INVESTIGATIVE REPORT

Cabinet for Health and Family Services

OFFICE OF INSPECTOR GENERAL

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Allegations of misconduct by certain employees of the Department for Community Based Services' Lincoln Trail Region related to the removal of children and/or the termination of parental rights based on alleged abuse, neglect, or dependency.

Report Date: January 10, 2007

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Investigative Report Regarding Allegations of Misconduct by Certain Employees of the Department for Community Based Services' Lincoln Trail Region Related to the Removal of Children and/or the Termination of Parental Rights Based on Alleged Abuse, Neglect, or Dependency

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SUMMARY OF THE INVESTIGATION

Introduction

On January 9, 2006, Robert J. Benvenuti III, Inspector General of the Cabinet for Health and Family Services[1] (Cabinet), ordered an investigation into allegations of serious misconduct by certain individuals, both known and unknown, of the Department for Community Based Services (DCBS) assigned to the Lincoln Trail Region/Hardin County DCBS Office. The Inspector General's order was based on a request for investigation by then Cabinet Undersecretary Dr. Eugene Foster.[2] Undersecretary Foster's request was based upon his review of a report entitled "the 'other' Kentucky lottery: Child Protection and Permanency for Abused and Neglected Children in Kentucky in 2005," which had been presented to the Cabinet for Health and Family Services on January 6, 2006 by the National Institute on Children, Youth and Family's, Inc. and Kentucky Youth Advocates, Inc.

The Office of Inspector General (OIG) conducted this investigation pursuant to Kentucky Revised Statute 194.030(c). The Inspector General assigned Mrs. Brenda Caudill-Barnes, the OIG's Internal Affairs Officer, as lead investigator. Mrs. Caudill-Barnes is retired from the Kentucky State Police where she served for 19 years before joining the OIG as the OIG's Internal Affairs Officer in 2005. Based on the nature and scope of the investigation, two investigators from the OIG's Division of Special Investigations, Mr. Robert Graham and Mr. Steve Simpson, were also assigned to the investigation. Mr. Simpson is retired from the Kentucky State Police where he served for 23 years before joining the OIG as a special investigator in 2005. Mr. Graham is retired from the Jefferson County Police Department where he served for 31 years prior to joining the OIG in 2005 as a special investigator.

During the course of this 12-month investigation, OIG received correspondence from nearly 250 individuals and organizations in the form of telephone calls, letters, and emails wishing to provide information relative to our investigation. The correspondence involved the Lincoln Trail Region[3] as well as 17 other counties in

[1] Prior to the reorganization of state government by Governor Fletcher in 2004, which created the Cabinet for Health and Family Services, DCBS was part of the Cabinet for Families and Children.

[2] Dr. Eugene Foster served as Undersecretary for Families and Children from March 29, 2004 until November 10, 2006.

[3] Note that for purposes of this report, we refer to the Lincoln Trail Region as it was organized on the starting date of this investigation. On that date, the Lincoln Trail Region consisted of Hardin, Meade, Grayson, Larue, Marion, Nelson, Washington, and

Kentucky. Additionally, OIG interviewed 142 individuals, some on more than one occasion, and examined approximately 75 DCBS case files, in addition to various other records and documents. Those interviewed included DCBS staff, complainants, and other individuals that OIG believed had information material to the subject matter of the investigation. Finally, OIG met, both in person and by telephone, with various community partners and interested advocates. In total, OIG dedicated approximately 5000 hours to this investigation and received almost 400 allegations of wrongdoing in the Hardin County Protection and Permanency (P&P) office and Lincoln Trail Region DCBS office. The OIG is appreciative of all individuals who took the time and effort to provide information to us during the course of this investigation. The OIG is indebted to the Kentucky State Police for graciously providing interview facilities so Cabinet employees could talk freely with investigators without the fear that their statements could be overheard. In particular, we recognize the DCBS frontline employees that were willing to discuss their concerns and provide information to OIG investigators during the course of this investigation. The vast majority of the social service workers we encountered during the course of our investigation carry out their very difficult duties in a diligent, honest, and ethical manner. Finally, we recognize Dr. Eugene Foster and Tom Emberton Jr.[4] for their leadership and openness during our investigation.

This report is only intended to summarize the issues discovered during the course of the investigation. It is not meant to provide the reader with all of the evidence contained in each of the eighteen OIG investigative reports. We take this course of action because, at this time, it would be premature to release identifying information contained in the case reports prior to referral and review by the Hardin County Commonwealth's Attorney and the Cabinet's Office of Human Resource Management. However, we believe it is important that the Cabinet have our findings and recommendations without delay so that they can be considered expeditiously.

Before discussing our specific findings, it is important to expressly advise all readers of six threshold issues, in light of which this report must be read. First, OIG fully recognizes that the tasks which many social service workers face on a daily basis are, by their very nature, daunting. For example, we recognize that there are many times that a social service worker is called upon to make difficult judgment calls under highly stressful situations, wherein the health and safety of both the social service worker and those they are charged to protect are at risk. This investigation does not second-guess such professional judgment exercised in good faith by a particular social service worker wherein the social service worker believes that the child's health, safety, or welfare is in immediate jeopardy. It should be obvious to all that such good faith decisions must be made in certain circumstances and that the short-term removal of children is far more desirable than allowing a child to remain in a potentially dangerous situation. This is true even if such action is later determined to have been unnecessary. Thus, this report in no way whatsoever should be read or interpreted as second-guessing or criticizing a social service worker's good faith handling of such situations.

Rather, the primary purpose of this investigation was to fully examine the issues surrounding the removal of children from their biological parents based on alleged abuse, neglect, or dependency of the child and the process that follows, including, in some cases, the termination of parental rights and to identify any misconduct by Cabinet personnel relative to the same.[5] Accordingly, our investigation focused on those cases involving alleged neglect or dependency by a biological parent or parents and *did not* involve cases that resulted in criminal convictions against a biological parent based on abuse, neglect, or dependency.[6] Similarly, no one should read or interpret this report to mean that we believe the Cabinet should, in anyway, whatsoever, inhibit good faith actions of social service workers aimed at ensuring the health, safety, and welfare of children and/or curtail child protective services. Those who abuse, neglect, or create dependency of Kentucky's children must continue to face aggressive enforcement and appropriate penalties.

Breckinridge Counties.

[4] Tom Emberton Jr. became DCBS commissioner on July 1, 2005 and assumed the role of Undersecretary for Families and Children on November 15, 2006.

[5] Only two of the client cases examined involved allegations of physical abuse. All other cases examined involved allegations of neglect and/or dependency.

[6] Only one of the client cases we examined involved criminal charges. The individual charged in that case was later acquitted.

Second, our investigation revealed that the issues herein identified are long-standing and, to a certain extent, part of the culture that we found inherent among some employees in the Lincoln Trail Region. While not easily articulated, we discovered a culture, accepted by some staff and rejected by many others, which thrived on the power of controlling certain families, including but not limited to the ultimate exercise of power – facilitating the removal of children from their biological parents and the termination of parental rights. This attitude appears to have been exacerbated by the fact that DCBS regional approach was highly (and we believe inappropriately) decentralized under the previous administration. In fact, the evidence shows that the sixteen DCBS regional offices[7] (often referred by many DCBS staff as fiefdoms) were essentially permitted to operate as sixteen different agencies accepting, rejecting, or altering DCBS standard operating policy at their sole discretion.[8] The evidence shows that certain social service workers, both management and staff, had, at a minimum, enjoyed tacit, if not express approval to operate the Lincoln Trail Region autonomously. In so doing, regional management was, for practical purposes, free to exercise the Cabinet's statutory and regulatory authority at their sole discretion, free from any meaningful oversight. Further, we are deeply troubled by the fact that allegations of misconduct in the Hardin County office, and within the foster care system generally, made during the previous administration appear not to have been adequately investigated and corrected by the responsible Cabinet officials. Specifically, during the course of this investigation, several current and former workers stated they were fearful of cooperating in the OIG investigation and/or believed it was futile to report misconduct. Many advised they had reported their concerns regarding misconduct in the Lincoln Trail Region, in the past, and no action was taken to correct the issues identified. Further, they reported that subsequent to such reports being made, the subjects of the complaints were rewarded and promoted, while the complainants were disciplined. For example, they noted that in 2001, eleven P&P employees submitted a letter of complaint to the Cabinet Secretary advising of policy violations by regional supervisors that they believed were placing children at risk. The Cabinet responded by assigning a P&P team to evaluate and address the issues. Two hundred unassigned referrals were located in one regional supervisor's office. The regional supervisors, who were responsible for the policy violations, were not disciplined, but frontline supervisors and workers who signed the complaint letter were disciplined and reportedly targeted for retaliation. Only two of the original eleven complainants are still working in the Lincoln Trail Region. At minimum, this environment allowed the now discovered misconduct to continue and, in all likelihood, exacerbated the feeling among many staff that the Cabinet condoned and/or was uninterested in addressing allegations of misconduct within DCBS.

Third, during the course of our investigation, we discovered evidence of potential individual criminal conduct and have informed the appropriate prosecuting authority of our evidence and will forward those cases for possible criminal prosecution within the next 30 days, as provided under KRS 194.030(c)(4).[9] Such individual misconduct is cause for grave concern and must not, in any way whatsoever, be condoned, minimized, or excused. Likewise, it must not be viewed as a complete and just conclusion to the issues identified in this report surrounding the removal of children and the Termination of Parental Rights (TPR) process. Based on our findings, we believe it would be imprudent to ignore the serious nature of the issues identified herein by only addressing individual misconduct while failing to fully address the conditions that ripened the environment for individual misconduct. It is the opinion of the OIG that such issues flourished, in large part, from the shroud of secrecy that so fully envelops the TPR process as to leave it highly susceptible to individuals or groups of individuals desirous of corrupting the process. For example, we believe strongly, the cloak of secrecy that currently dominates this process is not in the best interest of Kentucky's children and must be removed as part of any material reform. Simply stated, these are not matters of national security, wherein effectiveness often requires secrecy. Rather, they are social service issues that demand the full light of day in order to better ensure the integrity of the process. The fact that children are involved in the process should no longer be used as an excuse to protect these proceedings from meaningful public oversight.

[7] The Lincoln Trial Region was reorganized into the Salt River Trail Region as announced in February 2006 and effective September 16, 2006. Under the DCBS modernization, DCBS regional offices were reduced from 16 to 9.
[8] DCBS leadership has and continues to implement standards aimed at increasing consistency among regional offices.
[9] Kentucky Revised Statute (KRS).

Fourth, Cabinet officials have initiated several positive measures aimed at increasing oversight of field operations and bringing consistency and fairness to the processes discussed in this report, along with continuing to work to improve related operations. While not a complete list, we commend the implementation of a mechanism for DCBS employees to anonymously request specific cases be reviewed. This has afforded employees, statewide, the ability to assure issues are reviewed, without fear of retaliation. Another innovative program, the Parent Advocate Program, which has demonstrated positive results, has been implemented in the Jefferson County area. These actions, as well as the recent reorganization of Service Regions, which has resulted in the merger of areas of responsibility, increased oversight, and the reassignment of certain supervisors, are commendable.

Fifth, it must be recognized that while DCBS is the government agency primarily responsible for the subject matter of this investigation, some parts of the processes examined herein are not under the direct control of the Cabinet. It is clear that every component of the process is vital to the effective operation of the child protective system. Accordingly, it must operate with appropriate checks and balances to protect against unjust results. We trust that the Cabinet, the Legislature, and the Judiciary will work together to ensure that the children of the Commonwealth are protected from abuse, neglect, and dependency in a manner that is consistently ethical, moral and legal.

Sixth, termination of parental rights is one of the most significant and far-reaching actions the Commonwealth can take against an individual. With this in mind, we believe implementing the recommendations set forth in this report will facilitate the enhancement of the integrity of the process as well as the reputation and credibility of the Cabinet.[10] Further, such efforts will result in significantly increasing DCBS worker safety, as well as the health, safety, and welfare of Kentucky children.

SUMMARY OF THE FINDINGS

During the course of our investigation, OIG discovered credible evidence which clearly supports the findings set forth below. The evidence used in support of these findings is contained in the OIG Division of Special Investigations master case (Case #2006-030-047).

