



Other Critical Incidents: Notifications received under 2) (b) are called "Other Critical Incidents" in the table below. This category covers all other notifications received about a child in foster care. These notifications cover any situation that would not normally occur such as non-routine hospitalizations, injuries, suicide attempts or neglect or abuse by substitute caregivers. There were 98 Other Critical Incidents reported. OCFO has not received data from CFSD regarding neglect or abuse by a substitute caregiver.

Alerts: Notifications received under 2) (c) are called "Alerts" by OCFO. OFCO receives an electronic notification each time a third report on a child is entered by CI within a twelve-month period. This includes a new report to CI and a new incident related to an open report. Alerts are received through the MFSIS. A data analysis of Alerts revealed that the data is unreliable and inaccurate. Individual notifications of the third report on the same child are delivered inconsistently, with duplicates, and other conflicting information. CFSD has been notified of the errors, however due to the number of case management issues identified in MFSIS related directly

to field work, the cost of corrections, and the priority to direct resources efficiently, the Alerts will not be accurate. All prior years of Alert data should be disregarded.

Table 3: Notifications received by OCFO.

Type of Notification	2020	2021	2022
Cross Reports	4,647	5,047	5,092
Runaways	108	156	179
Other Critical Incidents	10	98	96

Duty: Procedure Review

2022 Request Trends

MCA 41-3-1211 (7) directs OCFO to "periodically review department procedures and promote best practice and effective programs by working collaboratively with the department to improve procedures, practices, and programs." OCFO *Findings Reports* include case-specific procedure reviews for separate CFSD investigations and Dependent Neglect Temporary Legal Custody (TLC) cases. In 2022, CFSD continued a comprehensive review and revision of policy and procedure that started in 2020. CFSD supplied the change to OCFO and trained both their staff and OCFO in the new practices.

The 2021 Montana State Legislature passed House Bill 625 which directs OCFO to:

> "...identify and report on systemic trends in the CFSD handling of cases and to make recommendations to improve the child protective system."

MCA 41-3-1215 allows OCFO to broaden case analysis from a single case review requested by a citizen, to include reviewing multiple cases to research how a pattern and a trend of practices in CFSD is occurring and to report on those issues twice each year. DPHHS CFSD is required to respond to the systemic issue reports within 60 days and provide a description of how recommendations will be implemented, or a description of the reasons a recommendation may not be implemented.

In June 2022, OCFO investigated the timeliness of CPS responses to reports designated P2, requiring CFSD to see the child face to face within 72 hours, as well as the barriers identified by the field when the timelines are missed. *The First Knock at the Door: A Systemic Report* provides the outcome of that investigation. The report is available for review on the Department of Justice, Special Service Bureau's website.

OCFO consults with DPHHS and CFSD leadership regularly to discuss casework, emerging trends, receive practice updates and maintain good communications. The information OCFO collects and maintains regarding trends and patterns in Montana's child welfare system are available to DPHHS administration and management team. In 2023, OCFO will continue to produce public reports to disseminate this information.

Duty: Outreach and Education

General Outreach

To ensure that citizens and stakeholders are made aware of the purpose, services, procedures, and contact information for the ombudsman, OCFO is statutorily mandated to offer outreach.

2022 Outreach included:

- Multiple statewide CFSD field staff presentations
- Presentation to Montana Coalition Against Domestic and Sexual Violence staff and domestic violence shelter directors
- Presentation to Elevate Montana, Helena Affiliate
- Presentation to Montana Legal Services Association
- Attendance at the Kinship Navigator Advisory Council meetings
- Attendance at the CFSD State Advisory Council meetings
- Participating in the Justice for Montanans AmeriCorps Program
- The Montana Child Abuse and Neglect Conference
- The Children's Justice Conference
- CFSD Field Offices

Presentations included direct outreach to over 150 citizens.

CFSD Field Offices

In January 2022, OCFO mailed 29 packages to all the main CFSD field offices across the state. Each package contained an Outreach Letter, a physical copy of a Request for Assistance form, two OCFO posters, and a handful of OCFO brochures.

