Members

Rep. Kevin Mahan, Co-Chairperson
Rep. Rebecca Kubacki
Rep. Gail Riecken
Rep. Vanessa Summers
Sen. Travis Holdman, Co-Chairperson
Sen. Carlin Yoder
Sen. Timothy Lanane
Sen. John Broden
Anita Harden
Judge Christopher Burnham
Gloria Hood
Viola J. Taliaferro
Jean Willey Scallon
Jeff Darling
Charles Pratt
Justice Loretta Rush
David Judkins
Dave Powell
Larry Landis
Kevin Moore

LSA Staff:

KC Norwalk, Attorney for the Committee
Ann Naughton, Attorney for the Committee
Bill Brumbach, Fiscal Analyst for the Committee

Authority: P.L. 48-2012

DEPARTMENT OF CHILD SERVICES INTERIM STUDY COMMITTEE

Legislative Services Agency
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Indianapolis, Indiana 46204-2789
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MEETING MINUTES[1]

Meeting Date:	**November 27, 2012**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**Indiana Government Center South, Conference Rooms 4 and 5**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**6**

Members Present: **Rep. Kevin Mahan, Co-Chairperson; Rep. Rebecca Kubacki; Rep. Gail Riecken; Sen. Travis Holdman, Co-Chairperson; Sen. Carlin Yoder; Sen. Timothy Lanane; Sen. John Broden; Anita Harden; Judge Christopher Burnham; Gloria Hood; Viola J. Taliaferro; Jean Willey Scallon; Jeff Darling; Charles Pratt; Justice Loretta Rush; David Judkins; Dave Powell; Larry Landis; Kevin Moore.**

Members Absent: **Rep. Vanessa Summers.**

Sen. Holdman called the meeting to order at 10:05 a.m. and described the approach that would be taken to the Committee's consideration of the issues to be discussed and voted upon during the meeting.

Sen. Holdman stated that four small groups, each led by legislator members and including any lay members that wished to participate in a group, would have 30 minutes to discuss their assigned issue, consult with Department of Child Services (DCS) staff members and other interested parties, and formulate a

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[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

recommendation for Committee discussion for purposes of inclusion in the Committee's Final Report. The four group issues included:

(1) Committee on DCS Oversight - Preliminary Draft (PD) 3640[2], led by Sen. Yoder and Sen. Broden.
(2) Child Fatality Review Teams - PD 3438[3], led by Rep. Riecken.
(3) Commission on Improving the Status of Children - PD 3592[4], led by Sen. Lanane.
(4) Centralized Call Center Issues[5], led by Rep. Mahan and Rep. Kubacki.

Sen. Holdman also noted that the Committee would discuss two additional issues:

(1) Prosecuting Attorney Filing of Child in Need of Services (CHINS) petitions.
(2) DCS Attorney Issues.

Small Group Recommendations

Following the small group discussions, Sen. Holdman requested that the members provide to the Committee the recommendations from each group:

(1) Committee on DCS Oversight - PD 3640 - Sen. Yoder reported that this group had suggested changes to the PD. He and Sen. Broden described the changes, including the following:

(a) An additional member appointed on the recommendation of the Superintendent of Public Instruction.
(b) Appointment of the judicial member on the recommendation of the Chief Justice of the Supreme Court.
(c) Meetings held at least quarterly.

In response to a question from Sen. Lanane, Judge Burnham explained the need for the proposed committee to study a new category of "at risk" children, who do not "fit" into the current categories of CHINS or juvenile delinquent, so that DCS services may be made available to the at risk children.

The Committee, by unanimous voice vote, approved PD 3640, as amended, for introduction during the 2013 session of the General Assembly.

(2) Child Fatality Review Teams - PD 3438 - Rep. Riecken reported that this

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[2]Attachment 1.

[3]Attachment 2.

[4]Attachment 3.

[5]A handout concerning this issue is contained in Attachment 4.

group recommended further work to draft new legislation to improve local and statewide child fatality review teams, including addressing:

(a) an advisory role for the statewide team;
(b) improvement of cooperation and communication between the statewide team and the local teams;
(c) hiring of staff to facilitate the work of the teams; and
(d) ensuring multidisciplinary membership on the statewide team.

Mr. Landis suggested that protection of the privacy of personal information be a consideration in the drafting of the legislation.

The Committee, by unanimous voice vote, recommended that continued work be pursued to draft legislation for introduction during the 2013 session of the General Assembly to improve local and statewide child fatality review teams.

(3) Commission on Improving the Status of Children - PD 3592 - Sen. Lanane reported that the group considering this issue had suggested changes to PD 3592 and described the changes, including the following:

(a) Increasing membership on the Commission to include the Executive Director of the Prosecuting Attorneys Council, or his designee, and the Executive Director of the Public Defender Council, or his designee.
(b) Requiring the Commission to file an annual report with Legislative Council.
(c) Requiring the Commission to review state rankings and outcomes concerning children who witness domestic violence or violent crimes and delinquent children.
(d) Allowing the Commission to make recommendations and propose legislation.

The Committee, by unanimous voice vote, approved PD 3592, as amended, for introduction during the 2013 session of the General Assembly.

(4) Centralized Call Center Issues - Rep. Mahan reported that the group determined that a combination of amended proposals[6] would be the recommendation to the Committee. There was discussion among the members, including:

(a) differences among the proposals;
(b) desired legislative changes to the centralized call center's enabling statute;
(c) procedural changes to the current call center system;
(d) the need to monitor the results after changes are implemented;
(e) anticipated results, including operation of the centralized call

[6]See Attachment 4.

center more as a dispatch center for local DCS offices; and
(f) anticipated costs.

The Committee, by unanimous voice vote, recommended that legislation be drafted for introduction (by Rep. Mahan, Rep. Kubacki, and Rep. Riecken in the House and Sen. Yoder and Sen. Lanane in the Senate) during the 2013 session of the General Assembly to do the following:

(a) Require DCS to hire:
(i) 50 family case manager intake specialists;
(ii) 10 family case manager intake specialist supervisors;
(iii) 80 family case managers; and
(iv) 16 family case manager supervisors.
(b) Require DCS local offices to review all reports resulting from calls to the DCS centralized call center.
(c) Require DCS to assign reports resulting from calls to the DCS centralized call center to local DCS offices.
(d) Require DCS local offices to assign all reports of suspected child abuse or neglect from professional reporters.
(e) Grant emergency rulemaking authority to DCS to adopt rules to implement the requirements.

PD 3586

Sen. Holdman referred to PD 3586[7], concerning petitions to modify custody and visitation, and requested comment from the members. After discussion among the members, wording changes were made to the PD, including the following:

(1) Requiring the petition in the bill draft to be verified.
(2) Requiring that a person who files a petition to establish a guardianship of a child, parenting time, or custody must make the statements required in the bill draft.
(3) Adding "person" to the individuals who can file the petitions in the bill draft.

The Committee, by unanimous voice vote, approved PD 3586, as amended, for introduction during the 2013 session of the General Assembly.

PD 3325

Sen. Holdman requested that Mr. Powell discuss PD 3325[8], concerning prosecuting attorney filing of CHINS cases. Mr. Powell provided a brief history of the involvement of prosecuting attorneys in filing these cases. There was

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[7]Attachment 5.

[8]Attachment 6.

discussion among the members and amendments to the PD were made, including the following:

(1) Removing the sunset provision.
(2) Allowing a petition to be filed for any type of child in need of services case.
(3) Providing that the prosecuting attorney may represent the interest of the state in subsequent proceedings.

The Committee, by unanimous voice vote, approved PD 3325, as amended, for introduction during the 2013 session of the General Assembly.

DCS Attorney Issues

Sen. Holdman discussed the history of child welfare department attorney practices, including political and other influences on the use of staff attorneys and contract attorneys. He noted a potential benefit of conducting a trial allowing local DCS office directors to contract with local attorneys to perform work for the local DCS office, rather than exclusively using DCS staff attorneys.

Final Report

There was discussion among the members and staff concerning the recommendations to be added to the draft Final Report[9]. Following the discussion, the Committee, by unanimous voice vote, approved the Final Report.

Other Business

Sen. Holdman noted the House and Senate sponsors of the PDs that were approved during the meeting, as follows:

PD 3640 - Rep. Mahan and Rep. Riecken; Sen. Holdman and Sen. Broden.
PD 3586 - Rep. Riecken and Rep. Kubacki; Sen. Yoder and Sen. Broden.
PD 3592 - Rep. Riecken and Rep. Mahan; Sen. Lanane and Sen. Holdman.
PD 3325 - Rep. Kubacki and Rep. Riecken; Sen. Holdman and Sen. Broden.

Sen. Holdman expressed his appreciation for the participation of the members and DCS staff in the Committee's work throughout the Interim. He noted that significant changes in DCS practices have occurred as a result of the Committee's recommendations. Rep. Mahan agreed and particularly expressed his appreciation for the participation of the lay membership.

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[9]Attachment 8.

With no further business to discuss, Sen. Holdman adjourned the meeting at 12:30 p.m.

(Additional written testimony[10] from individuals not testifying at the meeting was distributed to the members.)

[10]Attachments 8 through 12.

PRELIMINARY DRAFT
No. 3640

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2013 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 2-5-36.

Synopsis: DCS oversight committee. Establishes the committee on child services oversight to oversee the delivery of child services in Indiana. Specifies that the committee exists until January 1, 2019. Repeals the law establishing the department of child services interim study committee.

Effective: July 1, 2013.

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 2-5-36 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]:

Chapter 36. Committee on Child Services Oversight

Sec. 1. As used in this chapter, "child in need of services" means a child described in IC 31-34-1.

Sec. 2. As used in this chapter, "committee" refers to the committee on child services oversight established by section 4 of this chapter.

Sec. 3. As used in this chapter, "department" refers to the department of child services established by IC 31-25-1-1.

Sec. 4. The committee on child services oversight is established.

Sec. 5. The committee consists of ten (10) voting members appointed as follows:

(1) Two (2) members of the senate appointed by the president pro tempore, not more than one (1) of whom may be from the same political party.

(2) Two (2) members of the house of representatives appointed by the speaker, not more than one (1) of whom may be from the same political party.

(3) The director of the department of child services or the director's designee.

(4) The director of the division of mental health and addiction or the director's designee.

(5) The executive director of the prosecuting attorneys council or the executive director's designee.

(6) The executive director of the public defenders council or the executive director's designee.

(7) A provider to the department of foster care, residential, or group home services, appointed by the president pro tempore.

(8) One (1) juvenile or family court judge, appointed by the

speaker.

Sec. 6. A vacancy on the committee shall be filled by the appointing authority.

Sec. 7. (a) The president pro tempore shall appoint a member of the committee described in section 5(1) of this chapter to serve as chairperson of the committee from January 1 through December 31 of odd-numbered years.

(b) The speaker shall appoint a member of the committee described in section 5(2) of this chapter to serve as chairperson of the committee from January 1 through December 31 of even-numbered years.

Sec. 8. The committee shall do the following:

(1) Review monthly reports from the department, as determined by the committee and including outcome reports.

(2) Review annual reports from the office of department of child services ombudsman established by IC 4-13-19-3, as determined by the committee and including outcome reports.

(3) Determine whether any contractor with the department has properly performed the terms of the contractor's contract.

(4) Study and make legislative and administrative recommendations to improve the delivery of child services in Indiana, including the following:

(A) Juvenile court commitment of juveniles to mental health facilities.

(B) Restoration of IC 31-34-1-6 filing authority to prosecuting attorneys.

(C) Specification of a new category under IC 31-34-1 for at-risk children for which the following may apply:

(i) Ability for prosecuting attorneys to file and pursue a case.

(ii) Probation personnel may enter information under Title IV-E of the federal Social Security Act (42 U.S.C. 671 et seq.) and use department of child services funds to provide necessary services.

(iii) Courts, the department, and probation personnel may supervise the children.

(D) Specification of a new category under IC 31-34-1 for status offender children.

(E) Consideration of methods of delivering department services to children without labeling the children as juvenile delinquents.

(F) Composition and duties of regional service councils.

(G) Funding for tangible resources needed to keep children with their families on an emergency basis.

(H) Consolidation of all bodies in existence on July 1, 2013,

that address child welfare issues into one (1) committee with working subcommittees.

(I) Call center staffing, turnover, morale, cross training, and other issues.

(J) Ongoing training of local child protection teams.

(K) Sufficiency and timeliness of service provider payment, availability of services, use of regional service councils, coordination of public and private services, and availability and use of outcome data.

(L) An independent audit of the department's operations.

(M) Followup care for children after resolution of the department's case.

(N) Followup care for children about whom a report of suspected abuse or neglect is received but not substantiated and who are in need of services, regardless of the absence of substantiation.

(O) An independent assessment of the history and current number of service providers and services offered on behalf of the department in each county in Indiana.

(5) Study and make recommendations concerning any other matter related to the department.

Sec. 9. The committee shall meet at the call of the chairperson.

Sec. 10. (a) Except as provided in subsection (b), the committee shall operate under the policies governing study committees adopted by the legislative council.

(b) The committee may meet at any time during the calendar year.

Sec. 11. This chapter expires January 1, 2019.

SECTION 2. P.L.48-2012, SECTION 77, IS REPEALED [EFFECTIVE JULY 1, 2013]. ~~SECTION 77. (a) As used in this SECTION, "committee" refers to the department of child services interim study committee, as established by subsection (b).~~

~~(b) There is established the department of child services interim study committee. The committee shall do the following:~~

~~(1) Review and study the progress and improvements made by the department of child services since its creation in 2005.~~

~~(2) Review best practices concerning child welfare, child mental health, and delinquent children.~~

~~(3) Receive and review status reports from the department of child services ombudsman.~~

~~(4) Review and study the department of child services child abuse and neglect hotline, including the process used to refer a report to a local office.~~

~~(5) Make legislative recommendations concerning the department of child services.~~

~~(c) The committee shall operate under the policies governing study~~

~~committees adopted by the legislative council.~~

~~(d) The committee consists of the following members:~~

~~(1) Four (4) senators appointed by the president pro tempore of the senate in consultation with the minority leader of the senate, not more than two (2) of whom may be members of the same political party.~~

~~(2) Four (4) representatives appointed by the speaker of the house of representatives in consultation with the minority leader of the house of representatives, not more than two (2) of whom may be members of the same political party.~~

~~(3) The director of the department of child services or the director's designee, who shall serve as a nonvoting member.~~

~~(4) The director of the division of mental health and addiction or the director's designee, who shall serve as a nonvoting member.~~

~~(5) The executive director of the prosecuting attorneys council or the executive director's designee, who shall serve as a nonvoting member.~~

~~(6) The executive director of the public defenders council or the executive director's designee, who shall serve as a nonvoting member.~~

~~(7) A provider of foster care services to the department of child services, who shall serve as a nonvoting member, appointed by the president pro tempore of the senate.~~

~~(8) A provider of residential or group home services to the department of child services, who shall serve as a nonvoting member, appointed by the speaker of the house of representatives.~~

~~(9) One (1) juvenile or family court judge, who shall serve as a nonvoting member, appointed by the president pro tempore of the senate.~~

~~(10) One (1) juvenile or family court judge, who shall serve as a nonvoting member, appointed by the speaker of the house of representatives.~~

~~(e) The affirmative votes of a majority of the voting members of the committee are required for the committee to take action on any measure, including final reports.~~

~~(f) This SECTION expires December 31, 2013.~~

PRELIMINARY DRAFT
No. 3438

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2013 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 16-18-2; IC 16-19; IC 31-9-2; IC 31-25-2-20.4; IC 31-33; IC 34-30-2; IC 36-2-14.