Falsification of Records/Dishonesty:

1. During the investigation, biological parents were contacted and investigators verified that home visits, documented in case files, did not occur. Many biological parents reported workers claimed to have attempted home visits and no one was home. One parent stated, although six home visits were documented, in reality, the worker had never been to the home. In another situation, children were removed from a biological mother and placed with the biological father, after the biological father reported allegations proven later to be unsubstantiated. Eighteen months later, although home visits were documented in the file stating the children were with their biological mother during the visits, the biological mother had not seen the children since their removal, had not met the caseworker, and did not have a case plan. One contact, dated three days after Christmas, stated the children were looking forward to Christmas. The case was closed after a year, with no services provided to the biological mother. The biological father also reported never meeting the caseworker or having a home visit completed, although visits and conversations with the biological father were documented in the file, as well.

2. Both current and former workers report documentation was omitted or added to case files to intentionally mislead the court. In some cases, this was to assure children were returned to their

[10] OIG does not believe the recommendations contained herein necessarily reflect all possible solutions. With this in mind, we encourage all readers to submit their ideas and recommendations to the Cabinet.

biological parents and, in other cases, it was reportedly to assure the Judge would rule for termination of the parents' rights. One worker conveyed that a frontline supervisor, at the direction of a regional supervisor, instructed her to enter information/contacts into a file for incidents that occurred prior to the worker being assigned the case. The former caseworker had already resigned from DCBS, so that worker was unable to verify if the information she was being asked to enter into the file was accurate.

3. There have been instances of dishonesty by DCBS employees, in documentation, in court, and in interactions with clients. OIG investigators have determined home visits and attempted home visits were documented in case files and the TWIST computer system that did not in fact occur. One caseworker advised a biological mother that her child had been to see a doctor, since the mother's last visit, without knowing if the child had seen a doctor or not. A caseworker advised she was unaware of any information regarding a child's parents or grandparents when there was a large volume of information on the relatives in the case file and the TWIST computer system. A veteran caseworker used the term "sexual predator" to describe a parent in the TWIST computer system and the case file. She stated the use of this was appropriate because a professional assessor had used this term and she was merely repeating his term. The caseworker used the term in a July 2005 court report and the assessment report she claimed to have obtained the term from was not completed until almost seven months later. Additionally, a review of the assessment report determined the term "sexual predator" was not used in the assessment report, so it would have been impossible for the term to have been derived from this report.

4. DCBS staff has routinely signed official documents as other staff members, usually supervisors. These documents included timesheets, travel vouchers for reimbursement of travel expenses, reports to the courts, purchase requests, and computer access approval forms.

5. During the 2001 Council on Accreditation (COA) review, Lincoln Trail regional supervisors manipulated caseload assignments and reported them to COA as lower than they actually were. Reportedly, this was intended to assure compliance with COA standards. Workers reported their cases were reassigned to them when COA left. Regional supervisors reported this act was not repeated during the 2006 COA review because they decided to let COA see the situation as it really was and, therefore, the caseloads were out of compliance.

6. In 2000, an SRA falsely advised the Cabinet that an employee's workstation was an office location closer to the employee's residence than her actual workstation. The primary benefit would be that the employee would be permitted to claim travel reimbursement for driving to work, daily. Descending SRAs permitted the situation to continue. Although other employees requested the same benefit, their requests were denied and they were advised this was a decision made by a previous supervisor and a previous administration, and it could not be changed.

"Fast Tracking" Adoptions:

7. The Adoptions and Safe Families Act, Public Law 105-89 (ASFA) was signed into law in 1997. It was intended to prevent children from languishing in foster care until they were no longer likely to be adopted. This law mandated permanency hearings to be held no later than 12 months after a child enters out-of-home care (OOHC). It also required state child welfare agencies to monitor the time children remain in care, and required the initiation of TPR proceedings for children who have been in state custody for 15 of the most recent 22 months. Only three circumstances are to be considered as reason not to have initiated TPR proceedings by the time the 15 month deadline occurred: (1) the child is in the care of a relative, (2) the state agency documents a compelling reason why filing is not in the best interest of the child, or (3) the Cabinet has not provided the services deemed necessary to the child's family to return the child to a safe home. The receipt of federal adoption subsidies was made contingent upon the adoption of ASFA by state governments. All 50 states have adopted the guidelines.

8. No pattern of 'fast tracking' adoptions was located in the Lincoln Trail Region. Although there were cases where a lack of services provided to the biological parents, by DCBS, most likely increased the chances the case would result in the termination of the parents' rights (TPR), there were no cases located in the course of this investigation where termination of parents' rights was completed prior to the child being in OOHC for at least 15 months. The average time between TPR and finalization of adoption was significantly lower in the Lincoln Trail Region: less than half of the state average. A child adopted out of foster care, in Kentucky, spent an average of over three years in the Cabinet's custody. In the Lincoln Trail Region, the average time is just over two years. Only three of the eight counties in the Lincoln Trail Region reported completing adoptions in federal fiscal year 2005. Those counties were Grayson, Hardin, and Marion. Although the averages in these counties were lower than the state average, they still exceeded ASFA timelines[11].

County	Average Months Between Removal and Termination of Both Parents' Rights	Average Months Between Termination of Both Parents' Rights and Finalization of Adoption	Average Months Between Removal and Finalization of Adoption
Grayson	22.49	3.27	25.76
Hardin	28.52	6.74	35.25
Marion	15.42	6.32	21.65
Lincoln Trail Region Average	**22.14**	**5.44**	**27.55**
State Average	**24.84**	**11.52**	**36.20**

Supervision Issues:

9. There was an obvious lack of a clear chain of command in the Hardin County DCBS office and the Lincoln Trail Region. When the SRA should have been in command, the SRCA was the primary decision-maker and employees reported that supervisors were not permitted to supervise their staff because the SRCA was communicating directly with the frontline staff. Social service workers reported contacting the SRCA instead of their supervisor. The frontline supervisors complained they were not permitted to be supervisors. The SRCA instructed one FSOS not to review a member of her staff's work, but to approve an investigation in the TWIST computer system anyway. The FSOS was advised this was to assure compliance with COA standards. Supervisors instructed workers to include false information in case files or not to document items in the case file. Workers were instructed and routinely completed home visits at times when it was known that parents would not be home. This was intended to prove the parents were uncooperative with the Cabinet. Supervisors have signed approval on court reports which made recommendations not supported by the documentation in the case file.

10. Supervisors do not routinely monitor subordinates, or hold them accountable while they are out of the office. There is no logging or reporting mechanism, used by supervisors, to assure staff is completing activities, as reported. Supervisors are unable to advise which activities a subordinate was involved in, on any given day. This provides a potential for abuse of process and/or power, by employees, and the inability of staff to confirm contacts were completed when challenged by clients. This same lack of oversight creates a significant worker safety issue in that workers could be missing and/or in harms way for an extended period of time without the knowledge of supervisory staff.

11. The regional emphasis was placed on adoption, instead of family reunification. For example, ASFA permits an extension in mandated timeframes for "compelling reasons", but no documented use of such

[11] Kentucky's Adoption Policies – Alleviating the Barriers, Auditor of Public Accounts, Tables 17 and 18; December 2006.

an extension was located. Further, Lincoln Trail Region P&P staff was evaluated according to whether the adoption goal was reached, but not evaluated on the number of families reunified. During 2005, most employees received a rating of four on the adoption item, with five being the highest possible score. The employees assigned to the Permanency Team received a rating of five on this item.

12. The Lincoln Trail Region exhibited autonomy in policy development and application. The region operated under a Critical Decision Making Protocol, developed for use in this region by regional supervisors, which mandated regional supervisors made virtually all case-related decisions, and denied case managers and frontline supervisors the ability to make case-related decisions. These decisions were made without appropriate factual support. Another example is the separation and specialization of team responsibilities, observed in the Lincoln Trail Region. This organization of tasks limits a caseworker's ability to provide continuity to clients and has only been identified as being in use in one other region. Supervision in that region, reportedly, were assigned to the Lincoln Trail Region, previously, and assisted in development of the concept. Under this structure, there are five separate teams operating in the P&P office: Intake, Investigative, Ongoing/Treatment, Recruitment and Certification (Foster Home), and the Permanency Team. This means a typical family would be assigned a minimum of four different workers and a Social Service Aide during the initial fifteen months children were placed out of their parents' home. Additionally, workers complained of policies enacted on a "whim" by regional supervisors. One example was the short-lived requirement to petition Family Court on every child sexual abuse referral, whether or not the allegation was substantiated. Reportedly, workers were told this was because the spouse of a regional supervisor was affiliated with the Court-Appointed Special Advocate (CASA) program and had complained about the small number of sexual abuse petitions.

Policy:

13. Workers reported a lack of consistency in training, in the acceptance of referrals, and the application of policy. Policy was applied inconsistently in determining whether a child should be removed from the biological parents' home, whether children were placed with a relative, or if siblings were to be separated. In some situations, policy appeared to be used "after the fact" to justify actions. As an example, relatives were not immediately considered for placement and the children were placed in foster care. Even after a relative specifically requested custody, one home evaluation was delayed months and, then, completed within one day. It was a favorable evaluation, but the relative was advised that due to the length of time the child had been in care, there was an attachment to the foster parents so the child would not be placed with the relative. Some relatives are denied placement for questionable reasons and no action was taken to remedy the situation, even after the CHFS Office of the Ombudsman justified the relative's complaint. Although the Cabinet is required to seek out relatives (SOP 7E), after one family advised DCBS of several relatives interested in placement of a large sibling group, only one home evaluation was completed and, after several weeks, one relative, who contacted a regional supervisor to inquire when she could anticipate completion of her interstate home evaluation, was asked why she waited so long to request custody. There is no documentation of the initiation of any request for the interstate home evaluation in this case file and the parents' rights were not terminated until more than a year later. Some relatives report they are not permitted visits with children in foster care, unless the visit is during the parents' visitation and is pre-arranged with their caseworker. In spite of the fact such visitation was approved by the court, in the case plan, and relatives had not acted inappropriately, some relatives were advised to leave visitation, even when they attend with the biological parents.

14. Policy and legal requirements are not explained to clients and foster/adoptive parents. This results in confusion and suspicion for both parties. For example, DCBS staff has in-depth contact with Comprehensive Assessment and Training Services Project (CATS) assessors prior to an assessment. Although DCBS staff states this contact is to brief the assessors on the case and issues involved, this is

viewed by clients as an effort to taint results. Several clients complained that CATS assessors cited unsubstantiated referrals and false innuendos, related to them by DCBS staff, as if they were fact.

15. Activities, events, and contacts are not consistently documented in TWIST or the case file. There is no mechanism/policy to assure documents are filed timely in case files. For example, service recordings and documents were added to the case files and the TWIST computer system just prior to COA review, after parents' rights were terminated, and after complaints to Central Office by the clients; often several months or years after the event allegedly occurred. Some original documents, dated from 2002 and 2003, were observed in various folders in a worker's office and had not been filed in the official case file.

16. The decision to remove a child from their parents' home is often completed under subjective standards, especially when the allegations involve neglect or dependency issues. The justification for removal is cited on the emergency custody petition, but is dependent on the social service worker's ability to verbalize an opinion of the situation. Cultural and socio-economic status issues are often interpreted as creating an inadequate environment for children. For example, a home that is cluttered, or not as clean as the worker would like, may be described as "filthy" to the court. Children are removed because the home is dirty versus unsafe. In two other situations, where a child fatality was ruled accidental by law enforcement, DCBS petitioned the court to remove the remaining children, as well as later born siblings, due to "neglect" even though all the children were attended at the time of the accidental death of a sibling. In one situation, the Judge was infuriated at the Cabinet, and while denying the petition, instructed the family they no longer needed to cooperate with the Cabinet because they had already been through enough.