Recommendations:

OCFO extends two recommendations to DPHHS.

Recommendation 1: The CFSD electronic case management system and databases should be updated, and the information contained in the three separate electronic records should be consolidated where possible. Policy and procedures on how information is entered into the case management systems should be standardized between regional offices.

Rationale 1: Since 2014, OCFO has conducted thorough investigation case reviews of over 900 CFSD cases. The three electronic case management and databases are the primary source of case review information. Case information and documents are entered in the databases differently between CFSD Regions and between field offices. The case record challenges are serious and significant for the children, families, CPS staff, courts, and service providers statewide. Given the serious nature of state intervention in a family's life, it is the responsibility of the state to provide CFSD a functioning comprehensive electronic case management system.

OCFO has also noted the following issues with multiple case management systems:

- One child's case information may be fragmented between electronic systems, which risks decision making based on incomplete information.
- The multiple records increase CFSD staff time for entering documentation and retrieving case information.
- There are significant differences in how information is attached to the electronic records from office to office and region to region. The discrepancies complicate all aspects of a case review.
- Legally required case documents may be kept in paper hard copy files in local CFSD offices and not uploaded to the electronic case management system. Thus, the electronic record for a case is not fully accurate or accessible from outside the local office.
- OCFO revealed that the data received from MFSIS Alerts is unreliable and inaccurate. Individual notifications of the third report of abuse and/or neglect on the same child are delivered inconsistently, with duplicates, and other conflicting information.

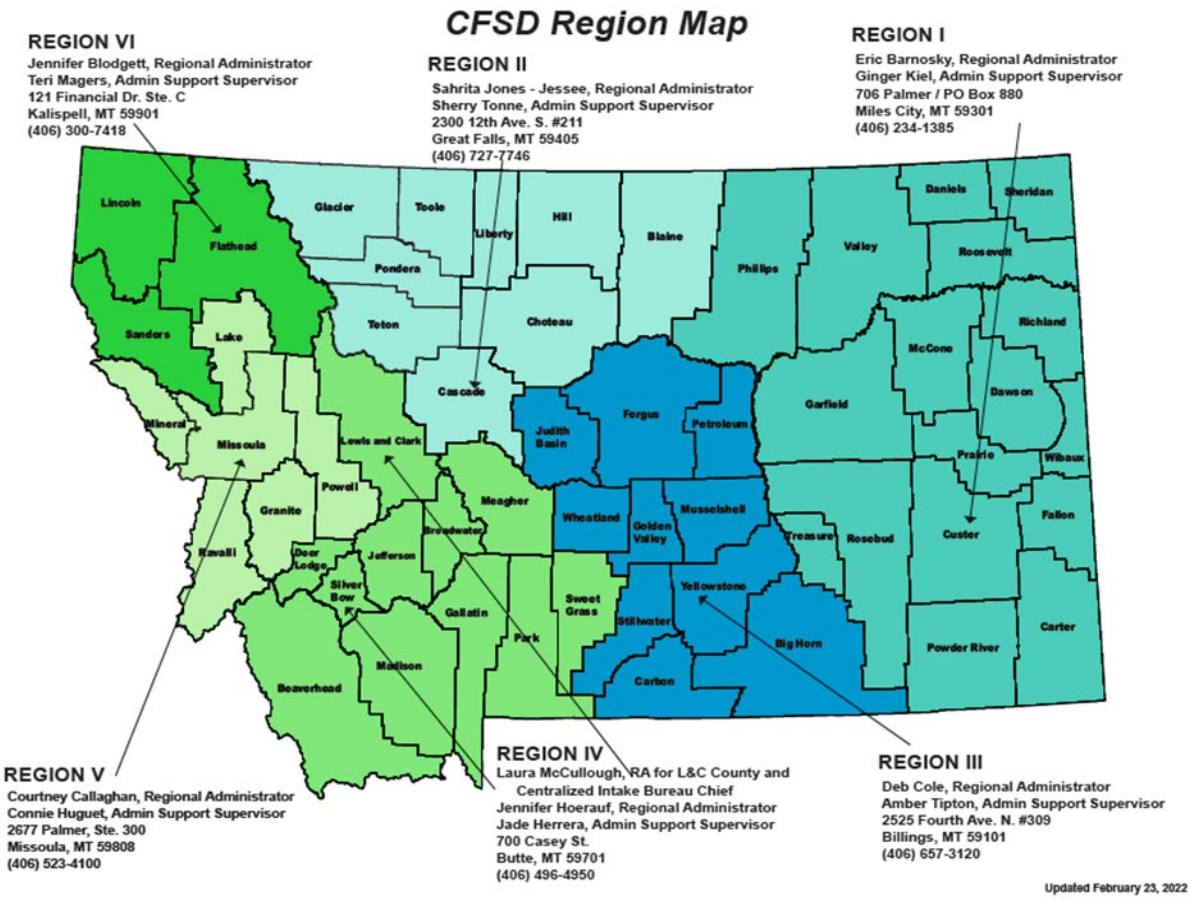
Recommendation 2: DPHHS CFSD to provide notification to OCFO regarding critical incidents of neglect or abuse by a substitute caregiver pursuant to MCA 41-3-209.