Synopsis: Child fatality reviews. Requires the state department of health to oversee and provide training to local child fatality review teams and the statewide child fatality review committee. (Under current law, the local child fatality review teams and statewide child fatality review committee are overseen and provided training by the department of child services.) Requires the legislative body of a county to: (1) establish a county child fatality review team; or (2) join with one or more other counties that have not established a county child fatality review team to form a regional child fatality review team. (Under current law, the department of child services establishes regions and local fatality review teams for each region.) Changes the manner in which the chairpersons and members are selected for a child fatality review team. Amends the definition of "mental health provider" for purposes of the child fatality review team provisions. Requires the statewide child fatality review committee to review every child's death that meets certain criteria. (Current law requires the committee to review a child death that meets certain criteria upon request of a local child fatality review team and allows the committee to review a child's death that meets certain criteria upon request by the child services

(Continued on next page)

Effective: July 1, 2013.

ombudsman.) Provides certain records regarding child abuse, abandonment, and neglect be made available to the state department of health. Repeals and relocates certain language regarding child fatality review teams and the statewide child fatality review team. Makes conforming changes.

A BILL FOR AN ACT to amend the Indiana Code concerning family law and juvenile law.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16-18-2-54.3, AS ADDED BY P.L.1-2010, SECTION 68, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 54.3. **(a) "Child", for purposes of IC 16-19-16, has the meaning set forth in IC 16-19-16-1.**

(b) "Child", for purposes of IC 16-19-17, has the meaning set forth in IC 16-19-17-1.

(c) "Child", for purposes of IC 16-35-8, has the meaning set forth in IC 16-35-8-1.

SECTION 2. IC 16-18-2-86.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 86.3. "County child fatality review team" for purposes of IC 16-19-16, has the meaning set forth in IC 16-19-16-2.**

SECTION 3. IC 16-18-2-110 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 110. **(a) "Emergency medical services", for purposes of IC 16-19-16, has the meaning set forth in IC 16-19-16-3.**

(b) "Emergency medical services", for purposes of IC 16-19-17, has the meaning set forth in IC 16-19-17- 2.

(c) "Emergency medical services", for purposes of IC 16-31, means the provision of emergency ambulance services or other services, including extrication and rescue services, utilized in serving an individual's need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

SECTION 4. IC 16-18-2-210.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 210.5. (a) "Local child fatality review team", for purposes of IC 16-19-16, has the meaning set forth in IC 16-19-16-4.**

(b) "Local child fatality review team", for purposes of IC 16-19-17, has the meaning set forth in IC 16-19-17-3.

SECTION 5. IC 16-18-2-225.8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 225.8. **(a) "Mental health provider", for purposes of IC 16-19-16, has the meaning set forth in IC 16-19-16-5.**

(b) "Mental health provider", for purposes of IC 16-19-17, has the meaning set forth in IC 16-19-17-4.

(c) "Mental health provider", for purposes of IC 16-36-1.5, has the meaning set forth in IC 16-36-1.5-2.

SECTION 6. IC 16-18-2-313.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 313.7. "Regional child fatality review team", for purposes of IC 16-19-16, has the meaning set forth in IC 16-19-16-6.**

SECTION 7. IC 16-18-2-340.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 340.5. (a) "Statewide child fatality review committee", for purposes of IC 16-19-16, has the meaning set forth in IC 16-19-16-7.**

(b) "Statewide child fatality review committee", for purposes of IC 16-19-17, has the meaning set forth in IC 16-19-17-5.

SECTION 8. IC 16-19-16 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]:

Chapter 16. Child Fatality Review Teams

Sec. 1. As used in this chapter, "child" means an individual less than eighteen (18) years of age.

Sec. 2. As used in this chapter, "county child fatality review team" means a fatality review team established under this chapter for a county.

Sec. 3. As used in this chapter, "emergency medical services" means the provision of emergency ambulance services or other services, including extrication and rescue services, utilized in serving an individual's need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

Sec. 4. As used in this chapter, "local child fatality review team" refers to a county or regional child fatality review team established under this chapter.

Sec. 5. As used in this chapter, "mental health provider" means any of the following:

(1) A registered nurse or licensed practical nurse licensed under IC 25-23.

(2) A clinical social worker licensed under IC 25-23.6-5.

(3) A marriage and family therapist licensed under IC 25-23.6-8.

(4) A psychologist licensed under IC 25-33.

(5) A school psychologist licensed by the Indiana state board of education.

Sec. 6. As used in this chapter, "regional child fatality review team" means a fatality review team established under this chapter for a region consisting of more than one (1) county.

Sec. 7. As used in this chapter, "statewide child fatality review committee" refers to the statewide child fatality review committee established by IC 16-19-17-6.

Sec. 8. (a) The legislative body of a county shall do one (1) of the following:

(1) Establish a county child fatality review team.

(2) Join with one (1) or more other counties that have not established a county child fatality review team to form a regional child fatality review team.

(b) A local child fatality review team shall review the death of a child that:

(1) occurred in the:

(A) county if the local child fatality review team is a county child review team; or

(B) region if the local child fatality review team is a regional child review team; and

(2) is one (1) or more of the following:

(A) Sudden.

(B) Unexpected.

(C) Unexplained.

(D) Assessed by the department of child services for alleged abuse or neglect that resulted in the fatality.

(E) Determined by a coroner in the area served by the local child fatality review team to be the result of a homicide, suicide, or accident.

- balance of privacy rights

(c) In conducting a child fatality review under subsection (b), the local child fatality review team shall review every record concerning the deceased child that is held by:

(1) the department of child services; or

(2) the local child fatality review team.

(d) Subject to IC 34-30-15, if the local child fatality review team requests records from a hospital, physician, coroner, law enforcement officer, or mental health professional regarding a death that the local child fatality review team is investigating, the hospital, physician, coroner, law enforcement officer, or mental health professional shall provide the requested records to the local child fatality review team.

Sec. 9. A child fatality review consists of a child fatality review team reviewing and discussing the individual circumstances leading to or involved with the fatality.

Sec. 10. A local child fatality review team consists of the

following members:

(1) A coroner or deputy coroner from the area served by the local child fatality review team.

(2) A representative from:

(A) a county health department established under IC 16-20-2;

(B) a health and hospital corporation established under IC 16-22-8; or

(C) a multiple county health department established under IC 16-20-3;

from the area served by the local child fatality review team.

(3) A pediatrician or family practice physician residing or practicing medicine in the area served by the local child fatality review team.

(4) A representative of law enforcement from the area served by the local child fatality review team.

(5) A representative from an emergency medical services provider doing business in the area served by the local child fatality review team.

(6) A regional manager of the department of child services from the area served by the local child fatality review team or the regional manager's designee.

(7) A representative of the prosecuting attorney from the area served by the local child fatality review team.

(8) A pathologist with forensic experience who is licensed to practice medicine in Indiana and who, if feasible, is certified by the American Board of Pathology in forensic pathology.

(9) A representative from a fire department or volunteer fire department (as defined in IC 36-8-12-2) from the area served by the local child fatality review team.

(10) A department of child services attorney from the area served by the local child fatality review team.

(11) A mental health provider providing services in the area served by the local child fatality review team.

(12) A representative from a school district in the area served by the local child fatality review team.

(13) The prosecuting attorney from the county where the child fatality occurred, as a nonvoting member.

Sec. 11. A local child fatality review team may have additional members from the following categories:

(1) A representative of a hospital located in the area served by the local child fatality review team.

(2) A representative from a juvenile or probate court in the area served by the local child fatality review team.

(3) Other representatives requested to serve by the members of the local child fatality review team.

(4) A representative from the department of natural resources who lives or works in the area served by the local child fatality review team.

(5) A representative from Prevent Child Abuse Indiana (an organization for the prevention of child abuse) who lives or works in the area served by the local child fatality review team.

(6) One (1) of the following:

(A) A court appointed special advocate who provides court appointed special advocate services in the area served by the local child fatality review team.

(B) A guardian ad litem who provides guardian ad litem services in the area served by the local child fatality review team.

Sec. 12. (a) If a county child fatality review team has been established for a county, the legislative body of the county that voted to establish the county fatality review team shall:

(1) adopt an ordinance for the appointment and reappointment of members to the county child fatality review team; and

(2) appoint members to the county child fatality review team in accordance with the ordinance adopted.

(b) If a regional fatality review team has been established for a region, the county legislative bodies that voted to establish the regional fatality review team shall:

(1) adopt an ordinance for the appointment and reappointment of members to the regional child fatality review team; and

(2) appoint members to the regional child fatality review team in accordance with the ordinance adopted.

Sec. 13. (a) The members of a local child fatality review team shall, at the first meeting, elect a member to serve as the chairperson of the local child fatality review team.

(b) The local child fatality review team shall meet at the call of the chairperson.

(c) The local child fatality review team chairperson shall determine the agenda for each meeting.

Sec. 14. (a) Except as provided in subsection (b), meetings of a local child fatality review team are open to the public.

(b) Meetings of a local child fatality review team that involve confidential records or identifying information regarding the death of a child that is confidential under state or federal law shall be held as executive sessions.

(c) If an executive session is held under subsection (b), each individual who:

(1) attends a meeting of the local child fatality review team;

and

(2) is not a member of the local child fatality review team;

shall sign a confidentiality statement prepared by the state department. The local child fatality review team shall keep all confidentiality statements signed under this subsection.

Sec. 15. Members of a local child fatality review team and individuals who attend a meeting of a local child fatality review team as invitees of the chairperson:

(1) may discuss among themselves confidential matters that are before the local child fatality review team;

(2) are bound by all applicable laws regarding the confidentiality of matters reviewed by the local child fatality review team; and

(3) except when acting:

(A) with malice;

(B) in bad faith; or

(C) with negligence;

are immune from any civil or criminal liability that might otherwise be imposed as a result of sharing among themselves confidential matters that are before the local child fatality review team.

Sec. 16. The state department shall provide training to local child fatality review teams.

Sec. 17. (a) The state department shall collect and document information surrounding the deaths of children reviewed by local child fatality review teams. The state department shall develop a data collection form that includes:

(1) identifying and nonidentifying information;

(2) information regarding the circumstances surrounding a death;

(3) factors contributing to a death; and

(4) findings and recommendations that include the following information:

(A) Whether similar future deaths could be prevented.

(B) A list of:

(i) agencies and entities that should be involved; and

(ii) any other resources that should be used;

to adequately prevent future child deaths in the area.

(C) A county or regional strategy that should be implemented to prevent future child deaths.

(b) The data collection form developed under this section must be provided to the following:

(1) The appropriate community child protection team.

(2) The chairperson of the statewide child fatality review committee.

(3) The chairperson of a local child fatality review team.

(c) Each local child fatality review team shall, using the form established under this section, report to the state department the findings for each fatality that the local child fatality review team reviews.

(d) The state department shall annually prepare a report concerning all child fatalities in Indiana that are the result of child abuse or neglect. The report must include the following information:

(1) A summary of the information gathered under subsection (a) for all child fatalities resulting from abuse or neglect.

(2) Demographic information regarding victims, perpetrators, and households involved in child fatalities resulting from abuse or neglect.

(3) An analysis of the primary risk factors involved in child fatalities resulting from abuse or neglect.

(4) A summary of the most frequent causes of child fatalities resulting from abuse or neglect.

(5) A description of the manner in which the information was assembled.

The state department shall post the report prepared under this subsection to the state department's Internet web site.

Sec. 18. A local child fatality review team is subject to the confidentiality provisions of IC 31-33-18 applying to records held by the local child fatality review team.

SECTION 9. IC 16-19-17 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]:

Chapter 17. Statewide Child Fatality Review Committee

Sec. 1. As used in this chapter, "child" means an individual less than eighteen (18) years of age.

Sec. 2. As used in this chapter, "emergency medical services" means the provision of emergency ambulance services or other services, including extrication and rescue services, utilized in serving an individual's need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

Sec. 3. As used in this chapter, "local child fatality review team" has the meaning set forth in IC 16-19-16-4.

Sec. 4. As used in this chapter, "mental health provider" means any of the following:

(1) A registered nurse or licensed practical nurse licensed under IC 25-23.

(2) A clinical social worker licensed under IC 25-23.6-5.

(3) A marriage and family therapist licensed under IC 25-23.6-8.

(4) A psychologist licensed under IC 25-33.

(5) A school psychologist licensed by the Indiana state board of education.

Sec. 5. As used in this chapter, "statewide child fatality review committee" refers to the statewide child fatality review committee established by section 6 of this chapter.

Sec. 6. The statewide child fatality review committee is established to review every child's death that:

(1) occurs in Indiana; and

(2) is one (1) or more of the following:

(A) Sudden.

(B) Unexpected.

(C) Unexplained.

(D) Assessed by the department of child services for alleged abuse or neglect that resulted in the fatality.

(E) Determined by a coroner to be the result of a homicide, suicide, or accident.

Sec. 7. (a) A child fatality review conducted by the statewide child fatality review committee under this chapter must consist of:

(1) determining whether similar future deaths could be prevented; and

(2) identifying:

(A) agencies and entities that should be involved; and

(B) any other resources that should be used;

to adequately prevent future deaths of children.

(b) In conducting the child fatality review under subsection (a), the statewide child fatality review committee shall review every record concerning the deceased child that is held by:

(1) the department of child services; or

(2) a local child fatality review team.