17. When a worker contacts a home to investigate a referral alleging unsafe living conditions, in essence, they are requesting to make a warrantless search to determine if conditions are safe for the children in the home. In situations where parents deny the social service worker entry into the residence, the worker has two options, contact law enforcement and request they verify the safety of the children or contact the court and request an emergency custody order (ECO). In most cases, the court is contacted. Once an ECO is issued, law enforcement must be utilized to serve the order. In this scenario, even if the worker, upon entry to the residence, determines conditions in the home are safe, they have no recourse but to remove the children. Since law enforcement is required to be involved in either situation, it would appear most prudent to contact law enforcement, prior to contacting the court. KRS 620.040 (5) (a) mandates: "If, after receiving the report, the law enforcement officer, the cabinet, or its designated representative cannot gain admission to the location of the child, a search warrant shall be requested from, and may be issued by, the judge to the appropriate law enforcement official upon probable cause that the child is dependent, neglected, or abused. If, pursuant to a search under a warrant a child is discovered and appears to be in imminent danger, the child may be removed by the law enforcement officer." By so doing, the number of children unnecessarily removed, based solely on the fact that parents initially denied access to the social service worker, would be reduced.

Staff Issues:

18. There are cases in which, prior to and during the TPR hearing, workers have failed to advise the court and the Guardian Ad Litem that there are relatives available or appropriate for placement of the affected children. The workers told OIG investigators they do not make the TPR decision as that is the role of the court. However, if DCBS does not fully disclose all available information to the court regarding the family, the TPR decision is based on incomplete information, some of which may be material and/or exculpatory.

19. Some Lincoln Trail Region DCBS employees displayed a prevalent attitude of omnipotence in interactions with clients and community partners. As an example, workers inappropriately used wording

with negative connotations in the TWIST computer system, case files, and reports. Statements reflecting personal bias against clients were used in documenting incidents and situations in the files. Calls routinely were not returned to community partners or clients. DCBS staff complained that other staff made comments reflecting racial stereotypes. Further, some workers told OIG investigators that they felt compelled to comply with supervisors' instructions and do not believe they have a duty to "do the right thing."

20. Some workers do not routinely review the client's entire case file when assigned an existing case. Therefore, they are not familiar with the case, the issues, or the involved parties.

21. Workers respond aggressively to any perceived challenge to their actions. For example, biological and foster parents complained children were removed from their home because they "talked back" to the workers. Justified complaints from the CHFS Office of the Ombudsman resulted in written responses from the Lincoln Trail Region staff and supervisors, insisting the Ombudsman's findings be revised. Often their responses cited contacts and information from the case file that were entered after the issuance of the Ombudsman's report, or were reportedly in the hard copy case file, but not documented in the TWIST computer system and were, therefore, unavailable to the CHFS Office of the Ombudsman during their review.

Central Office:

22. Prior to the OIG investigation, client complaints that were reviewed and justified by the Cabinet's Office of the Ombudsman, routinely resulted in no corrective action in the client's case and no disciplinary actions were initiated against the involved employees.

23. Prior to the initiation of the OIG investigation, Central Office staff was seldom present in the Hardin County/Lincoln Trail Region office. There was an absence of input or review from Central Office unless regional supervisors requested the input or a significant complaint was lodged with Central Office.

24. One Lincoln Trail Region supervisor was granted a class stipend to obtain a Ph.D., including time, travel expenses, and miscellaneous expenses. The contract was granted for a period from 2000-2010, and approved by the then Secretary. During the covered period of time, tuition assistance for undergraduate and graduate level classes had been limited or unavailable to other employees. This resulted in animosity by some staff who felt as though they did not have the necessary resources available to them to properly complete their job. Further, this resulted in the routine absence of a high-ranking supervisor during normal business hours.

Adoption:

25. The selection of which foster parents will have an adoptable child placed in their home is completed subjectively by regional supervisors. The region placement coordinator is not involved and often not advised of the decision.

26. Adoptive parents have been advised they must adopt all siblings in a sibling group, or they will not be permitted to adopt any of the siblings, even when one sibling is abusive to the other children. ASFA and DCBS policy require siblings to be placed together unless there is a reason not to. Potential adoptive parents report children previously separated, due to abusive behavior by one or more of the siblings, were reunited in their home. When the adoptive parents requested the abusive sibling be removed, they report being advised by DCBS staff that they would have to adopt all of the siblings or they would not be permitted to adopt any of them. Adoptive parents perceive they are pressured to adopt problem children who are less adoptable in order to be permitted to adopt the more adoptable siblings. They report they were not provided a full disclosure of pre-existing conditions of the children or the resources

that would be available to them after the adoption was finalized. Some of these resources must be requested prior to the finalization of the adoption, or they are no longer available.

Case Plans:

27. Case plans are intended to outline the goals biological parents must achieve to have their children returned to their home. Requirements were routinely included on case plans that were expensive, relative to the client's financial situation; required unnecessary travel; and were not relative to the family's issues, as identified by the worker. Workers reported there was a regional protocol requiring that a domestic violence assessment, mental health assessment, and substance abuse assessment be included on all case-plans, whether or not they were issues with the family. While a case plan should not be easy, some case plans were intentionally written to be too difficult to complete. Items were included on the case plan that appeared overly burdensome and unnecessary, such as requiring the client to attain a General Educational Diploma (GED). Several workers, when discussing cases, stated the biological parents worked to get their children returned, and then, after several months, seemed to become overwhelmed with the feeling they could not achieve the goals established for them, and eventually quit trying. The case plans are to be developed in a team meeting, with supporting staff participating. Family Team Meetings do not routinely include community partners.

28. There is no mechanism to assure or verify services necessary to assist families in reunification were provided to them. Parents have been required to pay for assessments that were court-ordered to be paid by DCBS. There is no objective method to determine when a case plan is completed. This results in confusion between parents and DCBS staff. Various DCBS staff mandated differing results to fulfill the same case plan requirements, even to the extent that workers contradicted court findings. In turn, the parents' chances at successful family reunification may be primarily dependent on the caseworker assigned to their case. Parents have been required to complete the same items more than once, because one worker states they have fulfilled the requirement and the next worker states they have not. In one case where this situation occurred, after two years, it was determined the parents' original effort had fulfilled the case plan requirements. The child was out of the home the entire two years, and remains out of the home, although the parents appear to have fulfilled all case plan requirements.

Placement:

29. There were placements completed without the knowledge of, or a consultation with, the Regional Placement Coordinator. According to staff in the Lincoln Trail Region, all decisions about removal of children are made primarily by one regional supervisor, and the number of Out-of-Home Care (OOHC) placements in the region has doubled in the last five years. Statewide, there were 10,174 children in OOHC in 2000 and 12,874 children in out of home care (OOHC) in 2005[12]. This is a 21% increase. In state fiscal year 2001, (the figures for SFY 2000 were unavailable), there were 501 children in OOHC in the Lincoln Trail Region and 749 in OOHC in state fiscal year 2005. This would indicate there was a 66% increase in the number of children in OOHC, in the Lincoln Trail Region, in that four-year period.[13]

30. Permanency decisions were made subjectively and not supported by documentation in the case files. The Adoption and Safe Families Act of 1997 encourages relative placements. However, relatives were not the preferred placement option when children are removed from their parents' home, as evidenced by the 6.5%, statewide, who are placed with relatives.[14] While some parents are not capable or are unwilling to properly parent their children, many have relatives who are. While workers have stated a home evaluation can be completed in an hour, some relatives' homes were never evaluated or the evaluation was delayed for months. Even when DCBS is aware of potential relative placements, some relatives are not approached about obtaining custody and a home evaluation is not completed until the

[12] Kentucky's Adoption Policies – Alleviating the Barriers, Auditor of Public Accounts, December 2006.
[13] Figures obtained from James Grace of CHFS DCBS DPP via e-mail to Brenda Caudill-Barnes, 12-28-06 at 0948 AM.
[14] Kentucky's Foster Care System is Improving but Challenges Remain, Legislative Research Commission, 2006.

relative requests it. Relatives report they are not aware the Cabinet is no longer working to return the child to the biological parents until late in the process. When they inquire about custody, then, they are asked why they waited so long. The child's attachment to foster parents is cited as the reason not to transition the child into a relative's home. During proceedings related to permanency and termination of parental rights (TPR), the courts have been advised there are no viable relatives, when relatives who have stated a desire for custody and who have received a favorable home evaluation exist. These relatives are not routinely notified of TPR proceedings, so the TPR could be granted without the relative being aware. One relative complained she was not aware of the TPR until she contacted DCBS to ask when she and the infant's siblings could visit with the infant again. She was advised she needed to obtain an attorney to find out anything about the infant. DCBS staff told OIG investigators that relatives are intentionally ignored until late in the process and, then, workers claim they were unaware of the relative.

31. Children were removed from the homes of non-relatives, who had maintained custody or care of children for extended periods of time, prior to DCBS involvement with the biological parents. Non-relative placements are not considered as an alternative to foster care, even though the non-relatives may be appropriate and the children have a significant attachment to them.

32. According to DCBS staff, foster children have been removed from foster homes, without proper justification. Foster parents perceive this is due to personality conflicts between the parents and DCBS staff, retaliation, or DCBS staff having a negative attitude toward the foster parents. Staff has reported that placement decisions and recommendations reflect the personal bias of some DCBS staff against the biological and/or foster parents.

Judicial Process Issues:

33. Some parents are not involved and do not work to reunite with their children, but these children have relatives interested in custody of the children and are advised by DCBS they are not an interested party, since KRS 625.060 limits the parties to the petitioner, the Cabinet, and the biological parents. These relatives are not advised of the TPR hearing. After the TPR is granted, the relatives are then told the child is no longer related to them, and they have no recourse. In a few instances, DCBS has worked with relatives, after the TPR, to have them approved as a foster home, so the child may be placed with them, in the hopes they may become adoptive parents. However, if the proper actions had occurred and the relatives had been considered in the beginning, this would not have been necessary.

34. Parents are not provided legal representation at the 72-hour hearing. This hearing is pivotal in determining if there is enough evidence to maintain children in out-of-home care or return them home. One court officer stated children are sometimes left in foster/adoptive homes instead of being returned to their parents, not because their parents are unable to keep them, but because the foster/adoptive homes are better.

35. There is an obvious lack of continuity of legal representation for many biological parents. One parent reported she had four attorneys assigned to her during the first year her children were placed out of her home. Some appointed attorneys do not meet with parents prior to court or fail to appear in court, leaving the parent without legal representation.

36. The Guardian Ad Litems are often not held accountable for meeting professional standards. Many do not meet with the child prior to court, do not actively participate in the court proceeding and do not prepare for the case, so they are unaware of the issues involved, or they are absent from court, leaving the client without representation or recourse.

Management:

37. KRS 431.600 (8) states: "To the extent practicable and when in the best interest of a child alleged to have been abused, interviews with a child shall be conducted at a children's advocacy center." However, a Lincoln Trail regional supervisor instructed workers not to use the Advocacy and Support Center of Elizabethtown. This center was developed to service the Lincoln Trail Area Development District and covered only the counties in the Lincoln Trail Region. This means a valuable resource was lost to both the Cabinet and the clients, including a safe location for social service workers to conduct such interviews. According to the Advocacy Center staff, they are now utilized frequently by DCBS from outside Hardin County.

38. There was a noted effort by regional supervisory staff to relieve supervisors of their inherent supervisory authority. For example, regional supervisors established a regional policy (Critical Case Decision Making Protocol) which essentially removed all decision-making authority from the FSOS positions. This resulted in a regional supervisor levying decisions, based on the verbal briefing of another staff member, and without any actual case knowledge. Often the verbal briefing was once or twice removed from the actual staff member involved in the situation and the decisions were in conflict with the staff member's recommendation for the case.

39. There is no policy mandating the proper filing and handling of case files and there is no requirement for prior approval or the maintenance of a tracking record on destroyed documents. Documents are not filed timely and case files are not properly updated. For example, in March 2004, Lincoln Trail/Hardin County DCBS secretarial staff was given a two-year backlog of MSW consults to enter into the TWIST computer system. When investigators requested one case file, they were presented three different folders, containing various unsecured documents in no particular order, along with the official case file. Some of the documents, not filed in the official case file for years, were the original copies of court orders. Case files have remained out of the filing room for months or years. There is no requirement to return files to the file room and the case manager is permitted to maintain possession of the file while the case is open. During one visit to the Elizabethtown DCBS office, OIG investigators requested to review fourteen case files. None of these case files were located in the Times Two file room. This means the case manager must be contacted to obtain the case file so files are easily misplaced and lost. One hard copy case file, in a high profile Lincoln Trail Region case, is missing and has not been seen in excess of a year. Another case file is missing in Grayson County, even though the Judge ordered it be brought before the bench.