Rationale 2: This recommendation is based on a review of critical incidents from 2020 to 2022 that found OCFO had not received notices of incidents of neglect or abuse by a substitute caregiver.

Conclusion:

The DOJ Special Services Bureau and OCFO recognize the impact case reviews and child fatalities have on citizens, communities, and professional stakeholders. Child abuse is a community problem; preventing and responding to child abuse requires strong collaboration among multiple agencies. We sincerely thank the Department of Public Health and Human Services for sharing information and considering recommendations for future system improvements. We extend our thanks to Attorney General Austin Knudsen, Division of Criminal Investigation Administrator Bryan Lockerby, and DOJ staff for their unwavering support and commitment to improving Montana's child protection and child welfare systems to build a better future for us all.

Appendix I: Child and Family Regional Map



Appendix II: Acronyms

Acronyms found in the recommendations are defined as:

ACE: Adverse Childhood Experiences

CASA: Court Appointed Special Advocate

CFSD: Child and Family Services Division

CCIM: Complaints and Critical Incident Manager

CPS: Child Protection Specialist

CPSS: Child Protection Specialist Supervisor

DN: Dependency and Neglect

DPHHS: Department of Public Health and Human Services; also referred to as "the Department"

FFA: Family Functioning Assessment

FCRC: Foster Care Review Committee

GAL: Guardian ad Litem

ICPC: Interstate Compact on the Placement of Children

MCAN: Montana Child Abuse and Neglect new worker training

OCFO: Office of the Child and Family Ombudsman

RA: Regional Administrator

SAMS: Safety Assessment Management System

TLC: Temporary Legal Custody

TPR: Termination of Parental Rights

Appendix III: 2022 Recommendations from OCFO to DPHHS

OCFO's statutory authority includes making case specific findings as well as recommendations to strengthen the system. Often the cases reviewed, and the findings determined, relate to specific actions of a worker and or higher-level administrator. While there is value in reporting back to the agency the areas of practice that were assessed during case reviews, it is the recommendations for overall case practice that stand to benefit the citizens of Montana. OCFO recommendations have directed the agency to clarify their policy and procedures for ease of use by field staff once they are working in the field.

As reflected in the agency responses, CFSD has been reviewing and updating policies and procedures over the past several years to improve clarity and ease of use by field staff. The new policy and procedure went live to the staff and public on April 1, 2022.

OCFO has determined that moving forward in 2022 to focus our recommendations which may identify challenges within an identified region with recommendations specific to that regional staff.

Recommendations from the twelve 2022 *Findings Reports* are listed in the order they were issued as written, apart from identifying information as to protect citizen confidentiality. Responses from DPHHS/CFSD are below each recommendation in blue.

There were a total of 32 formal recommendations to DPHHS. DPHHS agreed with 87.5% of the recommendations and disagreed with 12.5%. The responses which differ from the OCFO recommendation are in orange font.

DPHHS has responded to each OCFO recommendation from 2022 within the statutory 60-day timeline.