(c) Subject to IC 34-30-15, if the statewide child fatality review committee requests records from a hospital, physician, coroner, law enforcement officer, or mental health professional regarding a death that the statewide child fatality review committee is investigating, the hospital, physician, coroner, law enforcement officer, or mental health professional shall provide the requested records to the statewide child fatality review committee.

Sec. 8. The statewide child fatality review committee consists of the following members appointed by the governor:

(1) a coroner or deputy coroner;

(2) a representative from:

(A) the state department;

(B) a local health department established under IC 16-20-2; or

(C) a multiple county health department established under IC 16-20-3;

(3) a pediatrician;

(4) a representative of law enforcement;
(5) a representative from an emergency medical services provider;
(6) the director or a representative of the department of child services;
(7) a representative of a prosecuting attorney;
(8) a pathologist who is:
(A) certified by the American Board of Pathology in forensic pathology; and
(B) licensed to practice medicine in Indiana;
(9) a mental health provider;
(10) a representative of a child abuse prevention program;
(11) a representative of the department of education; and
(12) at the discretion of the department of child services ombudsman, a representative of the office of department of child services ombudsman established by IC 4-13-19-3.

Sec. 9. (a) The chairperson of the statewide child fatality review committee shall be selected by the governor.

(b) The statewide child fatality review committee shall meet at the call of the chairperson.

(c) The statewide child fatality review committee chairperson shall determine the agenda for each meeting.

Sec. 10. (a) Except as provided in subsection (b), meetings of the statewide child fatality review committee are open to the public.

(b) Except as provided in subsection (d), a meeting of the statewide child fatality review committee that involves:
(1) confidential records; or
(2) identifying information regarding the death of a child that is confidential under state or federal law;
shall be held as an executive session.

(c) If a meeting is held as an executive session under subsection (b), each individual who:
(1) attends the meeting; and
(2) is not a member of the statewide child fatality review committee;
shall sign a confidentiality statement prepared by the state department. The statewide child fatality review committee shall keep all confidentiality statements signed under this subsection.

(d) A majority of the members of the statewide child fatality review committee may vote to disclose any report or part of a report regarding a fatality review to the public if disclosure of the information is in the general public interest as determined by the statewide child fatality review committee.

Sec. 11. Members of the statewide child fatality review committee and individuals who attend a meeting of the statewide child fatality review committee as invitees of the chairperson:

(1) may discuss among themselves confidential matters that are before the statewide child fatality review committee;

(2) are bound by all applicable laws regarding the confidentiality of matters reviewed by the statewide child fatality review committee; and

(3) except when acting:

(A) with malice;

(B) in bad faith; or

(C) with gross negligence;

are immune from any civil or criminal liability that might otherwise be imposed as a result of communicating among themselves about confidential matters that are before the statewide child fatality review committee.

Sec. 12. The state department shall provide training to the statewide child fatality review committee.

Sec. 13. (a) The state department shall collect and document information surrounding the deaths of children that are reviewed by the statewide child fatality review committee.

(b) The state department shall develop a data collection form that is designed to include, when completed, the following concerning the death of a child:

(1) Identifying and nonidentifying information.

(2) Information regarding the circumstances surrounding the death.

(3) Factors contributing to the death.

(4) Findings and recommendations.

(c) The data collection form developed under this section must be provided to:

(1) the appropriate community child protection team established under IC 31-33-3;

(2) the appropriate:

(A) local health department established under IC 16-20-2; or

(B) multiple county health department established under IC 16-20-3; and

(3) the appropriate coroner and the pathologist who performed the autopsy on the child.

Sec. 14. The affirmative votes of a majority of the voting members of the statewide child fatality review committee are required for the committee to take action on any measure.

Sec. 15. The expenses of the statewide child fatality review committee shall be paid from funds appropriated to the state department.

Sec. 16. The testimony of a member of the statewide child fatality review committee is not admissible as evidence concerning an investigation by the statewide child fatality review committee.

Sec. 17. (a) The statewide child fatality review committee shall submit a report to the legislative council and the state department on or before January 1 of each year that includes:

(1) the status of child fatalities reviewed by the statewide child fatality review committee in the previous year; and

(2) recommendations concerning actions or resources to prevent future child fatalities in Indiana.

A report submitted under this section to the legislative council must be in an electronic format under IC 5-14-6.

(b) The state department shall post the report described in subsection (a) on the state department's Internet website.

Sec. 18. The statewide child fatality review committee is subject to the confidentiality provisions of IC 31-33-18 applying to records held by the statewide child fatality review committee.

SECTION 10. IC 31-9-2-43.3 IS REPEALED [EFFECTIVE JULY 1, 2013]. ~~Sec. 43.3. "Emergency medical services", for purposes of IC 31-33-24, has the meaning set forth in IC 31-33-24-2.~~

~~(b) "Emergency medical services", for purposes of IC 31-33-25, has the meaning set forth in IC 31-33-25-2.~~

SECTION 11. IC 31-9-2-76.4 IS REPEALED [EFFECTIVE JULY 1, 2013]. ~~Sec. 76.4. (a) "Local child fatality review team", for purposes of IC 31-33-24, has the meaning set forth in IC 31-33-24-3.~~

~~(b) "Local child fatality review team", for purposes of IC 31-33-25, has the meaning set forth in IC 3133-25-3.~~

SECTION 12. IC 31-9-2-80.5 IS REPEALED [EFFECTIVE JULY 1, 2013]. ~~Sec. 80.5. (a) "Mental health provider", for purposes of IC 31-33-24, has the meaning set forth in IC 31-33-24-4.~~

~~(b) "Mental health provider", for purposes of IC 31-33-25, has the meaning set forth in IC 31-33-25-4.~~

SECTION 13. IC 31-9-2-121.5 IS REPEALED [EFFECTIVE JULY 1, 2013]. ~~Sec. 121.5. (a) "Statewide child fatality review committee", for purposes of IC 31-33-24, has the meaning set forth in IC 31-33-24-5.~~

~~(b) "Statewide child fatality review committee", for purposes of IC 31-33-25, has the meaning set forth in IC 31-33-25-5.~~

SECTION 14. IC 31-25-2-20.4, AS AMENDED BY P.L.128-2012, SECTION 88, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 20.4. (a) The department shall establish at least three (3) citizen review panels in accordance with the requirements of the federal Child Abuse Prevention and Treatment Act under 42 U.S.C. 5106a.

(b) A citizen review panel consists of volunteer members who broadly represent the community in which the panel is established, including members who have expertise in the prevention and treatment of child abuse and neglect.

(c) The department shall appoint the citizen review panels in the

following manner:

(1) One (1) panel must be a community child protection team established in a county under IC 31-33-3-1, selected by the director of the department with the consent of the team.

(2) One (1) panel must be either:

(A) the statewide child fatality review committee established under ~~IC 31-33-25-6;~~ **IC 16-19-17;** or

(B) a local child fatality review team established under ~~IC 31-33-24-6;~~ **IC 16-19-16;**

selected by the director of the department with the consent of the committee or team.

(3) One (1) panel must be a foster care advisory panel consisting of at least five (5) and not more than eleven (11) members, selected to the extent feasible from the membership of any foster care advisory group previously established or recognized by the department. If the panel consists of seven (7) or fewer members, the panel must include at least one (1) foster parent licensed by the department and one (1) foster parent licensed by the department through a child placing agency licensed under IC 31-27-6. If the panel consists of more than seven (7) members, the panel must include two (2) foster parents licensed by the department and two (2) foster parents licensed by the department through a child placing agency licensed under IC 31-27-6. Additional members of the panel must include one (1) or more individuals who are employed by a child placing agency licensed under IC 31-27-6 and who provide services to foster families and children placed by the department in out-of-home placements, and may include other representatives of child welfare service providers or persons who provide training to current or prospective foster parents. All members of this panel must be individuals who are not employees of the department.

(4) The membership of any additional citizen review panels established under this section shall be determined by the director of the department, consistent with the guidelines for panel membership stated in subsection (b) and the purposes and functions of the panels as described in this section.

(5) Each citizen review panel shall be appointed for a term of three (3) years beginning July 1, 2007. Upon expiration of the term of the panel described in subdivision (1), the director of the department shall select a community child protection team established in a different county for the succeeding term. Upon expiration of the term of the panel described in subdivision (2), the director of the department shall select a different fatality review team, or committee, if available, for the succeeding term. Panels appointed under subdivision (3) or (4) may be reappointed for successive terms, in the discretion of the director of the

department. The director may appoint individuals as needed to fill vacancies that occur during the term of any panel appointed under subdivision (3) or (4).

(d) A citizen review panel shall evaluate the extent to which a child welfare agency is effectively discharging the agency's child protection responsibilities by examining:

(1) the policies and procedures of child welfare agencies;

(2) if appropriate, specific child protective services cases; and

(3) other criteria the citizen review panel considers important to ensure the protection of children.

(e) Each citizen review panel shall:

(1) meet at least one (1) time every three (3) months; and

(2) prepare and make available to the department and the public an annual report that contains a summary of the activities of the citizen review panel.

(f) The department shall, not more than six (6) months after the date the department receives a report from a citizen review panel under subsection (e), submit to the citizen review panel a written response indicating whether and how the department will incorporate the recommendations of the citizen review panel. The department shall at the same time provide appropriate child welfare agencies with copies of the department's written response.

(g) A child welfare agency shall make all reports and other materials in the child welfare agency's possession available to a citizen review panel established under this section, including any reports and materials that the child welfare agency has received from other agencies.

(h) A member of a citizen review panel may not disclose to a person or government official any identifying information that is provided to the citizen review panel about:

(1) a specific child protective services case or child welfare agency case;

(2) a child or member of the child's family who is the subject of a child protective services assessment; or

(3) any other individuals identified in confidential reports, documents, or other materials.

(i) If a member of a citizen review panel violates subsection (h), the department may remove the member from the citizen review panel.

(j) A child welfare agency shall cooperate and work with each citizen review panel established under this section.

SECTION 15. IC 31-33-18-1, AS AMENDED BY P.L.128-2012, SECTION 153, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 1. (a) Except as provided in section 1.5 of this chapter, the following are confidential:

(1) Reports made under this article (or IC 31-6-11 before its repeal).

(2) Any other information obtained, reports written, or photographs taken concerning the reports in the possession of:
(A) the division of family resources;
(B) the local office;
(C) the department; or
(D) the department of child services ombudsman established by IC 4-13-19-3.

(b) Except as provided in section 1.5 of this chapter, all records held by:
(1) the division of family resources;
(2) a local office;
(3) the department;
(4) a local child fatality review team established under ~~IC 31-33-24;~~ **IC 16-19-16;**
(5) the statewide child fatality review committee established under ~~IC 31-33-25;~~ **IC 16-19-17;** or
(6) the department of child services ombudsman established by IC 4-13-19-3;
regarding the death of a child determined to be a result of abuse, abandonment, or neglect are confidential and may not be disclosed.

SECTION 16. IC 31-33-18-1.5, AS AMENDED BY P.L.128-2012, SECTION 154, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 1.5. (a) This section applies to records held by:
(1) a local office;
(2) the department;
(3) a local child fatality review team established under ~~IC 31-33-24;~~ **IC 16-19-16;**
(4) the statewide child fatality review committee established under ~~IC 31-33-25;~~ **IC 16-19-17;** or
(5) the department of child services ombudsman established by IC 4-13-19-3;
regarding a child whose death or near fatality may have been the result of abuse, abandonment, or neglect.

(b) For purposes of subsection (a), a child's death or near fatality may have been the result of abuse, abandonment, or neglect if:
(1) an entity described in subsection (a) determines that the child's death or near fatality is the result of abuse, abandonment, or neglect; or
(2) a prosecuting attorney files:
(A) an indictment or information; or
(B) a complaint alleging the commission of a delinquent act;
that, if proven, would cause a reasonable person to believe that the child's death or near fatality may have been the result of abuse, abandonment, or neglect.
Upon the request of any person, or upon its own motion, the court

exercising juvenile jurisdiction in the county in which the child's death or near fatality occurred shall determine whether the allegations contained in the indictment, information, or complaint described in subdivision (2), if proven, would cause a reasonable person to believe that the child's death or near fatality may have been the result of abuse, abandonment, or neglect.

(c) If the juvenile court finds that the child's death or near fatality was the result of abuse, abandonment, or neglect, the court shall make written findings and provide a copy of the findings and the indictment, information, or complaint described under subsection (b)(2) to the department.

(d) As used in this section:

(1) "case" means:

(A) any intake report generated by the department;

(B) any investigation or assessment conducted by the department; or

(C) ongoing involvement between the department and a child or family that is the result of:

(i) a program of informal adjustment; or

(ii) a child in need of services action;

for which related records and documents have not been expunged as required by law or by a court at the time the department is notified of a fatality or near fatality;

(2) "contact" means in person communication about a case in which:

(A) the child who is the victim of a fatality or near fatality is alleged to be a victim; or

(B) the perpetrator of the fatality or near fatality is alleged to be the perpetrator;

(3) "identifying information" means information that identifies an individual, including an individual's:

(A) name, address, date of birth, occupation, place of employment, and telephone number;

(B) employer identification number, mother's maiden name, Social Security number, or any identification number issued by a governmental entity;

(C) unique biometric data, including the individual's fingerprint, voice print, or retina or iris image;

(D) unique electronic identification number, address, or routing code;

(E) telecommunication identifying information; or

(F) telecommunication access device, including a card, a plate, a code, an account number, a personal identification number, an electronic serial number, a mobile identification number, or another telecommunications service or device or means of account access; and

(4) "near fatality" has the meaning set forth in 42 U.S.C. 5106a.

(e) Unless information in a record is otherwise confidential under state or federal law, a record described in subsection (a) that has been redacted in accordance with this section is not confidential and may be disclosed to any person who requests the record. The person requesting the record may be required to pay the reasonable expenses of copying the record.

(f) When a person requests a record described in subsection (a), the entity having control of the record shall immediately transmit a copy of the record to the court exercising juvenile jurisdiction in the county in which the death or near fatality of the child occurred. However, if the court requests that the entity having control of a record transmit the original record, the entity shall transmit the original record.

(g) Upon receipt of the record described in subsection (a), the court shall, within thirty (30) days, redact the record to exclude:

(1) identifying information described in subsection (d)(3)(B) through (d)(3)(F) of a person; and

(2) all identifying information of a child less than eighteen (18) years of age.