40. Prior to a complaint from the Hardin County Attorney's Office, in November 2005, workers were routinely using a "Verbal Order" of the court to remove children, during normal business hours, instead of contacting the County Attorney's office for a removal petition. The County Attorney complained after workers failed to follow-up with the submission of the required petition, or the facts in the petition filed later did not match the information relayed to the judge verbally, and would not have resulted in the issuance of an Emergency Custody Order. Without a petition, cases are not docketed for review by the court and mandated timelines are not met. Most significantly, while this was occurring, children could potentially have been removed from their biological parents' home and remained out of the home without any formal review by the court.

41. Workers are overworked and are unable to complete documentation during normal work hours. Not all workers are permitted to work overtime, so they work weekends and "off the clock". One worker came to the office while she was in labor and worked for three hours, after her water broke, to complete casework because a regional supervisor told her she could not take maternity leave until her cases were up to date. Cases were not reassigned or covered when an employee was on extended leave.

42. Caseloads were redistributed, sometimes to vacant positions, prior to the 2001 COA review, to assure compliance with COA standards. Then, caseloads were reinstituted when COA departed. When a

worker leaves, the caseload may not be reassigned for several weeks, leaving cases unattended and clients in limbo. Some clients have been instructed to call a supervisor, if they need something, before their new caseworker is assigned. Some were not advised about their worker's departure until weeks or months later, when the new worker contacted them. However, cases were reassigned when the worker did not agree with the supervisor's decision for the case. There is a lack of continuity of workers when cases are transferred to new workers. Case managers report they do no have enough time to review everything in the case file, and many cases were assigned to multiple workers in a 1 to 2-year period of time.

43. Regional policy was not written and changed often. Although DCBS P&P policy is posted on the CHFS Intranet, workers stated whenever they wanted to know what the policy was, they asked a supervisor. The workers stated that policy taught in training classes was not the same policy used in the Lincoln Trail Region. One employee said trainers were confused when they told them how they had been instructed to handle situations.

44. There is a significant lack of quality in documentation. For example, while reviewing case files, investigators noticed many entries were similar to the previous entries and appeared to have been cut and pasted into the record. Some of the recommendations to the courts were not supported by documentation in the case file. When interviewed, workers claimed to have specific information that influenced key decisions in the case; however, the information was not documented. Letters of notification of investigative findings, advising biological and foster parents whether the allegation against them was substantiated or not and of their right to appeal the findings, were not forwarded to parents. One worker admitted her lack of quality in her documentation. However, her attitude was that it was not a criminal issue, so it was not important.

45. Although state and federal regulations prohibit discrimination, regional supervisors confronted a foster home worker for placing a white infant in an African American foster home. He was instructed to move the infant to a white foster home. When the foster parent pointed out that African American children are placed in White and Hispanic homes, for respite, a decision was made to leave the infant in the home.

Unprofessional Conduct:

46. Although the majority of the Hardin County DCBS staff are determined and dedicated professionals, a minority demonstrated a pervasive attitude of supremacy in interactions with clients and community partners. This attitude was not limited to select members of the Hardin County DCBS staff, but was present throughout the Lincoln Trail Region and among the regional staff. Many of the complaints received from biological parents, foster parents, community partners, and even P&P staff were the result of unprofessional behavior by DCBS staff. While such unprofessionalism is not criminal in nature, it is a violation of the CHFS 2.1 Conduct policy, which states:

> "The employee shall not engage in inappropriate, disrespectful, demeaning, and/or abusive behavior such as, but not limited to: loud, abusive, profane, foul, obscene, vulgar, crude, insulting or threatening language; inappropriate jokes or gestures; discriminatory slurs; or sexual comments (even if spoken in non-standard English/foreign languages). The employee shall not commit, or threaten to commit, acts of violence, whether physical or non-physical."

47. Hardin County staff has reported that other social service workers have boasted about making it difficult for clients to work with DCBS staff. Social service workers have laughed at parents as they advised them they were removing their children and during the removal process. Social service workers have called clients indecent names in the hallway and offices of the Hardin County DCBS office. One social service worker struck and cursed a biological parent during a visit with his child. The worker then entered a detailed service recording in the client's file documenting the parent's aggressive behavior, but

failing to document her own use of an obscenity toward the client or that she struck him in the chest with her hand. This incident was witnessed by other DCBS staff. The client petitioned the court to obtain a court order to have the worker removed from his case.

48. The actions of the supervisors may have contributed to the attitude toward clients and the unprofessionalism in the work place. For example, staff reported that regional supervisors have yelled at staff in public, in staff meetings, and in open office areas. It was reported to be routine for negative comments and disciplinary statements to be made in front of clients and other staff. Two DCBS workers were nicknamed "The Queen of Removal" and two Permanency Team workers were nicknamed "The Terminator". Additionally, a regional supervisor referred to the Permanency Team as "The TPR Team".

49. The Foster Care Review Board is charged with reviewing the cases of children in out-of-home care. There are several instances where a question, on the review form, from a board member resulted in a curt and unprofessional written response from the caseworker. One worker later admitted to OIG investigators that her actions were not appropriate, but she thought they were at the time.

50. Clients and community partners complained that DCBS staff acted unprofessionally to other professionals and clients. For example, community partners believed DCBS, on occasion, misrepresented facts and circumstances surrounding client cases. DCBS staff is not responsive to clients in the waiting room, and have ignored clients and closed the window on clients to continue a personal phone conversation. Clients and community partners complained about the lack of cleanliness of the office and visitation areas. Clients complained about the lack of comfortable facilities for visitation. An OIG investigator verified the visitation room is approximately a 12 X 12 room with hard stacking-type chairs and a small number of soiled toys. The floor is linoleum tile and it was dirty.

Foster Homes:

51. Foster parents provide a valuable service to the children of the Commonwealth. Often, foster parents wish to adopt, but not all do. Many foster parents feel they are powerless, relying on the mercy of DCBS and the whim of unreliable biological parents. A private childcare facility worker advised she has been told by four sets of foster parents that they had been instructed not to talk to OIG investigators, or they would not have children placed in their homes. Although this could not be confirmed, the fear of retaliation by certain social service workers operates as an undertone in many foster homes. The use of concurrent placements/resource homes creates a conflict for some foster parents, who wish to adopt, and discourages them from assisting the biological parents in having the family reunited. While many foster/adoptive parents maintain perspective, some ride a reverse roller coaster from the biological parents as they are placed in a conflicting role of supporting reunification or obtaining children of their own. Often, foster/adoptive parents receive adoption subsidies after the adoption is completed, so they have nothing to lose if the child is adopted and everything to lose if the child is returned home. While reviewing one case file, OIG investigators located correspondence from a foster mother reporting incidents and situations involving the biological parents, who had unsupervised weekend visits. Included in the correspondence were inappropriate comments and statements indicating her displeasure with the actions of the biological parents and reflecting that the biological parents did not meet her standards. There was nothing located to indicate the caseworker addressed the inappropriate comments. One foster parent supported the Cabinet's efforts to terminate a parent's rights to the children in his home, even though he noticed inconsistencies in the children's stories of abuse. Not long after the TPR was completed, the children lodged similar abuse complaints on the foster parents, before they could complete the planned adoption. The foster father said he believes, now, the biological mother was telling the truth when she denied the abuse.

52. Even though some foster parents choose not to adopt, they still become attached to the children in their home and have expressed concern that their conflicts with DCBS are used against the children. For

example, foster parents report children have been removed from their home because the parents have pointed out policy violations, corrected mistakes in documentation, or complained to the CHFS Office of the Ombudsman. DCBS staff has reported some workers and supervisors do not like certain foster parents and seize upon opportunities to remove children from their home and, then, do not place additional children in the foster home. Foster parents report they know they have to get along with DCBS or they will not have children placed in their home.

53. Complaints on foster homes were not consistently documented in the foster home files or addressed with the home. For example, when an investigation is conducted, they have not consistently been completed within the 30-day timeframe established in policy, and no investigative extension is documented. Foster home investigations have been delayed or prolonged, sometimes causing the home to be placed "on hold" for a year or longer. The "on hold" status means the home cannot have any children placed in it. Some foster parents complained that DCBS utilizes allegations, even unsubstantiated allegations, as the reason to remove foster children from foster homes that DCBS deems as uncooperative.

Biological Parents:

54. Biological parents complained they are held to a higher standard than some foster homes. For example, once children are placed in a foster home, some biological parents have experienced difficulty in assuring abuse and neglect allegations are investigated in the foster home. In one case, where the biological parent made numerous complaints about the inappropriate actions of the foster mother, cleanliness of the children and recurrences of head lice, including complaints to the Hardin County workers, the CHFS Office of the Ombudsman and the DCBS Commissioner's Office, a review of the foster home file did not indicate any problems or concerns with the foster home. Multiple visits by OIG investigators to the home revealed unsafe, unsanitary, and cluttered conditions, with an untended and trash-filled lawn, and two goats roaming freely in the front yard.

55. Some biological parents are not advised of, or permitted to attend, school functions or to make medical decisions for their children in out-of-home care, in spite of the fact, they are to be included, absent a court order to the contrary. One FSOS instructed, against the parent's wishes, that a male child was not to be circumcised, unless medically necessary. Another worker advised a biological mother she need not attend a medical treatment-planning meeting for her child, but the foster mother was invited and attended.

56. While it is obvious, the amount of time a child spends with an adult will enhance the relationship and bonding, some biological parents whose case goal is reunification report visits with their children have been reduced. The parents have been told this was due to the lack of available DCBS staff to supervise the visit. Some parents suggested alternatives to DCBS staff supervising the visits, and one parent was advised by the court that she could have visits supervised by a clergy member. When her clergy attended the case-planning meeting, he was told this was not possible and a DCBS staff member was required to supervise all visits.

57. Domestic violence victims have been advised by social service workers to leave their abusive spouses and go to a domestic violence shelter. Once they are living at a shelter, some victims have been told the shelter is not appropriate for children and their children will be removed if the parent does not find an alternative residence.

58. Children in foster care, who are parents, are not permitted to take their children with them when they leave, even though they do not have substantiated abuse/neglect allegations. The Cabinet maintains custody of the infant, as a dependent child, until the parent can complete a case plan and prove they are capable of caring for their child. This is a higher standard than other parents are required to meet, since

there is no obligation for biological parents to prove they can adequately provide for their child before leaving the hospital after a child is born.

Community Partners:

59. The Hardin County DCBS office does not effectively utilize community partners. Referrals from community partners are routinely not accepted or investigated, and the reason is not provided to the community partner. Offers from community partners to provide free training and joint training opportunities are not accepted. Although DCBS staff assisted in the development of one training course, when the training was provided, workers were expressly forbidden to attend. One worker attended the training and was advised, at lunchtime, not to return for the afternoon session.

Intimidation and Retaliation Against Clients, Foster Parents, and Staff:

60. Employees were retaliated against, through employment, case assignments, and promotions, for opposing supervisors. One employee was advised in March 2006, that regional supervisors believed she initiated complaints which lead to the OIG investigation of the Hardin County DCBS office. Three months later, supervisors forwarded a request for major disciplinary action on the employee to Office of Human Resource Management (OHRM). Included in the request, as evidence of improper use of the state computer, were e-mails sent to OIG investigators in which the employee was providing evidence in the investigation.

61. Employees were selectively disciplined over past due cases. Some workers report being permitted to work overtime to get cases current and did not receive discipline. Other workers were counseled over past due cases, but not permitted to work overtime to get them up to date.

62. Workers were targeted when they took extended sick leave or maternity leave. One employee advised supervisors of her pregnancy, and maternity leave was requested months in advance. The employee was approved for 10-12 weeks of leave. Near the end of her pregnancy, she was advised she was only permitted 6 weeks of leave and all her cases had to be current before the leave began. She verified with OHRM that she had enough leave time to cover the requested leave and there was no prohibition to the additional weeks of leave. She was eventually permitted to take the extra leave time. Within months of returning from maternity leave, a co-worker, who began employment with DCBS the same day, held the same positions, had the same evaluations, and used the same amount of leave time, received an automatic reclassification. When the original employee questioned why she did not receive the reclassification, she was advised it was due to the amount of maternity leave she used. Again, when she contacted OHRM, she was advised this was not a valid excuse and she was reclassified a month later.