2022 Recommendations from OCFO to DPHHS	
Report 1: **DPHHS Response:**	1) DPHHS direct CFSD to review policies and procedures on Investigation/Assessment, including the Montana Safety Assessment and Management System (SAMS) philosophy and key principles, safety planning, substantiation, and case closure requirements. Clarify and enhance policies and procedural expectations for ease of use by field staff. CFSD recognizes the benefit of regular policy and procedure reviews and will implement this recommendation by reviewing policy and procedure on investigations at regional meetings. CFSD has been reviewing and updating policies and procedures over the past twenty months to improve clarity and ease of use by field staff. In 2022, the SAMS model will be retrained to Regional Administrators and CPS supervisors. Throughout 2022, the CPS supervisors will train the SAMS model at unit meetings and through individual supervision with CPS staff. CFSD staff will receive the benefit of reviewing SAMS interview and investigation protocol through these trainings and supervision. This process aligns with the recommendations from the Legislative Practice Audit. 2) DPHHS direct CFSD to review policies and procedures on Documentation and the importance of capturing the Decision Points clearly. Clarify and enhance policies and procedural expectations for ease of use by field staff. CFSD recognizes the benefit of regular policy and procedure reviews and will implement this recommendation by reviewing policy and procedure on documentation at regional meetings. CFSD has been reviewing and updating policies and procedures over the past twenty months to improve clarity and ease of use by field staff Due to changes in the relevant statutes made during the 2021 legislative session, the Department is currently developing a certification process that includes ongoing training for field staff consistent with statutory requirements.
Report 2: **DPHHS Response:** **DPHHS Response:**	**1)** CFSD to re-train Regional Administrator and CPSS in Region 6 on contacting reporter, making face-to-face contact with the child and alleged maltreating parent, completing an IDA in investigations when the report is from a party listed in MCA 41-3-201. The Regional Administrator (RA) has been working with regional CPSS on an individual basis with training, including reviewing FFAs and discussing fidelity to the safety model including contacting the reporter, making face to face contact with all children and the alleged maltreating parent, and completing IDAs. CFSD is completing fidelity reviews at scheduled statewide supervisor meetings and at monthly regional leadership meetings. Region 6 is also completing weekly enhanced staffings to assess specific cases more comprehensively. **2)** CFSD direct CPSS in Region 6 to formulate written plans, including next steps for the case, in the FFA for out of policy actions. It was documented in the FFA out of policy section that the investigation would continue in R/R 521933. CFSD is working with leadership through

	multiple training venues on the documentation of next steps during the investigative process.
Report 3: **DPHHS Response:** **DPHHS Response:** **DPHHS Response:**	1) CFSD direct the Region 6 Administrator to train regional CPSS to assess the completion of required monthly home visit during supervisory staffing for children in out-of-home placement and/or THV. Staffing notes shall be entered into ACTD and instruct the assigned CPS to have face-to-face contact with the children within the end of the month. CFSD can generate a Home Visit with Child (HVC) list which shows the date of home visit completions for children in foster care. The Region 6 Regional Administrator (RA) has been sending that list to R6 CPSS monthly and has been working with CPSS staff in monthly individual staffings to address completing and documenting monthly home visits for children in out-of-home placements or on THV. In these monthly staffings, the RA also trains CPSS staff on entering staffing notes on case decision making points and tasks that need to be completed, including face-to-face contacts with children. The Region 6 RA has been attending at least one staffing a month between CPSS and each CPS they supervise to train staff on how to track and verify home visits with children are being completed and entered. 2) CFSD direct the Region 6 Administrator to re-train regional CPSS and CPS on conducting identified activities on IHSP. The Region 6 RA has trained regional CPS and CPSS on conducting and monitoring activities on IHSPs by taking the IHSP to the home during home visits and reviewing the IHSP during the visit to verify what activities are occurring and discuss any modifications that may be necessary or warranted. Region 6 has also reinstated enhanced staffing that occurs monthly. A routine activity conducted during enhanced staffings is reviewing IHSPs and how to monitor them. 3) CFSD direct the Region 6 Administrator to re-train regional CPSS and CPS on re-assessing IHSP when a safety resource can no longer be a part of the IHSP. The Region 6 RA has trained regional CPS and CPSS on conducting and monitoring activities on IHSPs by taking the IHSP to the home during home visits and reviewing the IHSP during the visit to verify what activities are occurring and discuss any modifications that may be necessary or warranted. Region 6 has also reinstated enhanced staffing that occur monthly. A routine activity conducted during enhanced staffings is reviewing IHSPs and how to monitor them.
Report 4:	1) CFSD direct Region 3 Administrator to retrain regional CPSS and CPS on Policy 202-3 specifically relating to using the Field Guide's Information Collection Protocol while "*assessing safety, including face to face contact and individual interviews with all members of the household in which the abuse and/or neglect has allegedly occurred, contacting the mandatory reporter, conducting home visits in the home where maltreatment is alleged*."