(h) The court shall disclose the record redacted in accordance with subsection (g) to any person who requests the record, if the person has paid:

(1) to the entity having control of the record, the reasonable expenses of copying under IC 5-14-3-8; and

(2) to the court, the reasonable expenses of copying the record.

(i) The data and information in a record disclosed under this section must include the following:

(1) A summary of the report of abuse or neglect and a factual description of the contents of the report.

(2) The date of birth and gender of the child.

(3) The cause of the fatality or near fatality, if the cause has been determined.

(4) Whether the department had any contact with the child or the perpetrator before the fatality or near fatality, and, if the department had contact, the following:

(A) The frequency of the contact with the child or the perpetrator before the fatality or near fatality and the date on which the last contact occurred before the fatality or near fatality.

(B) A summary of the status of the child's case at the time of the fatality or near fatality, including:

(i) whether the child's case was closed by the department before the fatality or near fatality; and

(ii) if the child's case was closed as described under item (i), the date of closure and the reasons that the case was closed.

(j) The court's determination under subsection (g) that certain

identifying information or other information is not relevant to establishing the facts and circumstances leading to the death or near fatality of a child is not admissible in a criminal proceeding or civil action.

SECTION 17. IC 31-33-18-2, AS AMENDED BY P.L.48-2012, SECTION 39, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 2. The reports and other material described in section 1(a) of this chapter and the unredacted reports and other material described in section 1(b) of this chapter shall be made available only to the following:

(1) Persons authorized by this article.

(2) A legally mandated public or private child protective agency investigating a report of child abuse or neglect or treating a child or family that is the subject of a report or record.

(3) A police or other law enforcement agency, prosecuting attorney, or coroner in the case of the death of a child who is investigating a report of a child who may be a victim of child abuse or neglect.

(4) A physician who has before the physician a child whom the physician reasonably suspects may be a victim of child abuse or neglect.

(5) An individual legally authorized to place a child in protective custody if:

(A) the individual has before the individual a child whom the individual reasonably suspects may be a victim of abuse or neglect; and

(B) the individual requires the information in the report or record to determine whether to place the child in protective custody.

(6) An agency having the legal responsibility or authorization to care for, treat, or supervise a child who is the subject of a report or record or a parent, guardian, custodian, or other person who is responsible for the child's welfare.

(7) An individual named in the report or record who is alleged to be abused or neglected or, if the individual named in the report is a child or is otherwise incompetent, the individual's guardian ad litem or the individual's court appointed special advocate, or both.

(8) Each parent, guardian, custodian, or other person responsible for the welfare of a child named in a report or record and an attorney of the person described under this subdivision, with protection for the identity of reporters and other appropriate individuals.

(9) A court, for redaction of the record in accordance with section 1.5 of this chapter, or upon the court's finding that access to the records may be necessary for determination of an issue before the court. However, except for disclosure of a redacted record in

accordance with section 1.5 of this chapter, access is limited to in camera inspection unless the court determines that public disclosure of the information contained in the records is necessary for the resolution of an issue then pending before the court.

(10) A grand jury upon the grand jury's determination that access to the records is necessary in the conduct of the grand jury's official business.

(11) An appropriate state or local official responsible for child protection services or legislation carrying out the official's official functions.

(12) A foster care review board established by a juvenile court under IC 31-34-21-9 (or IC 31-6-4-19 before its repeal) upon the court's determination that access to the records is necessary to enable the foster care review board to carry out the board's purpose under IC 31-34-21.

(13) The community child protection team appointed under IC 31-33-3 (or IC 31-6-11-14 before its repeal), upon request, to enable the team to carry out the team's purpose under IC 31-33-3.

(14) A person about whom a report has been made, with protection for the identity of:

(A) any person reporting known or suspected child abuse or neglect; and

(B) any other person if the person or agency making the information available finds that disclosure of the information would be likely to endanger the life or safety of the person.

(15) An employee of the department, a caseworker, or a juvenile probation officer conducting a criminal history check under IC 31-26-5, IC 31-34, or IC 31-37 to determine the appropriateness of an out-of-home placement for a:

(A) child at imminent risk of placement;

(B) child in need of services; or

(C) delinquent child.

The results of a criminal history check conducted under this subdivision must be disclosed to a court determining the placement of a child described in clauses (A) through (C).

(16) A local child fatality review team established under ~~IC 31-33-24-6.~~ **IC 16-19-16.**

(17) The statewide child fatality review committee established by ~~IC 31-33-25-6.~~ **IC 16-19-17.**

(18) The department.

(19) The division of family resources, if the investigation report:

(A) is classified as substantiated; and

(B) concerns:

(i) an applicant for a license to operate;

(ii) a person licensed to operate;

(iii) an employee of; or

(iv) a volunteer providing services at;
a child care center licensed under IC 12-17.2-4 or a child care home licensed under IC 12-17.2-5.
(20) A citizen review panel established under IC 31-25-2-20.4.
(21) The department of child services ombudsman established by IC 4-13-19-3.
(22) The state superintendent of public instruction with protection for the identity of:
(A) any person reporting known or suspected child abuse or neglect; and
(B) any other person if the person or agency making the information available finds that disclosure of the information would be likely to endanger the life or safety of the person.
(23) The state department of health.

SECTION 18. IC 31-33-24 IS REPEALED [EFFECTIVE JULY 1, 2013]. (Child Fatality Review Teams).

SECTION 19. IC 31-33-25 IS REPEALED [EFFECTIVE JULY 1, 2013]. (Statewide Child Fatality Review Committee).

SECTION 20. IC 34-30-2-64.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 64.2. IC 16-19-16-15 (Concerning a member of a local child fatality review team or an individual who attends a meeting of a local child fatality review team as an invitee of the chairperson).**

SECTION 21. IC 34-30-2-64.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 64.5. IC 16-19-17-11 (Concerning a member of the statewide child fatality review committee or an individual who attends a meeting of the statewide child fatality review committee as an invitee of the chairperson).**

SECTION 22. IC 34-30-2-134.3 IS REPEALED [EFFECTIVE JULY 1, 2013]. ~~Sec. 134.3. IC 31-33-24-12 (Concerning a member of a local child fatality review team or a person who attends a meeting of a local child fatality review team as an invitee of the chairperson).~~

SECTION 23. IC 34-30-2-134.6 IS REPEALED [EFFECTIVE JULY 1, 2013]. ~~Sec. 134.6. IC 31-33-25-11 (Concerning a member of the statewide child fatality review committee or a person who attends a meeting of the statewide child fatality review committee as an invitee of the chairperson).~~

SECTION 24. IC 36-2-14-6.3, AS AMENDED BY P.L.128-2012, SECTION 183, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 6.3. (a) A coroner shall immediately notify:
(1) the local office of the department of child services by using the statewide hotline for the department; and
(2) ~~either:~~ **both the:**

(A) ~~the~~ local child fatality review team; ~~or~~ **and**

(B) ~~if the county does not have a local child fatality review team;~~ ~~the~~ statewide child fatality review committee;

of each death of a person who is less than eighteen (18) years of age, or appears to be less than eighteen (18) years of age and who has died in an apparently suspicious, unexpected, or unexplained manner.

(b) If a child less than eighteen (18) years of age dies in an apparently suspicious, unexpected, or unexplained manner, the coroner shall consult with a child death pathologist to determine whether an autopsy is necessary. If the coroner and the child death pathologist disagree over the need for an autopsy, the county prosecutor shall determine whether an autopsy is necessary. If the autopsy is considered necessary, a child death pathologist or a pathology resident acting under the direct supervision of a child death pathologist shall conduct the autopsy within twenty-four (24) hours. If the autopsy is not considered necessary, the autopsy shall not be conducted.

(c) If a child death pathologist and coroner agree under subsection (b) that an autopsy is necessary, the child death pathologist or a pathology resident acting under the direct supervision of a child death pathologist shall conduct the autopsy of the child.

SECTION 25. IC 36-2-14-6.7, AS ADDED BY P.L.225-2007, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 6.7. (a) This section applies to a child who:

(1) died suddenly and unexpectedly;

(2) was less than three (3) years of age at the time of death; and

(3) was in apparent good health before dying.

(b) A child death pathologist or a pathology resident acting under the direct supervision of a child death pathologist shall conduct an autopsy of a child described in subsection (a).

(c) A county coroner may not certify the cause of death of a child described in subsection (a) until an autopsy is performed at county expense.

(d) The county coroner shall contact the parent or guardian of a child described in subsection (a) and notify the parent or guardian that an autopsy will be conducted at county expense.

(e) The child death pathologist shall:

(1) ensure that a tangible summary of the autopsy results is provided;

(2) provide informational material concerning sudden infant death syndrome; and

(3) unless the release of autopsy results would jeopardize a law enforcement investigation, provide notice that a parent or guardian has the right to receive the preliminary autopsy results;

to the parents or guardian of the child within one (1) week after the autopsy.

(f) If a parent or guardian of a child described in subsection (a)

requests the autopsy report of the child, the coroner shall provide the autopsy report to the parent or guardian within thirty (30) days after the:

(1) request; or

(2) completion of the autopsy report;

whichever is later, at no cost.

(g) A coroner shall notify:

(1) a local child fatality review team; ~~or~~ **and**

(2) ~~if the county does not have a local child fatality review team,~~ the statewide child fatality review committee;

of the death of a child described in subsection (a).

SECTION 26. IC 36-2-14-18, AS AMENDED BY P.L.3-2008, SECTION 257, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: Sec. 18. (a) Notwithstanding IC 5-14-3-4(b)(1), when a coroner investigates a death, the office of the coroner is required to make available for public inspection and copying the following:

(1) The name, age, address, sex, and race of the deceased.

(2) The address where the dead body was found, or if there is no address the location where the dead body was found and, if different, the address where the death occurred, or if there is no address the location where the death occurred.

(3) The name of the agency to which the death was reported and the name of the person reporting the death.

(4) The name of any public official or governmental employee present at the scene of the death and the name of the person certifying or pronouncing the death.

(5) Information regarding an autopsy (requested or performed) limited to the date, the person who performed the autopsy, where the autopsy was performed, and a conclusion as to:

(A) the probable cause of death;

(B) the probable manner of death; and

(C) the probable mechanism of death.

(6) The location to which the body was removed, the person determining the location to which the body was removed, and the authority under which the decision to remove the body was made.

(7) The records required to be filed by a coroner under section 6 of this chapter and the verdict and the written report required under section 10 of this chapter.

(b) A county coroner or a coroner's deputy who receives an investigatory record from a law enforcement agency shall treat the investigatory record with the same confidentiality as the law enforcement agency would treat the investigatory record.

(c) Notwithstanding any other provision of this section, a coroner shall make available a full copy of an autopsy report, other than a photograph, a video recording, or an audio recording of the autopsy,

upon the written request of a parent of the decedent, an adult child of the decedent, a next of kin of the decedent, or an insurance company investigating a claim arising from the death of the individual upon whom the autopsy was performed. A parent of the decedent, an adult child of the decedent, a next of kin of the decedent, and an insurance company are prohibited from publicly disclosing any information contained in the report beyond that information that may otherwise be disclosed by a coroner under this section. This prohibition does not apply to information disclosed in communications in conjunction with the investigation, settlement, or payment of the claim.

(d) Notwithstanding any other provision of this section, a coroner shall make available a full copy of an autopsy report, other than a photograph, a video recording, or an audio recording of the autopsy, upon the written request of:

(1) the director of the division of disability and rehabilitative services established by IC 12-9-1-1;

(2) the director of the division of mental health and addiction established by IC 12-21-1-1; or

(3) the director of the division of aging established by IC 12-9.1-1-1;

in connection with a division's review of the circumstances surrounding the death of an individual who received services from a division or through a division at the time of the individual's death.

(e) Notwithstanding any other provision of this section, a coroner shall make available, upon written request, a full copy of an autopsy report, including a photograph, a video recording, or an audio recording of the autopsy, to:

(1) the department of child services established by IC 31-25-1-1, including an office of the department located in the county where the death occurred;

(2) the statewide child fatality review committee established by ~~IC 31-33-25-6;~~ **IC 16-19-17;** or

(3) a county child fatality review team or regional child fatality review team established under ~~IC 31-33-24-6~~ **IC 16-19-16** by the county or for the county where the death occurred;

for purposes of an entity described in subdivisions (1) through (3) conducting a review or an investigation of the circumstances surrounding the death of a child (as defined in IC 31-9-2-13(d)(1)) and making a determination as to whether the death of the child was a result of abuse, abandonment, or neglect. An autopsy report made available under this subsection is confidential and shall not be disclosed to another individual or agency, unless otherwise authorized or required by law.

(f) Except as provided in subsection (g), the information required to be available under subsection (a) must be completed not later than fourteen (14) days after the completion of:

(1) the autopsy report; or

(2) if applicable, any other report, including a toxicology report, requested by the coroner as part of the coroner's investigation;

whichever is completed last.

(g) The prosecuting attorney may petition a circuit or superior court for an order prohibiting the coroner from publicly disclosing the information required in subsection (a). The prosecuting attorney shall serve a copy of the petition on the coroner.

(h) Upon receipt of a copy of the petition described in subsection (g), the coroner shall keep the information confidential until the court rules on the petition.

(i) The court shall grant a petition filed under subsection (g) if the prosecuting attorney proves by a preponderance of the evidence that public access or dissemination of the information specified in subsection (a) would create a significant risk of harm to the criminal investigation of the death. The court shall state in the order the reasons for granting or denying the petition. An order issued under this subsection must use the least restrictive means and duration possible when restricting access to the information. Information to which access is restricted under this subsection is confidential.

(j) Any person may petition the court to modify or terminate an order issued under subsection (i). The petition for modification or termination must allege facts demonstrating that:

(1) the public interest will be served by allowing access; and

(2) access to the information specified in subsection (a) would not create a significant risk to the criminal investigation of the death.

The person petitioning the court for modification or termination shall serve a copy of the petition on the prosecuting attorney and the coroner.

(k) Upon receipt of a petition for modification or termination filed under subsection (j), the court may:

(1) summarily grant, modify, or dismiss the petition; or

(2) set the matter for hearing.

If the court sets the matter for hearing, upon the motion of any party or upon the court's own motion, the court may close the hearing to the public.