63. Regional supervisors have attempted to interfere with staff transfers. One supervisor at a community partner organization reported being advised she could not interview a DCBS employee, as a job applicant. A former employee's new supervisor, at another state agency, was contacted by a regional supervisor in an attempt to block the employee's transfer. Two current DCBS employees, who have transferred outside the Lincoln Trail Region, reported their new supervisors were contacted in an effort to delay their transfers.

Promoting Adoption Over Reunification:

64. The Lincoln Trail Region promoted termination of parental rights and adoption over family reunification. Lincoln Trail Region employees stated the number of children being placed in foster homes has doubled in the past five years. During state fiscal year 2001, there were 501 children in foster care in the Lincoln Trail Region and 308 in Hardin County. In state fiscal year 2005, there were 749 children in foster care in the Lincoln Trail Region and 370 in Hardin County. While this does not show a 100% increase in five years, it does reflect a 66% increase in four years. Most Lincoln Trail Region employees have an item on their Annual Employee Performance Evaluations related to

achieving the goal for the number of adoptions completed. Therefore, at a minimum, there is the appearance that workers benefited from the removal of children from the biological parents' home and the eventual termination of the parents' rights. For the 2005 evaluation period, the employees on the Permanency Team received a score of five, the highest possible rating, in this area. The employees on other teams received a score of four in this area. There is, reportedly, no item related to the number of children returned to their parents or the number of families reunited on the Lincoln Trail Region employees' Annual Employee Performance Evaluation.

Mishandling Cases:

65. The regional supervisors established an unwritten regional policy that required every family to obtain a professional assessment for domestic violence, mental health, and substance abuse, even if there were no domestic violence, mental health, or substance abuse issues present in the family. This unnecessarily increased the amount of time children were out of their parents' homes, added to the stress and requirements of the parents, and caused additional expense for families that were already struggling financially.

66. In some situations, Lincoln Trail Region DCBS has failed to follow-up or provide services to clients. Referrals were delayed to other service agencies, such as Communicare and the CATS assessors, so parents were unable to begin working on required components of their case plan. Community partners, such as the Advocacy and Support Center of Elizabethtown, were not utilized or consulted to provide services to clients. Relatives, who requested home evaluations for the placement of children, were not evaluated. Case plans were not completed on time and copies were not provided to the parents. Cases have been assigned to the Permanency Team without being provided the services of the Treatment Team. Some workers were instructed to go to client homes during times they knew clients would be absent (i.e. during work hours) in order to establish evidence that the biological parents were uncooperative. Routinely, workers are not reviewing case files when a case is reassigned to them, so they are not familiar with the case history or the issues involving the family. The Foster Care Review Board believes cases were intentionally hidden from them to prevent their review. In January 2006, eleven cases were presented to the Hardin County Foster Care Review Board for the first time. These cases included 26 children and some cases were 18 months old. Therefore, a valuable check, via an independent process, was not performed until late in the life of the case.

67. Although the region has a contract for a Regional Placement Coordinator to track out-of-home care (OOHC) placements, the regional supervisors completed most of the OOHC placement decisions. Often, this resulted in the Regional Placement Coordinator not being aware of children in the system or being notified when children were moved.

68. There is a lack of consistency in documentation. Some workers include detailed contacts in the TWIST system and others appeared to 'cut and paste' the same entries at each entry date, with very little new information. There is an obvious lack of documentation in the case files and in the TWIST computer system to support workers' statements and recommendations. Caseworkers were required, by their supervisors, to make recommendations to the court that they do not necessarily agree with and workers are unable to justify these recommendations, when challenged in court. When DCBS completed investigations in some cases, the letters of findings (Substantiated/Not Substantiated) were not sent to clients at the end of their investigations. This meant the 30-day period established to permit parents to appeal the finding before they are included in the Child Abuse and Neglect (CAN) database elapsed without the parents even knowing about the findings. Once parents realized they had been included in the database, often when they were denied employment, they were required to prove they did not receive the notice before they were permitted to appeal the finding. In one case, this caused a biological parent to lose employment as a teacher for an entire school year.

69. Parental visitations were changed or cancelled without proper notice to the parents or foster parents. One father was ten minutes late to his scheduled visit and was told he was not permitted to visit with his child. As the father was walking across the parking lot, to enter his car to leave, his child rode by him in another vehicle. The worker had cancelled the visit, because the father was tardy even though both the father and child were present in the DCBS building. In some cases, children or parents appeared for visits and then were told the visit has been cancelled. In other cases, the visits were reduced, in length and frequency, and the biological parents were advised such changes were based on the fact that DCBS did not have enough staff to supervise the visits. Although DCBS SOP 7E states family members, significant to the child, should be included in visitations, relative visits with children in out-of-home care were delayed or not permitted, without cause.

Breach of Confidentiality:

70. Although several clients complained that relatives contacted DCBS and requested information, or that community partners were provided information on their case, no evidence of a Breach of Confidentiality was located. Investigators determined that DCBS employees were extremely hesitant to release any information, even to other professionals, as permitted by KRS. This was apparently due to a lack of understanding of the federal Health Information Privacy Protection Act (HIPPA) and KRS. Employees were unable to differentiate between HIPPA protected information and confidential client information. One caseworker even used HIPPA as an excuse not to leave a message for a client to return her call, at a place of business.

SPECIFIC INVESTIGATIVE CASES

As a result of this investigation, the Special Investigations Division of the OIG opened a master case (Case # 2006-030-047) and seventeen individual cases:

Case Number	Allegation	Type of Issues	Findings	Actions
2006-021-047	Falsification of Records and Retaliation Against Employees	Employee claimed a false official work station, claimed expenses for days not worked, instructed another employee to commit forgery, instructed another employee to falsify public records, violated DCBS policy in the placement of children into out-of-home care, retaliated against subordinate staff members, falsified adoption documents, instructed staff to violate CHFS policy in completing client case plans, and assigned staff to conduct investigations on other staff.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-022-047	Unprofessional Conduct and Interference with an Administrative Hearing	Supervisor cursed a subordinate employee in public, instructed a subordinate employee not to attend an administrative hearing.	Unsubstantiated	No action required
2006-023-047	Falsification of Records	Intentionally falsified case documentation by not including information into the case file, falsely reported information to community partners.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-024-047	Divulging a Computer Password	Provided computer password to a subordinate.	Unsubstantiated	No action required
2006-025-047	Divulging a Computer Password	Provided computer password to a subordinate.	Unsubstantiated	No action required
2006-026-047	Falsification of Records	Provided false testimony in court, falsified documentation in case files, falsely advised parent on condition of a child, changed client's SSN to an incorrect number, and falsely reported to FCRB that documents were in file that were not present.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management

Case Number	Allegation	Type of Issues	Findings	Actions
2006-027-047	Falsification of Records and Dishonesty	Falsely accused client of threatening her, entered false documentation into a client's file, falsified testimony in court.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-028-047	Falsification of Records and Unprofessional Conduct	Did not report all facts to the court, cursed and struck client, rude to clients, threatened clients, falsely reported information to the court, falsely signed a document as another employee.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-029-047	Falsification of Records	Falsely reported home visits and contacts with clients.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-041-047	Breach of Confidentiality	Divulged information to a person not permitted access to information.	Unsubstantiated	No action required
2006-118-047	Falsification of Records	Completed official reports with false documentation.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-119-047	Falsification of Records, Divulged Computer Password, and Retaliation Against Employees	Authorized administrative staff to sign as a supervisor, provided computer password to subordinates, instructed subordinates to remove documentation from the case file, aware of intentional lack of documentation in file and did not instruct subordinate to complete documentation, recommended disciplinary action against a subordinate she had previously blamed for initiating the OIG investigation.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management

Case Number	Allegation	Type of Issues	Findings	Actions
2006-120-047	Falsification of Records, Unprofessional Conduct, and Retaliation Against Employees	Yelled at subordinates, instructed subordinate to delete a contact in TWIST, solicited complaints on a subordinate, from other employees, she had previously blamed for initiating the OIG investigation.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-147-047	Falsification of Records	Falsely documented information in case files and reports.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-148-047	Falsification of Records	Falsely signed other employees' names to official documents.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-149-047	Falsification of Records	Instructed a subordinate to include false documentation in case files.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management
2006-150-047	Falsification of Records	Falsely signed a supervisor's name to an official document.	Substantiated	Referral to the Hardin County Commonwealth's Attorney and the CHFS Office of Human Resource Management

CASE SYNOPSES

As examples of the cases reviewed and the type of evidence gathered during the course of this investigation, attached to this report are thirteen (13) synopses of client cases. These brief descriptions are not intended to provide all the content of the original case; only the more significant events/issues involved in the case which lead investigators to the findings. For purposes of this report, individual identifiable information has been removed.

Client Case #1

The infant is the third child born to the biological mother. The first two children were in the custody of their 62 year old maternal great grandmother, at the time of the infant's premature birth, in February 2004. The biological mother tested positive for cocaine after the infant was born, but the infant tested negative. DCBS obtained custody of the infant in March 2004. The infant was released from the hospital in May 2004 and was immediately placed in a medically fragile foster home. She remained in this home until June 2005.

The initial caseworker, SW #1, wanted to place the infant with her siblings in the home of the maternal great grandmother, but the SRCA said the maternal great grandmother "did not need her." She said some DCBS staff did not like the maternal great grandmother because she was "head-strong." The SRCA did not want the paternal grandparents to get the infant because she thought they would give her to the parents. SW #1 said she thought the maternal great grandmother should have the infant and was taken off the case because she was "too close" to the maternal great grandmother and the case was then assigned to the Permanency Team. SW #1 said she was told to stay out of it. The maternal great grandmother and the paternal grandmother state they were never told the child would not be placed with them or why. According to a contact in TWIST, dated 09-01-04 and entered by SW #1, the SRCA advised that the infant would not be placed with the maternal great grandmother, but an affidavit should be filed to grant the maternal great grandmother permanent custody of the infant's two siblings, as soon as possible. The maternal great grandmother received permanent custody of the infant's two siblings on 12-15-04.

SW #2 was assigned as the caseworker and she said she was told to try to find a home for the infant. She said the maternal great grandmother already had custody of the child's two siblings (ages three and four at the time of placement) and wanted custody of the infant. SW #2 said the FSOS and the SRCA disagreed on whether to place the infant with the maternal great grandmother, due to her age and the demands of the other children in her home. SW #2 said the paternal grandparents also offered to take custody of the infant, but SW #2 was told they did not go to the hospital enough to bond with the infant, like the Cabinet wanted them to, and she was told they did not complete the required training in a timely manner. [OIG investigators located copies of the parents' and paternal grandparents' CPR certification, completed on 08-10-04, in the case file that were faxed to DCBS on 08-17-04.] The paternal grandfather was transferred to another state with the Army in November 2004. Prior to the transfer, the paternal grandparents maintained visitation with the infant. The paternal grandmother stated DCBS was advised of this move and a home evaluation was completed on their home, including a home visit, interviews, background checks, and letters of recommendation. [OIG investigators did not locate a home evaluation for the paternal grandparents in the case file. Additionally, no documentation referring to completion of this home evaluation was located in the TWIST contacts.] The biological parents lived with the paternal grandparents and moved to the other state with the paternal grandparents. Once they were settled, the paternal grandmother said she contacted DCBS with their new contact information and the contact information on the other state's Child Protective Services (CPS), so DCBS could request their assistance in the interstate compact. The paternal grandmother said she was then advised she would need to obtain an attorney before DCBS could provide her any further information. OIG investigators did not locate any documentation to indicate CPS in the other state was ever contacted by DCBS, or any action was taken to initiate approval of an interstate placement.