DPHHS Response:	In this case, CFSD staffed the decisions made during the early stages of the investigation with the RA, DA, and County Attorney. The decisions made in those staffings is documented in the FFA. There are times when exceptions to the Information Collection Protocol are deemed appropriate based on case specific circumstances, and those circumstances were present in this case. Beginning in April 2022, Region 3 has paired an intake unit with an ongoing unit to complete monthly fidelity reviews of a FFA and any accompanying protection plans. This fidelity review includes focuses on sufficiency of information and whether staff followed the information collection protocol and other procedures outlined in the investigative process. Furthermore, the Field Lead Training Specialist (FLTS) and Workforce Training Consultant (WTC) are working with regional CPS and CPSS to hold a monthly meeting with identified staff and complete a half-day full case review from the beginning of a report through the FFA and any prevention plans or legal intervention. 2) CFSD direct the Region 3 staff to send the birthparents their case file or denial letter within 30 days of the receipt of this findings report.
DPHHS Response:	CFSD promptly provided the birth parents their case files upon notice of the request, on May 12, 2022.
Report 5:	1) DPHHS direct CFSD to produce and upload into DocGen the Notice of Determination Substantiation Letter for R/R #360454 with the Certified Mail Return Receipt. In the event that CFSD is unable to produce these documents then OCFO recommends: 2) DPHHS direct CFSD to evaluate the suitability of the Notice of Determination Founded Letters for R/R # 452598 given the long lapse in time. 3) DPHHS direct CFSD and the Region 3 Administrator to re-assess the placement of the children# 561291, 606467 and 622375 with an ICWA kinship provider or a tribally licensed provider.
DPHHS Response:	CFSD does not have the Notice of Determination Substantiation Letter for R/R # 360454 or the Certified Mail Return Receipt. CFSD has evaluated the suitability of the determination of Founded in R/R #452598 and has concluded the facts and circumstances underlying the situation remain the same, despite the delay in letters being sent. The Northern Cheyenne tribe has intervened in the Dependent Neglect case has not objected to the current placements of children #561291, 606467, or 622375 and will continue to assist in identifying ICWA compliant placement options, as necessary.
Report 6:	1) CFSD direct Region 1 Administrator to retrain regional CPSS and CPS on investigations where physical abuse is alleged, specifically documenting injuries with photos as well as by physician's evaluations.
DPHHS Response:	The Investigation of Reports by Field Staff procedure will be trained at a Region 1 all staff meeting. The use of photographs during investigations is case specific and requires critical thinking and analysis of the