(l) If the person filing the petition for modification or termination proves by a preponderance of the evidence that:

(1) the public interest will be served by allowing access; and

(2) access to the information specified in subsection (a) would not create a significant risk to the criminal investigation of the death;

the court shall modify or terminate its order restricting access to the information. In ruling on a request under this subsection, the court shall state the court's reasons for granting or denying the request.

CSIC
November 27, 2012
Attachment 3.

PRELIMINARY DRAFT
No. 3592

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2013 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 2-5-36.

Synopsis: Commission on improving the status of children. Establishes the commission on improving the status of children in Indiana (commission). Requires certain departments, agencies, and boards to submit an annual report concerning the status of children to the commission by June 30 of each year and to submit any other reports and information requested by the commission. Allows the commission to request from other state agencies information and reports regarding matters related to children.

Effective: July 1, 2013.

children.

(4) Review and monitor progress on the implementation of laws, programs, and services provided by state agencies, organizations, and offices that affect children.

(5) Make recommendations regarding the commission's findings to the appropriate state agencies, including legislative committees and commissions that affect children.

(6) Review annually state rankings and outcomes concerning the status of children, including rankings on:

(A) academic success;

(B) early childhood education;

(C) childhood poverty and hunger;

(D) health;

(E) school suspensions, expulsions, and school based arrests;

(F) school drop outs;

(G) access to behavioral health care;

(H) child abuse and neglect;

(I) out-of-home placements;

(J) confinement in detention facilities and department of correction facilities;

(K) immunizations; and

(L) infant mortality rates.

(7) Track the progress made toward improving the rankings and outcomes described in subdivision (6).

(8) Cooperate with other child related commissions, the judiciary, the executive branch of state government, stakeholders, and members of the community to develop long term plans that promote progress in areas of priority for the advancement of children.

Sec. 10. The legislative services agency shall provide staff support to the commission.

Sec. 11. The commission may appoint a study group comprised of commission members, legislators, and other individuals who have an interest in children's issues to study specific issues relating to children.

Sec. 12. (a) The following shall submit an annual report that includes the information described in subsection (b) to the commission by June 30 of each year, and shall submit any other reports and information requested by the commission:

(1) The department of education.

(2) The department of correction.

(3) The criminal justice institute.

(4) The division of mental health and addiction.

(5) The department of child services.

(6) The office of Medicaid policy and planning.

(7) The department of health.

(8) The board for the coordination of programs serving vulnerable individuals created by IC 4-23-30.2-8.

(b) Each state agency listed under subsection (a) shall include in the state agency's report under subsection (a) the following information as it relates to the state agency:

(1) The status of children.

(2) The state rankings and outcomes concerning the status of children, as described in section 9(6) of this chapter.

(3) The measures taken to improve the status of children.

(4) Any plans established to improve the status of children.

(c) The commission may request information and reports regarding matters related to children from a state agency not listed in subsection (a).

CSIC
November 27, 2012
Attachment 4.

Estimated Cost of Hotline Modificatio[illegible]

1. Reduce Turnover at Hotline

- Proposal: Add 50 Intake Specialists to the Hotline. This will decrease hold time and allow for more flexibility at the hotline with staff. It will address concerns related to working late, not being able to take sick days without a doctor's note, and only getting a 30 min lunch.
- Additional Staff required: 60 staff
  - 50 FCM Intake Specialists
  - 10 FCM Supervisors
- Total annual costs (staff and space)- $3,431,408
- Total one time technology costs- $102,000

2. Assess all reports from professional report sources.

- Proposal: All reports received by professional report sources would be assessed. Professional report sources include hospital, community mental health center, managed care provider, referring physician, dentist, licensed psychologist, school, licensed child caring institution, licensed group home, secure private facility and licensed child placing agency (IC 31-33-7-8). This would result in approximately 15,000 more assessments every year.
- Additional staff required: 96 staff
  - 80 new Family Case Managers.
  - 16 new Family Case Manager Supervisors.
- Total annual costs (staff and space)- $5,490,253

3. Localize Hotline for professional reporters

- Proposal: Local FCM Intake Specialists would be assigned to each of the 18 DCS regions to receive professional reporter calls from 8am to 11pm (2 shifts) and between 11pm and 8am all calls would be routed to the Hotline. The centralized hotline would continue operating 24/7 for all non-professional report sources. The 8am to 11pm time period covers 90% of the calls received daily.
- Additional staff required: 345 staff
  - 288 new Family Case Managers
  - 57 FCM Supervisors
- Total annual costs (staff and space)- $19,722,527
- Total one time technology costs- $586,500

CSIC
November 27, 2012
Attachment 5.

PRELIMINARY DRAFT
No. 3586

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2013 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 29-3-2-7; IC 31-14; IC 31-17-2-26.

Synopsis: Petitions to modify custody and visitation. Provides that if a person files a petition to modify a guardianship, visitation, or child custody, the person shall state whether the person has been the subject of a department of child services (DCS) investigation, whether the child has been the subject of a DCS investigation, or if the child has been determined to be a child in need of services.

Effective: July 1, 2013.

A BILL FOR AN ACT to amend the Indiana Code concerning family law and juvenile law.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 29-3-2-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 7. (a) A person who files a petition to modify a guardianship of a person less than eighteen (18) years of age must set forth in the petition whether:**

(1) the person filing the petition or the person under the guardianship has been investigated by the department of child services; and

(2) the person under the guardianship has been determined to be a child in need of services under IC 31-34.

(b) If a person has been the subject of an investigation as described in subsection (a)(1), the petition must set forth:

(1) when the investigation occurred; and

(2) the results of the investigation.

(c) If the person under the guardianship has been determined to be a child in need of services as described in subsection (a)(2), the petition must set forth:

(1) the date of the child in need of services determination;

(2) the court that determined the child in need of services determination;

(3) under which statute the court determined the child to be a child in need of services; and

(4) whether the person is a child in need of services at the time of the filing of the petition.

(d) A court reviewing a petition to modify a guardianship may request information regarding the department of child services case or the child in need of services case of the person filing the petition or the person under the guardianship. The department shall answer the court's request for information not later than ten (10) days after the court requests the information.

SECTION 2. IC 31-14-13-12 IS ADDED TO THE INDIANA

CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 12. (a) A parent who files a petition to modify the custody of a child or parenting time with a child must set forth in the petition whether:**

(1) the person filing the petition or the child has been investigated by the department of child services; and

(2) the child has been determined to be a child in need of services under IC 31-34.

(b) If a person has been the subject of an investigation as described in subsection (a)(1), the petition must set forth:

(1) when the investigation occurred; and

(2) the results of the investigation.

(c) If the child has been determined to be a child in need of services as described in subsection (a)(2), the petition must set forth:

(1) the date of the child in need of services determination;

(2) the court that determined the child in need of services determination;

(3) under which statute the court determined the child to be a child in need of services; and

(4) whether the person is a child in need of services at the time of the filing of the petition.

(d) A court reviewing a petition to modify the custody of a child or parenting time with a child may request information regarding the department of child services case or the child in need of services case of the person filing the petition or the child. The department shall answer the court's request for information not later than ten (10) days after the court requests the information.

SECTION 3. IC 31-14-14-6 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 6. (a) A parent who files a petition to modify parenting time must set forth in the petition whether:**

(1) the person filing the petition or the child has been investigated by the department of child services; and

(2) the child has been determined to be a child in need of services under IC 31-34.

(b) If a person has been the subject of an investigation as described in subsection (a)(1), the petition must set forth:

(1) when the investigation occurred; and

(2) the results of the investigation.

(c) If the child has been determined to be a child in need of services as described in subsection (a)(2), the petition must set forth:

(1) the date of the child in need of services determination;

(2) the court that determined the child in need of services determination;

(3) under which statute the court determined the child to be a child in need of services; and

(4) whether the person is a child in need of services at the time of the filing of the petition.

(d) A court reviewing a petition to modify parenting time may request information regarding the department of child services case or the child in need of services case of the person filing the petition or the child. The department shall answer the court's request for information not later than ten (10) days after the court requests the information.

SECTION 4. IC 31-17-2-26 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2013]: **Sec. 26. (a) A parent who files a petition to modify custody of a child must set forth in the petition whether:**

(1) the person filing the petition or the child has been investigated by the department of child services; and

(2) the child has been determined to be a child in need of services under IC 31-34.

(b) If a person has been the subject of an investigation as described in subsection (a)(1), the petition must set forth:

(1) when the investigation occurred; and

(2) the results of the investigation.

(c) If the child has been determined to be a child in need of services as described in subsection (a)(2), the petition must set forth:

(1) the date of the child in need of services determination;

(2) the court that determined the child in need of services determination;

(3) under which statute the court determined the child to be a child in need of services; and

(4) whether the person is a child in need of services at the time of the filing of the petition.

(d) A court reviewing a petition to modify custody of a child may request information regarding the department of child services case or the child in need of services case of the person filing the petition or the child. The department shall answer the court's request for information not later than ten (10) days after the court requests the information.

CSIC
November 27, 2012
Attachment 6.

PRELIMINARY DRAFT
No. 3325

PREPARED BY
LEGISLATIVE SERVICES AGENCY
2013 GENERAL ASSEMBLY

DIGEST

Citations Affected: IC 31-34-9-1.

Synopsis: Authorization of prosecuting attorney to file CHINS petition. Allows a prosecuting attorney to request a juvenile court to authorize the filing of a petition alleging that a child is a child in need of services in certain circumstances and to represent the interests of the state in the child in need of services proceeding. Provides that the provisions expire on June 30, 2015.

Effective: July 1, 2013.

A BILL FOR AN ACT to amend the Indiana Code concerning family law and juvenile law.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 31-34-9-1, AS AMENDED BY P.L.146-2008,
2 SECTION 588, IS AMENDED TO READ AS FOLLOWS
3 [EFFECTIVE JULY 1, 2013]: Sec. 1. **(a)** The attorney for the
4 department:
5 (1) may request the juvenile court to authorize the filing of a
6 petition alleging that a child is a child in need of services; and
7 (2) shall represent the interests of the state at this proceeding and
8 at all subsequent proceedings on the petition.
9 **(b) A prosecuting attorney:**
10 **(1) may request the juvenile court to authorize the filing of a**
11 **petition alleging that a child is a child in need of services**
12 **under IC 31-34-1-6; and**
13 **(2) shall represent the interests of the state at this proceeding**
14 **and at all subsequent proceedings on the petition.**
15 **(c) Subsection (b) expires June 30, 2015.**

FINAL REPORT

Department of Child Services Interim Study Committee

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

In 2012, the Indiana General Assembly enacted legislation directing the Committee to do the following before its expiration on December 31, 2013:

(1) Review and study the progress and improvements made by the department of child services (DCS) since its creation by Executive Order in 2005.
(2) Review best practices concerning child welfare, child mental health, and delinquent children.
(3) Receive and review status reports from the department of child services ombudsman.
(4) Review and study the department of child services child abuse and neglect hotline, including the process used to refer a report to a local office.
(5) Make legislative recommendations concerning the department of child services.

The Legislative Council assigned the following additional responsibilities to the Committee:

(1) Conduct a study of the laws relating to:
- (a) DCS procedures;
- (b) funding of DCS;
- (c) funding for the placement of children;
- (d) DCS personnel issues;
- (e) children in need of services;
- (f) child support;
- (g) procedures concerning the determination of placements of children inside and outside Indiana;
- (h) homeless children;
- (i) the youth service bureau;
- (j) child welfare programs;
- (k) family preservation services;
- (l) the regulation of residential child care;
- (m) termination of parent-child relationships;
- (n) missing children; and
- (o) the DCS ombudsman.

(2) Study federal requirements or incentives for states to pass certain laws or establish specific programs.
(3) Determine the long range needs of DCS and recommend policy priorities.
(4) Identify critical problems in DCS and recommend strategies to solve the problems.
(5) Propose plans, programs, and legislation for improving the effectiveness of DCS.

(6) How it is determined whether a family and/or child is eligible for services by DCS.
(7) The wrap-around services available to families involved in DCS proceedings.
(8) The follow-up provided by DCS staff to determine whether services were provided and the adequacy of those services.
(9) The communication between family court and DCS to collaborate on families' involvement in each entity.

II. INTRODUCTION AND REASONS FOR STUDY

Current Indiana law establishing the DCS was enacted in 2006. The law has been amended each subsequent year.

III. SUMMARY OF WORK PROGRAM

The Committee met six times during the 2012 Interim.

Meeting 1 - August 22, 2012

The Committee was provided information by DCS personnel concerning the following:
(1) Progress and improvements made by DCS since its creation.
(2) DCS personnel issues, including staff training and turnover.
(3) Funding of DCS, including services provided.
(4) Progression of a child in need of services case.
(5) The centralized DCS child abuse and neglect call center.

Meeting 2 - September 5, 2012

The Committee received the following information:
(1) Status report from the DCS Ombudsman.
(2) Public testimony concerning the centralized DCS child abuse and neglect call center.

Meeting 3 - September 24, 2012

The Committee heard testimony concerning the following:
(1) Resignation of the Executive Director of DCS.
(2) Suggestions for addressing issues identified during the September 5, 2012, meeting of the Committee concerning the centralized DCS child abuse and neglect call center.
(3) DCS provider issues.

Meeting 4 - October 11, 2012

The Committee heard testimony concerning the following:

(1) The work of the Attorney General in connection with DCS cases.
(2) Best practices of agencies and others serving children in need of services due to abuse or neglect.
(3) Suggestions for addressing issues identified by those testifying and by the members during the interim, for discussion on November 8, 2012.
(4) Follow up information concerning DCS issues raised during the previous meetings.

Meeting 5 - November 8, 2012

The Committee did the following:

(1) Received follow up information concerning DCS issues raised during previous meetings.
(2) Received additional information concerning best practices.
(3) Considered and discussed a list of 40 issues (and possible solutions to those issues) raised during the 2012 Interim.

Meeting 6 - November 27, 2012

The Committee considered the following:

(1) Proposed legislation for introduction during the 2013 session of the General Assembly.
(2) The Committee's final report for the 2012 Interim.

IV. SUMMARY OF TESTIMONY

The Committee heard testimony from representatives of the following groups:

(1) Alliance for Children and Families.
(2) Ball State University.
(3) Bedford Police Department.
(4) Casey Family Programs.
(5) Chaucie's Place.
(6) Child and Parent Services.
(7) Children's Coalition.
(8) Child Welfare Policy and Practice Group.
(9) Damar Services
(10) DCS.
(11) DCS Ombudsman Office.
(12) DCS personnel.
(13) Family Advocacy Group.