SW #2 said she discussed the relatives with the SRCA, but she was unbending and refused to put the child with any of the relatives. SW #2 said there was no meeting with them to tell them they were not going to get the child. SW #2 believed the infant should have been placed with the maternal great grandmother because she was family and already had custody of the two other siblings. SW #2 was not aware that a great aunt was also seeking custody of the infant. SW #2 said she believes personal issues of DCBS staff were taken out on the family. She said relatives should be permitted to visit with the children, to improve bonding between them and to give the foster parents a break. SW #2 said this is in the best interest of the child and she talked to the SRCA about this, but the SRCA did not like the idea.

SW #3 was assigned to the case and she stated the SRCA did not want the maternal great grandmother to have the infant because of the maternal great grandmother's illness (high blood pressure), that another child may be too much for the maternal great grandmother. The maternal great grandmother obtained a doctor's statement verifying she was healthy enough to take care of three children. SW #3 said the SRCA also commented on the maternal great grandmother's criminal record (no liability insurance on her car). SW #3 said the SRCA did not want the maternal great grandmother to have visits and, at one year of age, the infant had only visited with her twice. SW #3 initiated the visits and the infant did not know her family and cried. She said other DCBS staff members commented that something was wrong, so SW#3 began conducting the visits in the maternal great grandmother's home.

The maternal great grandmother contacted the CHFS Office of the Ombudsman in March 2005, to complain that she was not being considered for placement of the infant. However, after the maternal great grandmother contacted the Ombudsman, and they contacted the Lincoln Trail Region, the SRCA instructed SW #3 to contact the private childcare agency the maternal great grandmother had previously contracted with, as a foster home, to obtain a letter advising that the maternal great grandmother was no longer a certified foster home for them. The maternal great grandmother had previously asked to no longer be a foster home for the private childcare agency. The SRCA used the letter as evidence the maternal great grandmother was an unfit home for placement of the infant. The maternal great grandmother's complaint was justified by the Office of the Ombudsman. There is no documentation in the case file to indicate any action was taken to correct the issued identified by the Ombudsman's review.

Once it was apparent that the maternal great grandmother would not be permitted to have the infant placed in her home, the maternal great aunt contacted DCBS and requested to have the infant placed with her. She was in the process of obtaining a divorce and lived by herself in a two-bedroom trailer, near the maternal great grandmother. The maternal great aunt was advised she would need to obtain a larger residence, so she contacted a realtor to sell her home and locate an acceptable home. [OIG investigators did not locate a home evaluation for the maternal great aunt or any documentation reflecting she was being considered for placement in the case file.]

SW #4 was the last caseworker assigned to the case and she said the FSOS told her all relatives had been exhausted and all she had to do was complete the termination of parental rights (TPR). SW #4 stated she followed up with the maternal great aunt prior to the TPR and determined she had not obtained a larger home. The maternal great aunt denies that anyone ever followed-up with her and she could not understand why her 2 bedroom home had been large enough for DCBS to place the infant's two siblings with her, prior to placing them with the maternal great grandmother, but not large enough for just the infant. SW #4 said she thought the TPR was correct in this case, but could not state why she thought this. She said all decisions had been made before she was assigned the case. SW #4 stated she contacted the maternal great grandmother and advised her of the TPR date. The maternal great grandmother adamantly denies being advised of the TPR date. She said she was not aware anything was happening with the case until she called the DCBS office to find out when the next visit was scheduled and was advised she would need to get a lawyer to find out anything about the case.

The biological parents' rights were terminated on 06-14-05 in Hardin County and the child was moved to a basic foster/adoptive home on 06-27-05. This would indicate the infant was no longer "medically fragile", although there is nothing in the case file to indicate when the infant was no longer considered "medically fragile". SW #5, the foster home caseworker, thinks the infant was no longer "medically fragile" six months prior to TPR. SW #3 said she tried to get the baby released from the "medically fragile" status at one year of age, but the doctor wanted to monitor her a little longer due to her lungs and "just to be safe." SW #2 said DCBS should have reconsidered the relatives when the child was no longer "medically fragile", but that was not done. A transition schedule reflects the prospective adoptive parents began to visit with the infant on 05-01-05 and the adoption was final on 08-17-05, six weeks after the child was placed in the home.

An FSOS said his involvement began when the SRCA told him to find an adoptive home for the infant, after the parents' rights had been terminated. He said his involvement was limited to producing a "short list" of three prospective adoptive homes and providing it to the SRCA. He said the SRCA made the decision where the infant was to be placed/adopted.

On a 07-28-05 report to the court, a DCBS employee reported there was no information available on the biological parents or either set of grandparents, that the child had tested positive for cocaine at birth and was in the hospital from birth (February 2004) until May 2005. The DCBS employee stated there was no information available on these family members and you "don't make it up." She said she had talked to the caseworker (SW #4) and looked at TWIST screens to assist her in completing this report. When the DCBS employee was told both sets of grandparents, and even a great-grandmother, had attempted to gain custody of the infant, the biological father was presumed to be the husband of the biological mother, there were two siblings placed with the great-grandmother by DCBS, and that several workers had told the investigators at least three family members wanted to adopt the infant and the case file mentions all of these relatives, the DCBS employee said she was never made aware that any home studies were completed, and she just wrote the report from the information she had been given. She said she did remember something about the biological parents being in another state, but she had no other information. She continued to maintain that at the time she completed the report, there was no information on either set of the grandparents. However, she could not explain why she did not see the information on the relatives when she reviewed the case file. She said she knew the mother had cocaine in her system at the time of the infant's birth, but no other information was given to her.

The adoption presentation summary was completed by a DCBS contract employee in September 2005. Although the case file includes information on the maternal grandmother, the paternal grandparents, and the biological parents, the presentation summary reflects there is no information available on the biological father or either set of grandparents. It also indicates the child tested negative for cocaine at birth, the child has no siblings, but lists two half-siblings, and includes information on the biological mother.

SW #4 advised OIG investigators there was no information available on the biological father or either set of grandparents. She appeared surprised to learn the father was married to the biological mother and the maternal grandmother, paternal grandparents, and other family members had sought custody and reported they had home evaluations completed on their homes. SW #4 said the presentation summary was completed by a contract employee (adoptive/ foster parent and contract employee) and a former DCBS employee. SW #4 said during some of the time she was assigned this case she was on maternity leave and another social worker was assigned the case. [OIG investigators determined SW #4 was on maternity leave from late June 2005 until late August 2005.] SW #4 said no one is responsible for assuring the adoption report is completed correctly and accurately.

Although three relatives thought they were approved for permanent custody, none received the infant. Additionally, although the child's status of "medically fragile" was used as the reason to deny the relatives' placement of the child, they were not reconsidered once the child was no longer "medically fragile." Then,

although there was no documentation of a reason to split the siblings, the child was not placed with the siblings. The child was removed from the home she had been in since release from the hospital after her birth and placed with a non-relative in a new foster/adoptive home, and the adoption was finalized six weeks later.

Client Case #2

In April 2005, a referral was received that a child was observed walking along a busy highway. It was reported that a person took the child home and found the biological mother asleep. The referral source said this was a frequent problem and the biological mother was moving into a tent with her children, her mother, and her mother's ex-boyfriend. There is documentation in TWIST that indicates a prior history of domestic violence between the biological parents, with the biological father as the aggressor. One incident, reported by the biological father's relatives, stated he had thrown the biological mother and the children out of the home, which was located on his relative's property. At the time of the referral, the biological mother resided with her husband, the biological father of their three children, and the children.

SW #1 investigated. According to the CQA, SW #1 went to the home in June 2005 and found there was no running water and the children's teeth were rotten. SW #1 removed the children and placed them with the biological father. SW #1 followed the biological father to his home where a prevention plan was signed. Temporary custody was granted to the biological father. SW #1 documented in the CQA that the biological mother was offered services but failed to utilize them or provide the proper information for preventative assistance.

In August 2006, the biological mother was contacted at her residence. She stated her children were removed approximately one year ago based on a false allegation regarding drug usage initiated by her ex-husband. She said she had taken drug-tests, as requested by DCBS, and the results were negative. She stated no one from DCBS has attempted to contact her for the past year. The biological mother said, at first, she had supervised visits with her children at a McDonalds in Radcliff. She said she was sick and could not attend one scheduled visit. After that, her visits were suspended and no DCBS staff attempted to work with her or contact her. A review of the case file indicated, on 09-27-05, SW #2 documented that the biological mother's visitation was suspended due to not showing up for her scheduled visits with the children.

The biological mother said she went to the DCBS office about 6 months ago inquiring about her case and why she had not been allowed to see her children. She stated a woman at the front desk informed her that her case was closed and there was nothing that could be done. The biological mother said she just left the building.

According to the service recordings placed in the biological mother's case file, SW #2 documented three face-to-face home visits with her. When questioned, the biological mother said she has never spoken with or seen a male social service worker and has never heard of SW #2. She said she has lived at the same address for the past year, with her father, and no one from DCBS has been to see her. She said her ex-husband has custody of her children and she is not permitted to visit them. The biological mother said neither she, nor her parents, were allowed to see the children last Christmas. She said her father delivered presents to her ex-husbands house, but was not allowed to see the children.

In December 2006, SW #2 admitted he had never seen or spoken to the biological mother. SW #2 said the home visits with the biological mother, documented in the service recordings, were a mistake. He said those visits were home visits with the biological father, and not the biological mother. SW #2 said the 12-28-05 home visit which stated the children were looking forward to Christmas was a mistake. He said all three documented home visits with the biological mother were a mistake. SW #2 said he has never intentionally falsified a DCBS document, although the service recordings regarding the biological mother may not be entirely correct. SW #2 agreed it was his responsibility to work with the biological mother so she could be reunified with her children,

but said he thinks the biological mother could have taken more initiative and been more persistent regarding her case.

No documentation was located in the biological mother's file to indicate SW #2 attempted to work with her in any way. SW #2 did not contact her or develop a case/prevention plan. An OIG investigator spoke with the biological father, who stated he has only seen a caseworker one time and that was when the children were about to start school. The biological father said he did not remember the worker's name, but remembered the worker was a female. SW #2 disagreed with this and said he had been to the biological father home, more than once.

Client Case #3

In May 2005, the biological mother argued with her paramour and decided to leave the home they shared together, taking her two children with her, for the evening. The biological mother was pregnant with her third child. She went to the nearby home of her cousin and his girlfriend. They had a male visitor present in the home. While the children were in bed, the mother left the residence to visit a friend a few houses away from her cousin's home. According to the DCBS report (Inv-7), the two men were playing video games in one bedroom and the female was on the computer in the living room. The 11-month-old male child awakened and began crying for his mother. The males put him on the bed with them, but he crawled off the bed and fell asleep in the hallway. The biological mother returned to the residence, around midnight, and put the child in the same bedroom with his five-year-old sister, before leaving the residence again. Later, the two adult males decided to take a break and discovered the male child in a bathtub, where clothes were soaking in several inches of water and detergent. He was taken to the local hospital and then flown to a Louisville area hospital. The child died later that evening. SW #1 contacted a Family Court Judge and obtained a verbal removal order to remove the 5-year-old. The child was placed in a foster home. SW #1 and the SRCA consulted and decided DCBS would substantiate neglect on the biological mother for "choosing inappropriate caregivers" and not taking the 5-year-old to the doctor for an infected splinter in the child's foot. Additionally, they substantiated physical abuse due to bruising located on the 5-year-old's bottom and back and statements by the child that her biological mother had spanked her earlier in the week. The biological mother told OIG investigators that she was told at the case planning meeting that DCBS was substantiating neglect and asked to sign the case plan. She understood she admitted neglect when she signed the case plan and that she, then, had to plead guilty to the charge in Family Court. DCBS also substantiated neglect on the paramour due to the 5-year-old reporting she had witnessed domestic violence between the couple.