DPHHS Response:	circumstances of the case. This training will also include a discussion about the process of analysis specific to documenting injuries with photos during an investigation. 2) CFSD direct Region 1 Administrator to utilize R/R 529525 and the corresponding FFA, to train regional CPSS and CPS on prevention and safety planning, specifically utilizing planning and re-assessing the changes prior to closing. The sections of the SAMS Field Guide relevant to safety planning and ongoing assessment will be trained at a Region 1 all staff meeting. In this specific case, the closure of this Prevention Plan was initiated by the family's decision to stop engaging with the Department and was not initiated by the Department. The Department reassessed the case specific circumstances throughout the life of the case, resulting in a move from an Out-of-Home Protection Plan to an In-Home Safety Plan and a corresponding Prevention Plan. Upon being advised the family intended to disengage from the Prevention Plan, the Department assessed the current status of the family dynamics and determined there was no evidence to seek relief from a District Court.
Report 7: **DPHHS Response:** **DPHHS Response:** **DPHHS Response:**	1) CFSD direct Region 4 Administrator to retrain regional CPSS and CPS on supervision of out-of-home placement documentation of contacts, specifically addressing safety and well-being. Region 4 RA will train the Helena office CPS and CPSS on the supervision of out-of-home placement documentation of contacts, specifically addressing safety and well-being, at an all-staff meeting. CFSD has updated the Out-of-Home Safety Plan document to provide more comprehensive monitoring of out-of-home placements, including documentation of contacts specifically addressing safety and well-being. All CPSS will be trained on September 28, 2022, and the updated Out-Of-Home Safety Plan document will be effective October 1, 2022. 2) CFSD direct Region 4 Administrator to provide training to regional CPSS and CPS on the dynamics of child sexual abuse. On June 20, 2022, staff from the Helena Child Advocacy Center (CAC) provided in-service training to the Helena office CPS and CPSS on the dynamics of child sexual abuse. 3) DPHHS direct CFSD to consider drafting clear and specific procedures to address placing foster youth who have been convicted of sexual assault in out-of-home care with children and youth victims. Between late 2020 and early 2022, CFSD reviewed and updated policies and procedures to improve clarity and ease of use by field staff. On April 1, 2022, the updated Placement procedure went into effect. In the current Placement procedure, section D(d)(i) states when a child is being considered for placement with a licensed resource parent, the CPS will share with the licensed resource parent "information regarding reasons for placement, life experiences, educational services, medical and psychological information on the child as well as behavioral needs." CFSD is also in the process of updating the Out-of-Home Safety Plan and these

	updates will take effect November 1, 2022. The updated plan requires the CPS to identify supervision and behavioral management needs for the specific youth in the specific placement where the Out-of-Home Safety Plan is in effect. The safety plan identifies sexualized behaviors as a specific behavior to plan supervision around. CFSD believes the updated Placement procedure and Out-of-Home Safety Plan will result in informed and comprehensive planning for the safety of the foster youth and all children in any potential resource family home.
Report 8: **DPHHS Response:** **DPHHS Response:** **DPHHS Response:**	1) CFSD direct Region 4 staff to complete the FFA for R/R 538761 within 15 days of receipt of this report. The FFA for R/R 538761 was completed on August 4, 2022. 2) CFSD direct Region 4 Administrator to update the Protection Plan attached to R/R 538761 or replace the Protection Plan with an In-home or Out-of-home Safety Plan. The In-Home Safety Plan was implemented on July 22, 2022 and has been uploaded to the CAPS DocGen online database. 3) CFSD direct Region 4 Administrator to retrain regional CPS and CPSS on CFSD Procedures Investigation of the Reports by Field Staff and Family Functioning Assessment regardless of role as an intake or an ongoing worker, focusing on: o Immediate Danger Assessments o Protection Plans o Interview protocols for the FFA o Impending Dangers within a family o Case determinations The CFSD Regional Administrator for Region 4 will retrain regional CPS and GPSS on CFSD Procedures Investigation of the Reports by Field Staff and Family Functioning Assessment.
Report 9: **DPHHS Response:**	1) CFSD direct Region 6 Administrator to retrain regional CPSS and CPS about the Family Functioning Assessment procedure while assessing safety, including face to face contact and individual interviews with all members of the household in which the abuse and/or neglect has allegedly occurred, contacting the mandatory reporter, conducting home visits in the home where maltreatment is alleged, assessing Additional Information (AI's) received and having the completed FFA approved by the CPS Supervisor within 60 days from the date that Centralized Intake received the report. Region 6 CPSS and Field Lead Training Specialists (FLTS) have done two fidelity reviews since November 2021. During bimonthly meetings held with the Region 6 CPSS team, the RA selects a report and reviews the SAMS FFA field guide, the process of assessing and documenting decision-making points, and reinforces practice model guidelines and steps. One CPSS has already gone through the CPSS supervisory training and the other CPSS will attend upcoming supervisory trainings. The Region 6 CPSS facilitates unit meetings at least monthly. In those unit meetings, the FFA procedure and field guide are routine topics of