(14) Family members of children who have been the subject of DCS child abuse and neglect reports.
(15) Former DCS personnel.
(16) Foster families.
(17) IARCCA.
(18) Indiana Attorney General.
(19) Indiana Association of United Ways.
(20) Indiana Coalition of Family Based Services.
(21) Indiana Council of Community Mental Health Centers.
(22) Indiana Juvenile Justice Task Force, Inc.
(23) Indiana Juvenile Mental Health Screening, Assessment, and Treatment Project.
(24) Indiana University School of Social Work.
(25) Individual interested parties.
(26) National Alliance on Mental Illness.
(27) Pathways Youth Shelter and Family Services.
(28) Public Consulting Group.
(29) Safe Families.
(30) Social Workers.
(31) United Methodist Youth Home.
(32) Villages of Indiana.
(33) Wabash Valley Alliance.
(34) Youth Villages.

The Chairpersons of the Committee organized the responsibilities of the Committee into the following four categories:

(1) History and updates from DCS.
(2) Centralized child abuse and neglect call center.
(3) Service provider issues.
(4) Best practices.

History and Updates from DCS

The Committee heard testimony concerning the history, progress, and changes to DCS since its creation, including the following:

(1) Procedures and policies.
(2) Funding.
(3) Centralized call center.
(4) Personnel issues.
(5) The child welfare caseworker practice model.
(6) Child in need of services case progression.
(7) Data related to DCS performance.

(8) Interaction between DCS and the juvenile courts.

The DCS Ombudsman reported on the activities of the Ombudsman Office.

Centralized Child Abuse and Neglect Call Center

The Committee heard testimony and discussed the centralized call center, including the following:

(1) Call center procedures and development.
(2) Personnel issues and activities of intake employees.
(3) Call waiting times and reporting experiences of callers and call center employees.
(4) Direct reporting to local DCS offices versus reporting to the centralized call center.
(5) Determinations about whether a report is investigated or "screened out", and reviews of the determinations.
(6) Effect of local knowledge and cultural differences throughout Indiana on evaluation of reports.
(7) Concerns about retribution by DCS personnel related to disagreement with DCS actions with respect to children.
(8) Experience serving as a guardian ad litem (Indiana and Illinois).

Service Provider Issues

The Committee heard testimony and discussed service provider issues, including the following:

(1) Reports of intimidation of providers by DCS personnel related to complaints made by providers concerning DCS actions.
(2) Placement determinations.
(3) Shelter care.
(4) DCS priority of placing children with relatives.
(5) Payment rates and time frame for payments to providers.
(6) Administration of the Child and Adolescent Needs and Strength assessment.
(7) Use of outcomes and evidence based practices related to choice of provider.
(8) DCS procedures for work with homeless children and delinquency prevention work of the Youth Services Bureaus.
(9) Care and placement of children in need of services who are described in IC 31-34-1-6.
(10) Child welfare funding changes.
(11) Inclusion of provider comment in DCS policy and procedure adoption.
(12) Concerns about DCS procedures in connection with home visits and final placement decisions.
(13) Effect of DCS placement policies on residential and foster care providers

and availability of needed services.
(14) Consideration of evidence based practices and outcome data in connection with provider contracting.
(15) DCS communication with providers.
(16) Sufficiency and funding of follow up care for children and families following case closure.

Best Practices

The Committee heard testimony and discussed the following:

(1) The provision of appellate legal services to DCS by the Indiana Attorney General.
(2) DCS policy and functions related to state and federal law and policies.
(3) Use of outcome data and quality improvement measures.
(4) Comparison of other states' call centers with DCS's centralized call center.
(5) Effect of follow up services for children and families following case closure.
(6) Centralized call center data and tools.
(7) Child protection and intervention as government's primary child protection function.
(8) Development of a child welfare program based on best practices in a practice model that primarily addresses individualized family needs.
(9) Involvement of communities in preventing child abuse and neglect.
(10) Crisis intervention and provision of mental health services.
(11) Communication between DCS and the courts concerning actions involving children.

Minutes and attachments containing more detailed information concerning the Committee's 2012 interim work may be found at http://www.in.gov/legislative/interim/

V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Committee made the following findings of fact and recommendations:

(1) DCS Attorney Salaries -

(2) DCS Call Center -

(3) DCS Oversight Committee -

(4) Statewide Committee on Children -

(5) DCS, law enforcement, and court communications -

WITNESS LIST

Cynthia Amryn
Gina Andrew
Regina Ashley, DCS
Donna Baxter
Matt Brooks, Indiana Council of Community Mental Health Centers
Char Burkett-Sims, DCS
Tamara Carpenter
Carol Certain
Rick Crawley, Wabash Valley Alliance
Tammy Crose
April Dach
Jim Dalton, Damar Services
Carole Davis
Krista Davis, Safe Families
Susan Dreyfus, Alliance for Children and Families
Dennis Easley
Teresa Etchison
Kathy Fallon, Public Consulting Group
Fred Gilbert
Tiffany Girard
Bill Glick, Indiana Juvenile Justice Task Force, Inc.
Cathy Graham, IARCCA
Michelle Gwaltney, Indiana Coalition of Family Based Services
Mary Ann Halbert, National Alliance on Mental Illness
JauNae Hanger, Indiana Juvenile Mental Health Screening, Assessment, and Treatment Project
Caroline Hanna, Youth Villages
Linda Hartley
Nancy Hemphill
Robert Herr, Bedford Police Department
Michael Hicks, Ball State University
Sheryl Canon Hill
Susan Hoppe, DCS Ombudsman
Jennifer Hubartt, DCS
Barbara Jessen, United Methodist Youth Home
David Judkins, DCS
Georgia Kasting
Edith Kenna
Sue Lindborg Fisher, Pathways Youth Shelter and Family Services
Mary Beth Lippold, DCS
Daniel Luttrell
Nancy Maegerlein
Lockwood Marine

Doug McIntosh, Family Advocacy Group
Jerry Meadows
Caroline Meadows
Lucinda Nord, Indiana Association of United Ways
Patrick Oatis
Michael Patchner, Indiana University School of Social Work
James Payne, DCS
Tim Ray
Shirley Rhye
Lisa Rich, DCS
Richard Rowlison, DCS
Gary Russell
John Ryan, DCS
David Sanders, Casey Family Programs
David Sklar, Children's Coalition
Rick Snyder, Villages of Indiana
Toby Stark, Chaucie's Place
Doris Tolliver, DCS
Amber Turientine
Paul Vincent, Child Welfare Policy and Practice Group
Doug Weinberg, DCS
Candy Yoder, Child and Parent Services
Greg Zoeller, Indiana Attorney General

CSIC
November 27, 2012
Attachment 8.

Maureen Gordin [redacted]

From: Rhye, Shirley <srhye@usw.org> [redacted]
Sent: Tuesday, November 20, 2012 11:42 AM
To: s19@in.gov
Cc: Dolly Starnes
Subject: Another request to DCS and the Interim Study Committee
Attachments: DCS letter November 2012.docx

Shirley Rhye
510 Audrey Ct.
Dyer, Indiana 46311

November 20, 2012

Department of Child Services and
2012 DCS Study Committee
In Care of Interim Director, John Ryan
200 W. Washington St.
Indianapolis, IN 46204

Department of Child Services
Terrance Ciboch, Regional Director
19 E. Lincolnway
Valparaiso, IN 46383

Re: Child Molestation [redacted]

Attention Study Committee:

Last month, my daughter, [redacted] and I were invited to a family meeting at the Gary Office, Lake County DCS office, to discuss the most recent accusation of child molestation against my granddaughter [redacted] Also in attendance was a Jasper County CASA representative as well as [redacted] father [redacted] a resident of Porter County, and his mother [redacted]

The meeting followed my testimony at the Study Committee Public Hearing on September 24th. I write to the Study Committee and to the Porter County DCS because, as I explained at the public hearing, Lake County has not handled this matter professionally or in the best interests of the children. And since neither parent lives [redacted] County, I again ask the Committee to have this matter addressed, taken [redacted] County, and reassigned to Porter County.

A Brief Update

This situation started when my daughter took [redacted] to the hospital in March of 2011 [redacted] told her mom that her vagina was red because 'daddy' was kissing her 'pee pee' and "his hair hurts." [redacted] repeated that story on video to Lake County DCS Assessor, [redacted] who lied to the Lowell Police, stating that [redacted] did nothing. Despite the Prosecutor's refusal to prosecute [redacted] the fact remains that he lied. It is on video. Children from both the parents were then taken from them and placed in foster care; we have reason to believe the foster parents are friends of [redacted] family. The children still see the foster parents from time to time at church in Jasper County. The son of [redacted] girlfriend remained in the home. Six months later DCS decided that it was in the children's best interests to return the children to their custodial parents and mandated that my daughter could only see her two youngest children in a supervised setting, because she might speak ill of the accused molester. They determined that she was fine raising her two teenage boys. DCS set this precedence for eight months, devastating my young grandchildren. I was also prevented from seeing them without supervision and my visits were cut to once a month. I have reason to [redacted] that the molestation [redacted] continued during this time.

This past May I asked the Lake County DCS office, by email, not to close the case because [redacted] old me that her 'daddy' was spanking her naked butt when she was good and she didn't like his hard bony fingers. I asked DCS to have a professional expert in child molestation work with [redacted] to determine the extent of the 'good' spankings.' A week later, DCS, ignoring my email, closed the case and allowed my daughter and I unsupervised visits. At this time I notified the newspaper about the video and the prosecutor who had ignored my frequent inquiries on why the assessor, who remains on staff, was allowed to obstruct justice. The reporter watched the video and shortly after the article was printed, the Study Committee was established in Indianapolis; obviously the department has more than one problem. I testified at the Study Committee on September 24th at 2:00 p.m. requesting action.

Shortly after I testified, Lake County DCS visited my daughter at her Porter County home when she had all four children because, as we were told, someone had filed a molestation complaint. A few days later my daughter was invited to a Family Meeting in Lake County.

At the meeting Lake County DCS asked what we wanted:

I again requested a psychiatric review of all the children living in the [redacted] home, specifically stating that [redacted] is now to afraid to speak of the incident; perhaps afraid her mother will again be taken from her. Therefore, a FAB interview would only scare her more. Ten days later, 'daddy' drove [redacted] to another FAB interview where, as my daughter was told, she said nothing. We have been denied the right to review the interview. [redacted] tells a different story from what my daughter was told.

We were told at the meeting that [redacted] would immediately begin to see a psychiatrist trained to work with molested children, not the useless therapists at [redacted] who did agreed that [redacted] had been molested (their advice was not to touch them too much). We still wait for those sessions by a pedophile expert.

I requested several times that [redacted] take another lie detector test to prove to me that he is innocent since this is the 2nd time a molestation took place in his home during the last six years and because he failed a lie detector test in April, 2011 – failed rather badly according to the detective. I was told that DCS [redacted] this authority. DCS didn't hesitate to take my [redacted]'s constitutional right to be with her children, all because SHE MIGHT speak ill of her ex-husband and yet, they claim they cannot [redacted] Although I mentioned the lie detector test several times, neither [redacted] nor his mother commented. I still want the lie detector test done and DCS [redacted] that power. They should not, but they do. Lie Detector tests aren't admissible in a court of law but can be considered by DCS. If he is innocent he should not have a problem taking a 2nd test.

I requested that [redacted] ake the sexual psychological exam recommended by the court and DCS in 2011, to ensure that he does not have pedophile tendencies. This time [redacted] spoke up and stated that he took this exam. Our attorney had provided us copies of all exams that both [redacted] and my daughter were forced to take and nothing indicates an exam to determine if he might be a pedophile. I request written proof that this exam was completed and that he was absolved of this possibility by a pedophile expert.

Current Situation and final request

We were assured at the October Lake County meeting that we would receive a report shortly after [redacted] had her interview [redacted] w how DCS would proceed. We are still waiting for that report. Have they again closed the case?

I still want the lie detector test completed.

I still want the sexual psychological test done.

I still want [redacted] and her brother [redacted] who I suspect has also been molested, and all children who have spent time alone with this man, to be counseled by a trained expert in child molestation who can make this determination.

I would also like to know why Lake County once again is involved in this case since both parents live in Porter County.

[redacted] has been to the doctor three times in recent weeks to have the redness and/or ulceration on her vagina checked. Like the FAB interview the evidence is not clear enough for anyone to act, except DCS. The good news or at least the best news I have had in the last two years, was when [redacted] told me last week that 'daddy' doesn't touch her 'pee pee' or butt anymore. I told her I was very happy for her. What a horrible thing to have to say to your granddaughter. I just pray he has the ability to stop permanently but unless you complete your job, I have my doubts.

Sincerely,

Shirley M. Rhye

cc: Dolly M. Starnes, Executive Assistant
Ethics Commission
Travis Holdman, Senator State of Indiana
Dolly M. Starnes, Executive Assistant
Detective James Woestman, Lowell Police

CSIC
November 27, 2012
Attachment 9.

Maureen Gordin

From: Anthony Dill <anthony.dill@benchmarkfs.org>
Sent: Friday, November 16, 2012 5:08 PM
To: h31@in.gov; s19@in.gov; Ryan, John P (DCS)
Cc: Shane Davis; Teresa Knisley
Subject: Emailing: Issues concerning payment from DCS
Attachments: Issues concerning payment from DCS.pdf

Categories: Sent

Hello Gentleman

My name is Anthony Dill, and I am the State Director for Benchmark Family Services a Therapuetic Fostter Care agency here in Indiana. I am seeking your help regarding payment issues with the Department of Child Services. Please see attached letter regarding these payment issues.

Thank you

Anthony Dill
State Director

Privileged/Confidential Information may be contained in this message. If you are not the addressee indicated on this message, (or responsible for delivery of the message to such person) you may not copy or deliver this message to anyone. In such case, you should destroy this message and kindly notify the sender by reply email. Please advise immediately if you or your employer does not consent to Internet email for messages of this kind. Opinions, conclusions and other information in this message that do not relate to the official business of our organization shall be understood as neither given nor endorsed by it.

For more information contact:
Benchmark Family Services
http://www.benchmarkfs.org

Benchmark
Family Services

Indianapolis Regional Office
2506 Willowbrook Pkwy, Ste 222
Indianapolis, IN 46205
317-352-9706
Fax 317-352-9709
www.benchmarkfamilyservices.org

November 16, 2012

Gentlemen,

Benchmark Family Services, Inc. would like to bring to your attention the issues concerning payment from Indiana Department of Children Services. Benchmark is a member of IARCCA and has provided therapeutic foster care in the state of Indiana since 2005. Benchmark currently serves 270 foster children in five regions, including, Indianapolis, Merrillville, Muncie, Mishawaka, and Ft. Wayne.