DCBS determined there was a history of domestic violence, due to previous referrals where the biological mother was the victim. The mother's paramour had a history of alcohol abuse. The biological mother had a prior history with DCBS both as a child and as an adult. After the child's death, DCBS opened Inv-8 due to an allegation the paramour's biological children had observed domestic violence and substance abuse while in the couples' home. This allegation was unsubstantiated. The next investigation (Inv-9) was opened due to an infant's birth in January 2006, after the death of the 11-month old. This was an allegation of neglect, and was substantiated by SW #2. In Ong-5, from March 2006, SW #2 stated this substantiation was "due to the history of the parents and their lack of progress on their case plan and continued denial of any issues within the family system needing work." In this same report, SW #2 stated the biological mother denied any responsibility for the child's death or for the 5-year-old child's neglect. She stated the biological mother has continued to reside with her paramour, although she has been told he is not cooperating with DCBS as they would like and this is a barrier to her having her children returned to her custody. SW #2 reported the paramour did not take two drug screens when she requested them, although he has taken one for DCBS and several for his probation officer and all of them have been negative. The paramour is self-employed and owns the home the couple resides in.

In January 2006, the foster mother confronted the biological mother over a disposable camera provided by DCBS for the biological mother to take photos during her infant's first bath. The foster mother insisted that

specific camera be returned. Since the photos had already been developed, the biological mother offered to provide a copy of the photos, but the foster mother continued to insist the biological mother had stolen the camera. At a later visit, the oldest child told her biological mother that the foster mother said she was a "thief". The child advised her biological mother that the foster mother told her that her biological mother's home had rats and made other inappropriate comments. The biological mother complained about the condition of her children when they appeared for visitations. The SSA supervising the visits documented, in March 2006, the infant had dried milk on her face, matted hair, had an unwashed smell, and wore the same outfit to every visit. The SSA stated the infant had dried feces on her bottom and it took nearly an entire box of wipes to get it off. An FSOS also witnessed the condition of the children and complained to other DCBS staff. During the CATS assessment in January 2006, the biological mother noticed the foster mother picking nits from the older child's hair. There were reportedly four different instances where this child had head lice while in the foster home. The biological mother complained that she was purchasing clothing for the children, but they presented at visitations in the same old and ill-fitting clothing. The biological mother said the oldest child appeared at one visit with the whole back open on her dress because of missing buttons. She said the children were not wearing underwear or socks in the month of January. She complained and completed a DSS 154 (complaint form), but was advised by the FSOS this did not meet criteria for an investigation. A review of the foster home file did not locate any documentation that these issues had been addressed with the foster parents. The biological mother continued to complain to Central Office and the Governor's Office. SW #2 came to her residence and instructed the biological mother to write down all her complaints. The biological mother refused and said she had already advised SW #2 of her complaints and no action was taken so she saw no reason to be redundant with her. The SSA was subpoenaed into court to advise the court of her observations during visits. The SSA advised OIG investigators that she was openly confronted by other DCBS staff and accused of taking the "other" side. In March 2006, the SSA was advised she was no longer permitted to supervise this family's visits.

On 08-01-06, and OIG investigator visited the foster home. The children's clothing appeared clean. The home was extremely cluttered with rows of boxes and clothes and the foster mother had to move stacks of clothing to permit seating on the couch. The carpeting was dirty and matted. The kitchen countertops were stacked with a variety of items, mostly paper, and there was no open counter space available. There was dried food on the dining table. A large puddle of water was present on the kitchen floor and the foster mother stepped across it, but did not take action to mop it up. The foster mother appeared embarrassed by the condition of the home and remarked that social service workers contact her in advance of coming to the home. The foster mother's biological son asked for several items of food and when she opened the refrigerator door, only a large jar of pickles was observable. She obtained a slice of salami for him and remarked that she did not have any bread, bologna, carrots, apples, celery, or bananas, as the child asked for them. At the front door of the home, the outside light hung by wires and a wooden step was broken. There were two goats loose in the front yard and trash was strewn around the front yard. The side yard had two pens. One pen held a large dog and the other was empty. A puppy ran loose in the yard. A small portion of the backyard was fenced with a 2-3 foot tall inflatable pool and several toys. There were large buckets containing standing water which, in addition to the pool, created a drowning hazard. On 09-15-06, three OIG investigators visited the same foster home. The two goats were standing at the end of the driveway, near the edge of the road. The foster mother refused to let investigators in her home, but stacks of clothing could be seen inside, and a dirty odor came from the home, as the foster mother stood in the doorway. A large dog, with a foul odor, was loose at the residence. The grass in the yard was overgrown and trash was omnipresent in the front yard. The outside light was still loose on the front of the home and the step was still broken. The two children in this case had been moved from this home, at the foster mother's request, about two weeks earlier. The foster mother contacted DCBS on 09-16-06 and advised she no longer wanted to be a foster home. When OIG investigators contacted DCBS to report their concerns, they were advised the foster mother had already contacted them.

SW #2 informed the biological mother that the plan for her children was adoption. The biological mother told investigators she could not understand the reasoning for this because she had completed all of the tasks in her

case plan. Every time she completed the case plan, SW #2 added other tasks to be completed. The biological mother said SW #2 told her she should never get her children back because she has not realized what she lost. The biological mother said she does not understand, if her children need to be removed for safety reasons, why DCBS has never limited their access or visitation with her paramour's other children. When she asked about this, SW #2 said she was going to recommend their access to those children be limited to supervised visitation, also, but no action has been taken on this issue. The biological mother said DCBS is aware of their unlimited access to these children and the children have even accompanied them to visitation with her biological children. A January 2006 TWIST entry states the paramour has been unable to begin anger management classes due to the expense ($65 registration and a fee for each of the eight weekly sessions). The biological mother was seeing a grief counselor and attending domestic violence counseling at the domestic violence shelter. She was scheduled to begin counseling through a community mental health agency in the next month. SW #2 documented, on 02-15-06, that the Family Court Judge advised the parents if they continued to make as much progress as they had in the previous month, she saw no reason why the children could not be returned to them.

A CATS assessment was completed on the family in January 2006 and the report was received in April 2006. It recommended the children remain in foster care for six months to permit the parents time to work on the families' issues. The biological mother advised OIG investigators, after this, her visitations were reduced and she was told this was because DCBS did not have enough staff to supervise the visits. Since the Family Court Judge had advised the family could have weekend visits if they had someone who would be present to supervise, the biological mother requested church members assist and her Pastor and his spouse came to the next Family Team Meeting. The Pastor advised an OIG investigator that he was shocked at the unprofessional manner in which the social services staff treated the biological mother: interrupting her sentences and being rude. DCBS staff advised that although the Judge had said it was permissible for others to provide supervision, DCBS would only accept DCBS staff to supervise the visits.

While OIG investigators were reviewing files in the Hardin County DCBS office, original copies of documents from this file were located in another client's case file.

The biological mother advised an OIG investigator, in September 2006, the paramour's mother had been requesting custody of the children for over a year. After she contacted the Governor's Office and the foster mother asked for the children to be removed from her home in August 2006, DCBS began to consider the paramour's mother as a placement for the children.

Client Case #4

The biological mother of a 19-month-old male child asked her sister to care for her child until the biological mother's landlord got the heat fixed in her trailer. The child's aunt lived in another state, five hours away, and took the child home with her in November 2000. In February 2001, the biological mother obtained a warrant for her sister, for custodial interference, because she would not return the child. It was determined the aunt had permitted her employer's daughter and the daughter's spouse to provide primary care for the child almost immediately upon arriving in the other state. Upon the child's return to Kentucky, the court denied a DCBS petition for neglect, determined the child was dependent, and placed the child in the custody of the Cabinet. The child was placed in a foster home, and the out-of-state couple was permitted to have visitation with the child. DCBS employees advised OIG investigators it was not policy to maintain contact with non-relatives, especially when the child had known them less than three months. In July 2001, the couple became approved as foster parents in their state. On 07-17-01, the case manager documented she consulted with a regional supervisor who advised "DCBS recommends custody/placement" with the out-of-state couple "as was originally scheduled."

No visits between the biological mother and child are documented from 07-17-01 until 06-24-02. The biological mother reported in November 2001 that she had $1,000 saved toward the purchase of a vehicle, so she could go visit her son. In January 2002, the biological mother expressed frustration that she had no transportation and requested the out-of-state foster parents meet her halfway. In February 2002, the case is "pre-permed" and the DCBS attorney advised against petitioning for termination of the mother's parental rights because of the lack of documentation of services offered to the mother. In March 2002, the biological mother was upset that the out-of-state foster parents wanted all visits to occur in their state. The out-of-state foster parents advised an OIG investigator they were not approached about visitations between the child and his biological mother until June 2002. They stated they were advised the biological mother did not want to have anything to do with the child. The biological mother and child met halfway between the two residences for visits from June 2002 until September 2002. In August 2002, the out-of-state foster mother complained the child was upset and acted out after visits and requested the court stop the visits. The judge refused and the foster parents cancelled the next visit.

In September 2002, the judge ordered the child be returned to Kentucky to give him easier access to his biological mother for the goal of reunification. He was placed in a Kentucky foster home. After a visit six days after his return to Kentucky, the new foster mother reported the child was obviously attached to his biological mother and cried after leaving her. It was documented in October 2002 that the child goes to visit the out-of-state foster parents every other weekend. In November 2002, the biological mother refused to attend counseling so the Judge removed her two younger children (born February 2001 and October 2002) and they were placed in the same home with the older child. In December 2002, the caseworker noted the child had no problem separating from the out-of-state foster parents and was happy to see his sister. The out-of-state foster parents have maintained regular visitation since the child's return to Kentucky. The child has been with them, out-of-state, anywhere from eleven to fourteen days a month. At a meeting between the out-of-state foster parents and five DCBS employees, on 04-23-03, the Intent to Adopt form was completed. In August 2003, the parental rights were terminated of the biological father of the oldest child. From September 2003-February 2004, a paternal relative was considered for custody of the children and provided supervision for the parents' visitation. From the TWIST contacts, it appears the biological mother became upset that the relative may obtain custody and requested the visits be conducted elsewhere. In July 2004, the biological mother was given unsupervised visitation from Friday until Sunday.

Documentation in the TWIST computer system and correspondence located by OIG investigators reflects this significantly reduced the visitations with the out-of-state foster parents, until April 2005. Several DCBS employees advised OIG investigators that, in late 2004, a regional supervisor instructed staff not to document contacts with the out-of-state foster parents, or the judge would not grant the TPR. Between September 2003 and September 2004, the out-of-state foster parents are mentioned, by name, in nineteen TWIST contacts. Between September 2004 and the TPR in September 2005, the out-of-state foster parents are mentioned by name in only five TWIST contacts. However, OIG investigators have obtained nine letters that were written to the out-of-state foster parents during the year prior to the TPR. None of these letters were located in the hard case file. The out-of-state foster parents advised an OIG investigator that during 2004/2005 there was contact between them and DCBS 3-4 times a month. They said this was via e-mail and phone calls.

The biological mother's parental rights were terminated on 09-12-05. This was reportedly the third attempt by DCBS to obtain a TPR in this case. OIG investigators were unable to confirm this, because the first volume of this case file is missing.

After the TPR was completed, the Kentucky foster home was permitted to adopt the child's two youngest siblings in December 2005. Both the Kentucky foster home and the out-of-state foster home desire to adopt this child. A 09-13-05 TWIST contact documented the child's therapist was not willing to recommend separation of the siblings, based on the child's attachment to the out-of-state foster parents.

A Comprehensive Assessment and Training Services Project (CATS) assessment was completed in June 2004. This is a sixty-two page evaluation of the child, and their recommendation for placement of the child. One social service worker said he was told, by the SRCA, the SRAA, and a Specialist, in a meeting, that the CATS assessment recommended the child be adopted by the out-of-state foster home. Although the report was a year old, this worker had not been permitted to see the report. When he obtained a copy, he observed, on page sixty-two of the report, paragraph one, it reads: (*Although the Kentucky foster home (sic) were not formally evaluated, the child (sic) appears to be doing well in this home. Should the Kentucky foster home (sic) be deemed appropriate, the current recommendation would be that the child (sic) could stay with the Kentucky foster home (sic) and his siblings, attend intensive therapy, and continue to visit with the out-of-state foster parents (sic).*)

In November 2005, there was a meeting among this worker, the SRA, the SRCA, the FSOS, the Specialist, and another social service worker. He said there was no justification to separate the siblings and he believes the Kentucky foster family is being discriminated against because they are Mennonites. The worker said there have been comments about how affluent the out-of-state foster parents are. He said the specialist has stated three times that the out-of-state foster parents are going to sue if they do not get to adopt the child, and that he will likely be included in the lawsuit. The specialist stated she was instructed by a regional supervisor not to include information on the out-of-state foster parents. The lack of documentation of the child's and DCBS's contact with the out-of-state foster parents was discussed and the SRA stated the specialist was behind in her documentation, but it would be added to the case file. The SRA told the worker he includes too much detail in his contacts. The worker understood this to mean the SRA wants information omitted from the case file so they can manipulate the case more to their liking. Since then, the FSOS was instructed to tell the worker to generalize the documentation of all of his cases, and be less detailed in his reporting. According to the worker, this goes against all of the training he has received.