DPHHS Response:	discussion and Region 6 is beginning to implement fidelity reviews of the safety model with CPS staff on an ongoing basis. 2) CFSD direct Region 6 Administrator to retrain regional CPSS and CPS on the minimal recording requirements of an investigation and clearly documenting all contacts, actions taken and safety decisions. Region 6 CPSS and FLTS have done two fidelity reviews since November 2021 and fidelity reviews are now scheduled monthly with the Region 6 Leadership Team. During bimonthly meetings held with the Region 6 CPSS team, the RA selects a report and reviews the SAMS FFA field guide, the process of assessing and documenting decision-making points, and reinforces practice model guidelines and steps. One CPSS has already gone through the CPSS supervisory training and the other CPSS will attend upcoming supervisory trainings. The Region 6 CPSS facilitate unit meetings at least monthly. In those unit meetings, the FFA procedure and field guide are routine topics of discussion and Region 6 is beginning to implement fidelity reviews of the safety model with CPS staff on an ongoing basis. The Region 6 RA is working with staff to include a worker analysis component within the FFA that pulls together the information in a way that expresses to the reader what the safety decisions are and how they were made.
Report 10: **DPHHS Response:** **DPHHS Response:**	1) CFSD direct Region 4 Administrator to review this case and correct the report to the court to include all the family members who have requested permanent placement. An amended report to the court was submitted on August 30, 2022. 2) CFSD direct Region 4 Administrator to confirm the licensing process is being followed for the paternal grandmother; re-assess the permanency determination and current placement with a neutral third-party review team from another region; document the rationale for the outcome to the case record and notify the paternal grandmother and the birth father in writing of the outcome. The Region 4 Regional Administrator has directed licensing staff to work with the paternal grandmother on the licensing process. The permanency determination and current placement were reassessed on August 18, 2022, by the CFSD Management Team and the determination was made it remains in the child's best interests to remain in the current placement with the sibling. Reunification efforts will continue with birth father. An additional meeting will be held with paternal grandmother, father, his attorney, Regional Administrator and Division Administrator to assess paternal grandmother's ability to be a permanent option. Regional Administrator will inform paternal grandmother and birth father of the decision to maintain the placement with the sibling at this time and request an additional meeting with them and father's attorney in writing.
Report 11:	1) CFSD direct Region 3 Administrator to retrain regional CPSS and CPS on procedures relating to the Placement of children in Unlicensed Kinship Care, specifically relating to the required home visit prior to or within 48 hours of placement, and the requirement of a CPS reviewing the agency

	expectations and responsibilities and signing the Kinship Care Agreement with the Kinship placement.
DPHHS Response:	Region 3 will train regional CPS and CPSS on procedures relating to the placement of children in unlicensed kinship care, completing a home visit prior to or within 48 hours of placement, and the CPS reviewing agency expectations and responsibilities and signing the Kinship Care Agreement with the kinship placement at an all staff meeting by August 2022.
	2) CFSD direct Region 3 and Region 5 Administrators to retrain regional CPSS and CPS on procedures relating to the required face to face monthly home visits with all children in foster care.
DPHHS Response:	CFSD generates a Home Visit with Child (HVC) list which shows the date of home visit completions for children in foster care. The Region 3 and Region 5 Regional Administrators (RA) have been sending that list to regional CPSS monthly and have been working with CPSS staff in monthly individual staffings to address completing and documenting monthly home visits for children in out-of-home placements or on Trial Home Visits. The CPSS review the HVC list with the CPS under their supervision during individual staffing times. If a CPS has a substantial number of needed home visits to be completed, a plan is developed and sent to the RA. That plan is reviewed during monthly staffings between the RA and CPSS.
	3) CFSD direct Region 3 Administrator to retrain regional CPSS and CPS on procedures relating to Independent Living Services and the required transitional living plan for children over fourteen.
DPHHS Response:	Region 3 had an all staff meeting on April 6, 2022, and the Chafee program staff within CFSD presented on the procedures relating to TLS. The development of the TLP is done with the youth by the Chafee Services contracted TLS provider in each region. CFSD Chafee program staff will be completing site visits of the contracted Chafee TLS providers throughout the rest of 2022 and will be reviewing the TLP development requirements and the process of providing the TLP to CFSD staff during these site visits.
Report 12:	1) CFSD direct Region 4 Regional Administrator to complete a fair and reasonable safety assessment of the father. Adhere to established policy and procedure if the child can be safely placed with the birth father. If the child cannot be safely placed with the birth father, explore all family resources per policy and procedure.
DPHHS Response:	The CFSD Case Management procedure directs staff to assess the CFR on an ongoing monthly basis to determine if the conditions for return have been met. In this case, the CFR were most recently updated on September 8, 2022, and the birth father still has not met the CFR for a trial home visit to begin. A PPT meeting was conducted in February 2022. CFSD documented in the case file the conclusions of the PPT meeting that child #652528 would remain in the current placement.