Benchmark receives the monthly newsletter from IARCCA. In the November 12, 2012 edition, we read of the discussions about the 40 recommendations given to DCS. Benchmark has experienced the same issues with payment that was addressed in the recommendations 31-34. We have worked with DCS regarding payment issues since the centralization of billing and payment. Over the past 2 to 3 years, payment and billing issues have dramatically increased. Payments for services are well over 60 days as a norm and invoice denials are at an extreme high. We have clearly communicated to DCS and DCS has admitted that this is an internal issue that they are trying to correct.

Benchmark currently has $630,000 in receivables that are 45 days and older. This includes all of September and prior month invoices that are "In Process" and/or "Denied" in the DCS Kidtraks system. This does not include another $570,000 in receivables for the month of October. This is a total receivable of $1.1 million and increasing daily as we continue to provide services to those in care. We have paid our foster parents, our staff, and our expenses for all of those months of outstanding receivables. Due to operating with this type of negative cash flow, Benchmark currently has a $425,000 line of credit.

Benchmark also operates in the states of Texas, Georgia, and Kentucky. In those three states combined, we serve an additional 1,120 children. We have one employee dedicated to receivables for those three states. In contrast, we have one employee solely dedicated to invoicing and receivables in the state of Indiana. This represents yet another financial burden as we attempt to accommodate the DCS invoice process and the constant communication we must have to get any payments. We do not experience issues with receivables from any of the other three states. For example in Texas, no invoices are required to be sent to the state. Texas has a system that very accurately shows where their children are placed and at what rate. From this system, we receive at least 75% of our receivables within 10 days of end of month. In the newsletter from IARCCA, it spoke of a business that had to close after 15 years of operation due to non-payment from DCS. We, too, would be in the same situation had it not been for the timely payments from the other states where we operate and access to our credit line.

Benchmark has attempted, over the past two years, to adhere to and improve the payment process. These attempts include a meeting with John Ryan, Doug Weinberg, and other DCS staff regarding payment and denial issues. This meeting came after numerous trainings, open discussions, provider calls, and personal meetings with Terry Suttle. While we appreciate the trainings, open discussion, provider calls, and personal meeting with Mr. Suttle, no consistent improvement has resulted. We value our relationship with Indiana DCS and desire a continued working relationship with the department; however, we are in need of a resolution to this payment issue.

Indiana sets our rates according to the cost report submitted by Benchmark. We experienced a significant rate drop in 2012 due to decreased costs on the cost report for 2010. We are expecting another rate decrease for 2013 based on our 2011 cost report. We had to cut expenses throughout 2010 and 2011 due to major cash flow issues caused by DCS slow payment and non-payment.

In closing, we hope that this letter will be received in the vane in which it is being sent--working towards resolution of this matter so that children can continue to be responsibly served. We would welcome any questions or even a meeting to further discuss how we can collaborate toward clarity and resolution to this issue. Please feel free to contact us with any questions or comments that may result in your receipt of this letter. We welcome any input that may bring this issue to closure.

Sincerely,

Anthony Dill
Indiana State Director
Anthony.dill@benchmarkfs.org

CSIC
November 27, 2012
Attachment 10.

November 9, 2012

Senator Travis Holdman, Co-Chairperson
2467 W. 1000 N.
Markle, IN 46770

Dear Senator Holdman:

I am writing this letter to voice my frustration and concern for the clerical and other staff at the Department of Child Services. In October, FCMs, Supervisors, and Directors were given a 6% - 10% retention increase. It is upsetting to me that not all staff were recognized for their efforts with the State.

I have been working for the State for almost 23 years. Over the years, I did not receive a pay raise at least three times. Although the cost of living rose, we were not given pay increases for various reasons. I accepted that because it was across the board. However, for clerical and attorneys in the local offices to be singled out to not receive an increase while all other staff did is like a slap in the face.

Clerical is asked to assist the FCMs with their duties so that they do not feel overworked. However, we do not get any recognition for the work we do. We are told that our job descriptions state "other duties as assigned" and this would include assisting FCMs with their work. To hear that they are given a "retention bonus" to keep them from leaving, yet clerical and attorneys receive nothing makes us feel that the State believes they can continue to run without clerical's or attorney's help.

I have years of experience, and I feel that if I were to walk out (which I wouldn't because of the time invested in the State), there would be aspects of my job that no one in my office would be able to do. I feel that if replaced, the time spent on retraining someone for my position is just as valuable as what it would be to have a FCM walk out.

I was always told we were a team and a team sticks together. We assist each other to get the job done. I do not feel like I am part of a team right now. We are paid the lowest on the pay scale, and we do not ever get recognition for the job that we do. We are expected to be on the front line and to assist with whatever is needed, but do not receive compensation for going the "extra mile". Since the decision of the retention bonus, the morale in our local office, as well as other offices, has decreased. We feel we are "second class" and not as important as those already making a lot more money than we do.

I work a part-time job in retail. I have been with the company for 12 years. With my pay raise this year at my other job, I will be making a few cents per hour less there than I do with the State. With us not getting a pay raise next year, when I get my raise from my part-time job, I will be making more than I am with the State. I think this is a shame. When I started 23 years ago, I thought it was great to have a State job. Now that I have invested all this time with the State, it aggravates me that my pay is not equivalent to the time invested with State employment.

I am not saying that FCMs, Supervisors, and Directors do not deserve a raise. However, it would have been better to "share the wealth" a little and give other staff **something** to show that they are an important part of the team as well.

I know I am a small voice speaking for many. I felt it was a concern worth sharing with you. I feel if the State is in such good fiscal shape to offer FCMs, Supervisors, and Directors a retention bonus, then perhaps that should have been given to ALL state employees. After all, I feel there is not one position within the State that is more important than another. If you had personnel from any position leave as a whole, I think the State would see quickly what a mistake was made by singling out these three positions.

Thank you for your time in reading my letter.

Sincerely,

Sandra Hines

Sandra Hines
Secretary III
Wabash County DCS

CSIC
November 27, 2012
Attachment 11.

11/26/12

Senator Holdman please see that all the committee members receives a copy of this e-mail.

The Policies and practices of the operation of the DCS are so ingrained in the staus quo, it will be an enormous task to make a massive overhaul of this government agency.
Political ramifications are high, but if the opportunity ever presented it's self, the timing is now.

One political Party is in charge in government now, and again I stress, the onus is on the Republicans to tear down a faulty DCS foundation.
The Governor elect and the legislators can build a solid new structure, that will err on the side of children in need first and not politics as usual.

We have a bureaucratic nightmare in DCS, we have children in the system that shouldn't be and children left to flounder in unsafe dwellings.
DCS can't be all things to all families, yet they don't want to relinquish control, they have little oversight, transparency is not in their vocabulary, teflon is on their backs.
The power of DCS exceeds their level of expertise!

The indoctrination of adults, has been so formulated in our minds, that we automatically revert to our environmental teachings instead of the well-being of children first.
Adults rely on their religious beliefs, their political leanings etc., when assuming they know what is best for children at-risk and not realizing children are not of
any particular persuasion. Children don't have any rights of their own to over ride the Hubris of DCS, the courts and the Indiana Legislators.

Recently, President Obama was addressing an audience in Burma on democracy, he said; "children in poverty in America have the same rights as the President".
He obviously doesn't realize that at-risk children have so little rights, that they are the only citizens forced to live with their abusers, their sperm donors and incubators.
The ACLU won't fight for abused children, they said they don't have the same rights as a terrorist they represent, that is trying to destroy America.

It's a real conundrum with the knowledge and money available, that we don't, and won't protect our most innocent and vulnerable citizens, we treat them in the abstract.

What really is going on, is that at-risk children are pawns for the politicians, special interest groups and the legal field, at -risk children are being pimped.

When the DCS can testify in the very first meeting, before you in this committee, that only 6% of the spending mix goes towards prevention, and no outcry from anyone, what are
you thinking? What exactly did you agree to by getting on this committee? The red flags presented in these hearings are like a mine field, but if you set back and not move, you
won't trigger any hurt to yourselves, again only the well-being of children in your care will be obliterated. Is it not a problem unless your affected directly?

I've been in the trenches, I've seen the underbelly of the seedy side of politics, and it AIN"T pretty! You and I, understand that politics is played with everything
in our lives.
Unfortunately innocent children who should be playing childhood games aren't privy to the grown up political games, that costs them their innocence.

Maybe there is a reason just south of a hundred million prospective voters didn't vote this past election. People are sick of politicians and politics.

There seems to be three important things missing in politics; HONESTY, PRIDE, INTEGRITY!

This committee took on an opportunity to dramatically change the draconian policies of a bloated bureaucracy, to not radically change the DCS operation
at this juncture, would be an egregious failure for everyone on this committee.

All long term legislatures, are well aware of the Indianapolis Star front pages over the years, of the plight of children in the Indiana child welfare system.
Especially, investigative reporting by Tim Evans has brought to light the atrocities of the failures of DCS.

I have made Attorney General Hogsetts office aware of two social workers suspicious deaths, who were whistle blowers on a very well documented DCS case.
Also a custody case that was so corrupted by the courts, Notre Dame took this case and then immediately was shut down, this case also is well documented.

These two mentioned cases alone, if investigated could blow a hole the size of Indiana in the operation of DCS.

As the late Sen. David Ford e-mailed to me years ago, legislators are well aware of these corruptions, but in his words; "there is too much vested interest" for the legislators
to correct the wrongs in the child welfare agency.

This committee should dismantle these special interests, NOW!

If Condorcets paradox was the mindset when convening this committee, It was a shameful act of deceit.
The hotline, is only one component of a plethora of deficiencies in DCS.

As Indiana lawmakers, you in essence have positioned yourselves as surrogate parents for the well-being of at-risk children.
By you as legislators, appointing DCS as inept nannies for YOUR children, everyone involved should be guilty of neglect and negligent homicide of children in DCS.

Reiterating again my suggestions from the Sep./05/12 meeting; these meetings seem to have put little credence in any testimony from the public.

#1) Eliminate the hotline, it's a Federal violation of the law, it's also costly not only monetarily but also to the lives of children at-risk.

The millions that has been suggested to make the hotline a LITTLE better is not conducive for the well-being of the local community child well-being!

What if a deputy sheriff was added in every county, for a DCS social worker to partner with, on a 24 hr. shift basis?

One of the concerns expressed from many in DCS and elsewhere, is the risk a DCS worker takes going into homes alone.
If the DCS worker is afraid can you imagine what the child is experiencing in these homes?

All child abuse report calls would go into the 911 emergency station and treated like any other safety personnel call.
If someone calls 911 to report a fire, the fire safety personnel is dispatched, the same would be the case for a child abuse report.
A child's life would not be further jeopardized, by waiting for someone at the hotline to determine if the call is urgent or not.

Every Sheriff knows their district better than a centralized bevy of operators, that cannot possibly be familiar with the quaintness of individual counties.

How many operators, supervisors, pay, perks, pensions etc. and building costs for the hotline operation, also how many social workers in each county,
that make house calls now? The amount of calls to the hotline last year, is proof we need immediate response to err on the side of the child.

There would be two witnesses and two sets of logged reports for records, partnering in one car.

Figure the costs of adding a deputy sheriff and DCS employee on a 24 hr. shift basis in each county.
Smaller neighboring counties could maybe share patrols.

LSA should be able to figure the costs of implementing this concept.

Child abuse is a crime! All suspected crimes should be investigated by law enforcement.

The state government has proven they do not make good parents.

The research and attention St. Judes Hospital gives, trying to make sick children well, is a team effort for the benefit of the children.
What Indiana government does contributing to the demise of children born healthy, for adult narcissism, is a travesty!

Maybe Tim Evans, could do some investigating, into how much money the state has invested in the hotline office and staff, and
what it might entail to put an innovative approach into protecting children first and foremost.

For what it's worth,

Carole Davis
812-477-0660

Carole Davis
3905 Needle Leaf Pointe
Evansville, IN 47715
September 2012
Address to DCS Legislative Study Committee

As a child advocate for decades, I have witnessed politics being played with the lives of children. Neither Republicans nor Democrats can hold their heads up with bravado.

Democrats, for instance, look to unions for votes and donations.
Significantly, when Indiana was #1 in child abuse deaths, child welfare employees were members of a public union.

Republicans, grovel for votes from Right to Life, which rallies for life before birth, but where Is the concern from these two groups for abused children dying after they are born?

All too often the Department of Child Services has shown itself to be unable to provide the protection needed to safeguard the lives of children-at-risk in their care. And yet, because the DCS has been allowed to function as an autonomous body, it has continued as usual without their providing a full disclosure of facts that may be self-incriminating.

Some time ago, in response to an email I had sent, I received an email from a state senator who stated, "I'm also convinced you are right in your opinion of the 'system'...Getting to the inside, however, is very difficult. They [the DCS] don't give all the facts, even to the legislature...They have an army of vested interests to protect them."

When other interests are considered more important than the lives of children-at-risk who are in the care of our state, there can be disastrous results. All too often these results never come to light because the DCS is allowed by the legislature to run as an autonomy. I have asked repeatedly for an update to the Indiana University School of Public and Environmental Affairs study entitled "Indiana Child Welfare: The State of Our Children--1997". The study reflected so badly on the DCS that another study has not been commissioned. For example, the study revealed that foster care expenditures increased more than 742% from 1991 to 1995. The study further revealed that Indiana lead the nation in cases of neglect and child abuse, with the USA average being 59% and Indiana's being 82%.

If a study was conducted today with complete transparency, what would this study reveal about DCS and its policies and practices?

Some of the most recent information available that was published by the Indianapolis Star indicates that there are troubling statistics concerning children in DCS. The Star asserted that based on Indiana's child population, DCS removes children from their homes at a rate of 10th highest in the U.S. and 59% higher than the national average.

What is more alarming is that Indiana continues to do poorly in what is considered one of the most important indicators of how well a child welfare system is performing: children who suffer repeat maltreatment within six months after a state intervention. The Indiana repeat maltreatment rate for 2008 was basically the same for 2008 as it was in 2004, the year the reform project was launched. It remains

worse than the national standard. In 2008, that translated into 506 repeat victims or almost 10 children every week.

Children in Indiana State custody really have the state positioned as surrogate parents. Shouldn't the state be responsible for neglect just as any parent who knows their child is being abused by someone and is charged for neglect by the state? What actions would be taken by the legislature if they knew they could be charged with neglect or for being responsible for a child's death? And that is my point: As representatives and senators, you have chosen to ignore this crisis and children today are being abused, neglected and even killed. Are you not responsible? For their sake, you need to take action now.

State and Federal law require a Community Child Protection Team and a Citizens Review Panel with each submitting periodic reports. These laws are not being followed, and consequently, there are no reports available for review.

And speaking of the law...

The family courts operate to decide "what is best" for the child. The judge decides this in a closed court usually with input from only the child's case worker and the parents. The judge can literally sentence a child to whatever life the court sees fit with scant evidence and no input from the child. The DCS states that the judge decides the case, while the judge says he must follow the law; thus, neither takes the ultimate responsibility for the decision. As legislators, you have the opportunity to pass laws that mandate transparency, that eliminate the autonomous structure of the DCS, and that provide oversight of the DCS policies and procedures.

The legal field is benefiting handsomely from the lives of children in need. I've been told custody battles are often their "bread and butter". However, neither the ACLU nor individual lawyers have made a concerted effort to lobby for the rights of children-at-risk in Indiana.

At the core of these inequities is the autonomous DCS itself and its failure to first adequately protect the children under its care and then, of course, under-reporting the information concerning the deaths of children in their care. Perhaps that explains why Indiana was one of the last four states to establish a statewide Fatality Review Team.

Obviously, having all the pertinent information is essential for accurate statistics and funding for the well-being of children. No private business could operate with such fraud and lackadaisical carelessness. The DCS touts success and yet is the only business I know of that grows despite its failures and remains immune to accountability and responsibility. Quite simply, the power of the DCS exceeds its level of expertise.

We are meeting in this legislative session to bring a critical priority to light: our concern for children-at-risk who are under the care of the DCS. I have testified for previous committees and found them lacking; they did not allow enough time to hear testimony from citizens who had vital information, and most important, they did not get the total truth from the DCS, which was not forthcoming with information that reflected badly on them.

But this is a new day and a new committee. It is my challenge that this committee should be solution-focused. To that end, I offer these suggestions:

1) Immediately recall the DCS 800# that is used for specifically reporting child abuse. This is discriminatory as stipulated by the 1964 Civil Rights Act. All suspected crimes should be investigated by law enforcement.

2) Revise and distribute the study of the 1997 "Indiana Child Welfare: The State of Our Children". The latest statistics concerning the DCS could be put in a user friendly format of graphs.

3) Conduct an in-depth vetting of all service providers and present the results on a cost and outcome effectiveness basis .

4) Implement a real time data search on each child in the system. We should care at least as much about the counting of our children as the balancing of our checkbooks. We have a bank headquartered in Indiana which would possibly loan manpower to help set up a data program.

5) Establish a chair on child maltreatment in an Indiana higher learning institution.

6) There should be legislative review of reports mandated monthly under a law which sets specific procedures to follow.

7) Review DCS supervisory longevity, pay, perks, and pensions. At what level is their turnover rate of personnel in DCS?

8) Review the policies and procedures that went into implementing the IBM partnership. Because government businesses are always monopolies, was the IBM privatization flawed from the beginning?

9) There is a critical need for addressing troubled pre-teens and teens in an environment that would not label them as juvenile delinquents.

10) Conduct an independent audit of the Indiana Department of Child Services in all aspects of their operation.

Indiana has been particularly discriminatory towards children in relation to their socio-economic position in life. These children have become economic assets to the DCS; they provide employment and all of its government benefits. These children are, in essence, their employers and therefore, DCS should be accountable for their well-being.

I'm here today as an advocate for the most vulnerable among us, children-at-risk in Indiana.

I'm making a formal request for a complete overhaul of the child welfare system here in Indiana. It's a "Humpty Dumpty" system. The Indiana Department of Child Services (DCS) is broken, and if we are to make a difference in the lives of these children, the DCS must be changed top down and made whole again.

Ignorance and indifference are the only two reasons for the epidemic of child maltreatment. Education solves ignorance; indifference is hopelessness. My hope is that this legislative body is enlightened by all of the available information and will act with speed and determination to bring real change to the Indiana Department of Child Services.

Best practices/solutions for problems with Indiana DCS and related government entities

In light of the recent recrimination that has occurred against some who have given testimony, I wish only to identify myself as "Determined Advocate" for purposes of public disclosure.

The following ideas for best practices/solutions for law regarding DCS are based on my experience in the trenches. I think there is more than incompetence and bureaucracy in the system. It is not just slow—in some cases it is completely stuck. In light of this:

1) **Build enforcement measures into every law you make.** *(Highest Priority!)* No enforcement means no compliance. Don't take for granted that the good people in the system have the power to make a good law work. Case workers must take orders from their directors—many times case workers are left in the dark about the reasons for the final outcome of a case. They may be afraid to challenge a decision for fear of losing their job, and there are not enough who have the courage to whistleblow. To catch the non-compliant, *design your law as though no one will obey it unless they are forced to.*

   Many directors themselves may have been intimidated by abusers who sometimes have wealth and political power. Some abusers are mentally unstable. Write your law in such a way that DCS workers have more of a reason to obey Indiana law than they do to obey intimidating outside forces.

2) **Make a plan for how to deal quickly and effectively with abusers who intimidate and threaten DCS personnel.** They are very vulnerable. You will need to work with law enforcement and the courts on this. Perhaps they need self-defense training and/or to be allowed to carry weapons if they feel threatened. Since the problems are so widespread, I have to wonder if some type of organized crime is involved. It would be safer to act as though there is organized crime than to assume that there isn't just because the idea frightens us.

3) **Decentralize power.** Make sure that DCS is accountable to the governor's office and to a legislative oversight committee. Don't just communicate with this agency through the head of DCS. Allow the oversight committee to hold DCS accountable by going directly to regional and local directors as well as case workers and clients for information. The directors won't like it. They are used to controlling things, but they've mismanaged it all so this is the consequence. Break up the control.

   Don't allow DCS directors to choose what foster home or organization children are sent to when they are taken from the home. This is to alleviate any financial kickbacks that may be happening. I know of at least one family where children were taken on the slimmest of circumstances and not placed with grandparents

who were willing to take them. Was it because the parent was low income and couldn't fight back effectively? Is somebody making money from this?

4) **Set up an emergency committee to review and investigate urgent cases.** Don't count on a local DCS taking an urgent case to the juvenile judge—it often doesn't happen. Some children who should be removed from the home are not taken because of a parent having money and political power. It appears some abusers have bought protection.

   Keep your hand in the pot to make sure things are functioning as you have established—leave yourselves room to directly intervene. Put the fear into any directors who are throwing cases. Let DCS know that their clients have direct recourse to your committee members.

5) **Appoint motivated citizens to committees to help you with the research that will need to be done so that the law you build is effective and airtight.**

   They can find models and resources for what needs to be done, such as below:

   a. *Why Does He Do That? Inside the Minds of Angry and Controlling Men,* Lundy Bancroft, Berkley Books, New York. http://www.lundybancroft.com/

   b. Duluth, MN – *Coordinating Community Response to Domestic Violence: Lessons from the Duluth Model,* edited by Melanie Shepard and Ellen Pence (Sage Publications)

      Domestic Abuse Intervention Project
      206 West Fourth St.
      Duluth, MN 55806
      (218) 772-2781
      www.duluth-model.org

   c. Look at the State of Florida – they deal very effectively with abusers. I have a sheriff contact there.

I have many resources I can pass on to you—some sent to us by Lundy Bancroft, who is the best I have found after years of research.

6) **Purge the directors** & put in people that are trustworthy. No law can be successful if the people who implement it are poorly trained or of poor character. Everyone has their public persona—dig to find out what they are really like on the job. Talk to case workers and talk to clients.

7) **Change language in law to clarify and specify exactly what you want to get.**

   For example, the definitions of:

a. Substantiated, indicated, and unsubstantiated in regard to an investigated case:

As I understand it, when a case is substantiated, it means there is a preponderance of evidence (51%) for abuse or neglect and DCS can act to protect the child.

If the case is unsubstantiated, there may be abuse or neglect, but there is not enough evidence at this time. *This does not mean the accused is innocent.* He may be or he may not be. But having past unsubstantiated cases has been thrown up by DCS in my client's face as though her current incident must be fabricated because other cases were not substantiated.

There used to be a category called indicated, and this used to mean that perhaps abuse or neglect could be indicated, so the situation needed to be watched. For some reason this was dropped out of Indiana Code. I think it needs to go back in to help case workers as they review history on a case. What reason could there have been for it ever to have been dropped?

8) Records of DCS reports should be:

a. **Kept until the statute of limitations runs out**, beginning when the youngest child involved in that report is emancipated. Before that the child cannot protect his or herself, must attend visitations, etc. Sometimes the abuser chooses the visitation supervisor—I know of a case. The judge okayed the choice, and the abuser would sit and verbally abuse the children in front of the supervisor.

b. **Turned over in a "timely" manner to the person who initiated the report and to all people mentioned in the report, and make all document fees reasonable.** Define "timely," for example one or two weeks if not immediately. Regarding cost: first five pages free and then a reasonable cost, like 10 cents a page or whatever the public library is charging.

For ideas on enforcement on release of records, look at state and federal Freedom of Information Act enforcement measures that had to be added to get government agencies to comply. In some cases, fines were levied personally at the employee who made the decision to refuse. Again, no enforcement, no compliance. My client constantly applied for her records, was told 6-8 weeks, but rarely ever got them.

Going to court to get enforcement of the law to release records is a ridiculous option. Is this particular record required by law to be released? Release it or be fined!

9) **Put the same case worker on repeated incidents with a family when possible**. If the case worker is too overloaded, at least consult with them on the new incident to get a sense of history. My client always got a different worker and was told they don't consult the history. What kind of detective ignores a rap sheet?

10) **Instruct DCS case workers to look at past history to see patterns** and determine if abuse may be indicated even if there is not enough hard evidence to act in the newest incident. Sexual harassment cases are all about patterns and statements by several witnesses because there is never any physical evidence, but there are convictions. Look for the patterns of abuse and neglect, which should be easier because there *is* likely to be physical evidence.

11) **Take seriously what children say.** There are only certain windows of time when they are not too fearful to speak. Evaluate their body language for deception, etc. Don't just say they are children so their testimony is meaningless. Honesty is not something that can be defined by age.

12) **Instruct DCS to determine strategies to uncover evidence in cases where abuse is "indicated."** In other words, if there are constant suspicious bruises, etc. monitor child exchanges to see on whose watch they appear, etc. Some of these abusers dance very close to the line but can be caught with a little extra work.

13) **Bring in national experts of good reputation to do training workshops for directors and require that they attend.** Video record these workshops and have local or regional directors hold them back home for local case workers and other employees directly involved in decision-making.

    a. **Lundy Bancroft**, as mentioned above. He is a national speaker and holds workshops to train professionals. His book above is the best I have read on this subject—he really understands what the abuser is like and knows how to handle them. He has an entire chapter on the way abusers manipulate professionals in the criminal justice system.

    b. **William A. Eddy**, attorney and clinical social worker, specializes in divorces and custody disputes involving "difficult personalities." His book *Splitting* will help you understand and deal with the mental illness side (personality disorders) of working with abusers and their victims. I don't think DCS, law enforcement or judges really know how to protect themselves from these types, which seem to be growing in number. Let's arm them for battle.

14) **Get a task force going concurrently to work on court problems**, namely bad judges and what to do about them. Judges are people and they can be intimidated and bribed. In some areas of Indiana the courts are like little fiefdoms. If you want to be a player you have to throw some cases to the powers that be. Make it easier to get a change of venue. But even with a good judge, the process is to slow and too costly.

    Some states provide attorneys for cases with sufficient evidence. (The pro bono system doesn't work well for various reasons, like corruption, too much work to do free, etc.) Research what to do about this, because frequently DCS will tell clients to go back to their civil court judge. The judge says go to the police, the police say go to DCS. Victims are caught in a loop.

15) **Give law enforcement computer access to civil court orders and specify which parts of the orders are to be enforced by them**. Sending people back to court is an unworkable solution as it can take months, costs hundreds of dollars, and more than likely there will be no enforcement anyway because they're civil orders. Law enforcement told my client they could not enforce civil orders. Again, build in enforcement into the law.

    Why this is important: some parents won't obey visitation orders because they know there is no enforcement. They keep the child for a holiday that is not theirs or go on an extended vacation. Basically, they do whatever they like.

    Where there are chronic disputes, arrange for child exchanges at the police station where both parties show I.D. and sign in or out with the children accounted for. Document everything. The officer should be enabled to look up the visitation schedule if there are any disputes.

    Enforcement measures should be in place for violators. Perhaps first a warning, then a fine, then overnight in jail—show them they must obey the law or suffer consequences. You can't count on judges to do this—it is just not happening. They often just re-order the same things, hoping the abuser will obey this time. Instead, the abuser just gets cockier because nobody is holding his nose to the wall--and the children become more and more damaged.

16) **Increase ombudsman staff and budget** so Susan Hoppe can do her job effectively. Pull money from some non-essential state projects and make protecting our children one of the highest state priorities.

17) **Bring in the feds** where you have evidence that there is corruption and the state's hands seem to be tied. Time means everything to a victim. It can mean saving a life.

18) **Let people go to any DCS of their choice in the state if they are having trouble with their local office.** The hotline screener, and even the social worker at an out-of-the city E.R., always calls back to the local director where the victim lives. If that office is compromised, the victims are trapped. They often cannot even leave the state because a judge has ordered them to stay local for visitation. They also are probably financially depleted due court and attorney fees and constant harassment by the abuser.

19) **Ask DCS to verify any assertions that are made by either the reporting party or the responding party when they are called in on a case.** This would clear up a lot of confusion. It's time we do the work needed to verify who is lying and who is desperately trying to protect themselves and their children. Many times it is just a matter of calling the doctor or looking at medical records. Constantly putting out brush fires means the case cycles on and on and more damage is done to the children. If a thorough investigation is done DCS might be able to put that fire out for good.

I don't particularly feel afraid to go public—but I know it is dangerous and unnecessary. I am happy to talk to legislators who would like to flesh out these ideas and to illustrate the rationale for these suggestions with personal incidents. Those legislators who would like to contact me may do so through Senator Holdman's office.