	2) CFSD direct Region 4 Administrator to retrain regional CPSS and CPS on the relevant law, and policy on the rights of noncustodial parents and established placement procedures.
DPHHS Response:	The Department's actions in this case comport with the applicable laws and have not arbitrarily interfered with the non-custodial parent/birth father's parental rights. However, CFSD recognizes the benefit of regular policy and procedure reviews. The CFSD Regional Administrator for Region 4 will therefore hold training for CPS and CPSS on the CFSD procedures relevant to non-custodial parents, including the Concurrent Planning Procedure and the Placement Procedure.
	3) CFSD direct Region 4 Administrator to confirm the licensing process is being followed for the paternal grandmother; confirm the intent of the paternal grandfather regarding the approved ICPC, re-assess the permanency determination and current placement with a neutral third-party review team from another region; document the rationale for the outcome to the case record and notify the paternal family and the birth father in writing of the outcome.
DPHHS Response:	As noted above, an ICPC request was made to the state of Tennessee to consider the paternal grandfather as a placement option because the birth father was living in Tennessee at that time. Shortly thereafter, the birth father moved to Butte, Montana, to be closer to child #652528 and the paternal family determined they wanted to have the paternal grandmother, who lives in Montana, considered as a placement option instead of the paternal grandfather. The permanency determination and current placement were reassessed on August 18, 2022, by the CFSD Management Team and the determination was made it remains in the child's best interests to remain in the current placement with the sibling. Reunification efforts will continue with birth father. The Regional Administrator informed paternal grandmother of the decision to maintain the placement with the sibling currently during an in-person meeting on September 26, 2022. As a result of that meeting, Regional Administrator determined that further investigation/exploration regarding the grandmother's ability to care for an infant was necessary. The Region 4 Regional Administrator has directed licensing staff to work with the paternal grandmother on the licensing process to help assess the grandmother as a concurrent placement option for child #652528. An additional meeting will be held with paternal grandmother, father, his attorney, the Regional Administrator, and the Division Administrator to continue assessing reunification efforts with birth father and paternal grandmother's ability to be a permanent option if reunification does not occur.
	4) CFSD direct Region 4 Administrator to review this case and correct the report to the court to include all the family members who have requested permanent placement of the child.
DPHHS Response:	On August 30, 2022, an amended report was submitted to the Court.
	5) CFSD direct Region 4 Administrator to retrain regional CPSS and CPS on the relevant law, policy, and procedure about the importance of kinship

DPHHS Response:	and the hierarchy of placement which best meets the child's lifelong permanency needs. CFSD procedure, state law, and federal law define the current placement as a kinship/extended family placement. Retraining of staff is unnecessary because CFSD comported with the law when making its determinations on how best to meet the child's lifelong permanency needs. The child's current placement is a kinship/extended family placement because the child has a half-sibling placed in the home. There is no hierarchy within the category of "extended family" that places one type of family member over another regarding placement preferences.