It was decided to have another assessment completed. The regional supervisors determined the assessment would not be completed by CATS, and selected a licensed clinical psychologist. She produced an eight-page evaluation, completed on February 9, 2006, recommending the child be adopted by the out-of-state foster family. The psychologist stated both homes were good and the decision could have gone either way, but she leaned toward the out-of-state foster parents because the Kentucky foster parents would be sending the child to a Mennonite school and he may not receive the educational assistance he might later require. Further, she thought the child might not get the ongoing extensive mental therapy he may need in the Mennonite home.

The worker said the Cabinet's goal is to keep siblings together, at all times, unless it would constitute a danger to the children. The SRA asked him why he cared so much about this case, and if it was because, as a child, he was in the system. He thinks it is important to keep siblings together, if possible. The worker told OIG investigators the SRA told him he has no ethical obligation to his clients.

When OIG investigators began to review this case, a decision had been made to permit the out-of-state foster parents to adopt the child. A review was then completed by DCBS Central Office and it was determined, since there was no reason to split the siblings, the child should be adopted by the Kentucky foster home. The report states any other placement would be in violation of the federal MEPA law and a violation of state policy. It states the Cabinet should always begin with the concept of placing the child with the siblings, and then determine if there are any specific and compelling reasons not to have the child in the home with the siblings.

A review of the TWIST contacts from mid 2001 until November 2005 indicated twelve different DCBS employees entered contacts in this case and five others were referenced.

Client Case #5

In June of 2004, the biological father of the child reported to a Detective, of a Police Department in Hardin County, that his two-year-old daughter had possibly been sexually abused. He stated she was acting out sexually and requested an investigation. The biological father admitted to the Detective there had been a history of disputes between the biological mother and himself. At the time of this complaint, there was an active emergency protective order (EPO) on the biological father, with the biological mother as the complainant. Three months earlier, the biological mother had the biological father arrested for violation of the EPO.

The Detective confirmed, through written documentation provided by the biological father's wife, that the biological mother had a prior history with social services. Although there were 29 allegations, only 4 were substantiated. The substantiated allegations were for abuse and neglect. These allegations were primarily due to the manner in which the biological mother's paramour disciplined the children (forced to do push-ups and wearing underwear on their head for incontinence). The biological father's wife also had an inactive CPS case with 21 referrals. It was noted that the biological father was babysitting while his wife was at work and her five-year-old daughter began to act out sexually, after he moved into the home in 2000. Some of the referrals in the biological father's wife's case included allegations of sexual abuse by her child's biological father.

The child was examined at a children's advocacy center in June 2004 and the physical exam showed no signs of sexual abuse. However, it was noted the child was 'acting out'. The Detective reports she researched and found that the biological mother has another daughter who was reported to have been abused by one of the biological mother's ex-boyfriends. Two days after the child's examination at the advocacy center, the Detective briefed a representative of the Hardin County Attorney's Office of the findings. The Assistant County Attorney agreed that the child should be removed from the home until such a time that she would be safe. The caseworker did not want to remove the child from the home because an abuser had not been named. The caseworker advised her supervisor, and the FSOS agreed with her. After this phone call, the Detective contacted the County Attorney's office and was advised to start the paperwork for an emergency removal and take it to the judge. A Hardin County Family Court Judge signed the paperwork to have the child removed. At the time that the child was removed from her biological mother's home, there were three other underage children residing in the home. There is no documentation in the file to explain why the home was unsafe for one child, but safe for the other children.

The child was temporarily placed in a foster home in June 2004. In August 2004, during a hearing, both biological parents agreed the child had either been exposed to sexual acts or had been a victim of sexual abuse. Neither parent admitted to the abuse, but said they thought it had occurred. Over the next few months, the child reportedly named several people as potential abusers, including her older sister and her stepbrother.

In September 2004, the Detective met with the maternal grandmother. She was reportedly angry with the biological mother because she had advised police that her mother she was running a "meth" lab at her home. The maternal grandmother reported to the Detective that the biological mother had been involved in sexual relations with her biological grandfather and stepfather. She provided seven photographs showing the biological mother engaging in sexual intercourse with her Uncle. It was determined the biological mother was a juvenile at the time the photos were taken. The maternal grandmother said her daughter's oldest child was placed with her prior to the younger child's birth. The older child told the maternal grandmother that she had been present at the biological father's home on one occasion when he was intoxicated and threatened to run down the biological mother and her children with his car.

The Detective made a recommendation to the court and DCBS that the biological father should receive custody, as long as he and his wife completed training and counseling before the child was placed in their home. The Hardin County Family Court Judge ruled that the child be placed in the custody of the biological father. The

child was placed into his home in January 2005 and in April 2005, she was removed and returned to foster care due to physical abuse by the biological father's wife.

The case file includes five copies of the biological father's Administrative Office of the Courts (AOC) Courtnet report. All five copies were printed prior to the child being placed in his home. The biological father has been charged with a long list of misdemeanor and felony charges, which include two charges of Sexual Abuse 2nd degree (rubbed his penis against the vagina of a 12-year-old female). He pled guilty, through a plea bargain agreement, to the charges of Unlawful Transaction with a Minor. He has spent time in prison on unrelated charges. His criminal history includes drug charges, DUI, theft, assault, and burglary charges.

On 09-14-05, SW #1 (ONG report) wrote: "The parents have completed Family Preservation, Sign of the Dove, and Anger Management. They have cooperated with DCBS in case planning and making changes in the home at the request of DCBS and the Family Court Social Worker. They are actively addressing mental, physical, vision and nutritional needs of the children. The children have been observed on a weekly basis by worker and have not appeared dirty, smelly or inadequately kept." After SW #1 transferred to another DCBS region in September 2005, the case was assigned to SW #2 and then to SW #3 in October 2005.

According to SW #3, although the child was removed from her mother's home in June 2004, then, removed from her father's home in April 2005 and placed in foster care, the out-of-home case plan was not established until November 2005.

On 11-07-05, SW #3 and SW #4 conducted a case planning meeting with the family. On the case plan, the address listed was their current address. On 12-01-05, SW #3 entered a contact in the TWIST computer system stating, "This worker and coworker SW #4 (sic) attempted a home visit with the biological mother (sic) and her family. Worker went to the wrong address for the biological mother (sic). She had moved out of this residence in November. Someone else was living there now." The biological mother, her paramour, and the family have lived at the same address since May 1, 2005. SW #1 had documented, on several occasions, that she had completed home visits at the correct address. The correct address was entered in the TWIST computer system in July 2005. It was also correctly listed in the case file and the KAMES computer system. When OIG investigators asked SW #3 what actions she had taken to determine the families current address and then to complete the required monthly home visit, she said she looked up the biological mother's telephone number and attempted another home visit on 01-03-06, but the biological mother was not home.

In January 2006, the biological mother and the biological mother's paramour contacted the CHFS Office of the Ombudsman and complained no home visits had been completed since August 2005. According to the TWIST computer system, no home visits were made until 01-03-06 and the biological mother was not home at the time. SW #3 returned for another visit along with SW #4 on 01-20-06. SW #3 documented that the biological mother's paramour refused to allow them entry on that date. The CHFS Office of the Ombudsman justified the complaint.

According to the Ongoing report completed 03-23-06 by a temporary worker, the biological mother had been participating in the domestic violence program, as a victim. She had completed approximately 6 drug screens, all with negative results. She was participating in a wellness program to prepare for counseling at a mental health agency and the mental health agency fees will be waived. The biological mother has no criminal history. The biological mother's paramour is disabled, has no criminal history, is supportive of the biological mother and her children, takes care of their home, and has no history of mental illness.

On 03-29-06, SW #3 forwarded a letter to the biological mother indicating the referrals were completed for a parenting class and a sexual offender assessment. [Since that time, the board that certifies the sexual offender assessor determined he has inappropriately completed sexual offender assessments on people who have not

been convicted of a sexual crime, and he utilized psychological instruments to make "diagnostic impressions" when he was not qualified to do so. He was chastised not to do this again and the Hardin County Family Court was issued letters advising the court not to consider his findings/report.]

A 05-04-06 letter to the court, written by SW #4, stated SW #3 referred the biological mother and her paramour to parenting classes and a sexual offender program, which the Cabinet had agreed to pay for. According to this letter, the biological mother and her paramour were referred to a sexual offender assessment/treatment program that provides "non-offending parent counseling." The Cabinet agreed to pay for this and, reportedly, the biological mother agreed to attend. Further, in this letter SW #4 reported that SW #3 had stated, "The biological mother (sic) has attended and completed several parenting programs prior to the child's removal from her custody; however, the programs do not appear successful as evidenced by her child's removal and the subsequent referral concerning her other three children living in the home." Obviously, this is a biased and incorrect statement since the child was not removed due to the biological mother's actions, or even the actions of the Cabinet. Additionally, the referral reference was unsubstantiated, so it is illogical to use either as the justification for why the biological mother needed to complete another parenting program.

On 11-27-06, a case planning meeting was conducted and the biological mother states the new case plan is five pages long and she and her paramour are now required to pay for the treatment contained in the case plan. She said SW #5 told her there would be a charge no matter where they were referred. The biological mother and her paramour have complained that SW #4 told them they will never get the child back no matter what they do. The biological mother's paramour has stated he believes DCBS is trying to wear them down to get them to give up on reuniting with the child. The biological mother's paramour is no longer allowed visitation with the child. The biological father and his wife separated in early 2006 and the biological father has a new paramour. He is no longer visiting with the child or participating in her case.

During a meeting, on 12-04-06 between a representative of the DCBS Commissioner's Office, two representatives of the CHFS Office of the Ombudsman, and an OIG investigator, the representative of the DCBS Commissioner's Office advised a paternal aunt is now being considered as a placement for the child. He stated that DCBS "continues" to believe the biological mother's paramour was the sexual abuser of the child. The representative of the DCBS Commissioner's Office was advised there is no documentation in TWIST, the hard copy case file, or in the Detective's report to indicate the biological mother's paramour was the abuser. The only child in the home of the biological mother and her paramour to act out, sexually, was the child removed from their home. She was also the only child to have contact with the biological father. However, the biological father's criminal history, the increase in the sexual acting out behavior noted by the child's foster mother after her visits with the biological father, and the biological father's wife's reports of her biological daughter's sexual acting out after he moved into her home, would indicate the biological father is the most likely sexual abuser.

Client Case #6

On June 9, 2004, Lincoln Trail Region DCBS received a referral regarding a newborn bi-racial girl. The biological mother tested positive for cocaine at the time of the child's birth. A petition for removal was obtained, and the infant was placed in a foster home, in Larue County, although the child's family was from a different county. It was documented that a thorough search of the infant's home county was negative for placement due to her need for a concurrent home. SW #1 documented in TWIST that the biological mother entered treatment at a mental health agency after being discharged from the hospital. A 5-day case planning conference was held in the DCBS office on 06-16-04, with the biological mother participating by phone. The biological mother's attorney requested, at the 06-22-05 case-planning meeting, that the relative of a boyfriend (who was later determined to be the paternal great aunt) receive custody of the infant; however, it is not documented in the record. The biological mother did not know who the child's father was and three other potential fathers were DNA-tested prior to the biological mother naming the paternal great aunt's nephew as the

father in July 2005. By this time, the biological father was deceased. The paternal great aunt had raised the biological father and his brother, after their mother suffered a debilitating stroke. There is no record of the determination of paternity until an 11-21-05 TWIST contact entered by the SSCL. He noted the foster mother was upset because she had just been told by SW #2 that the paternal great aunt was seeking custody. On 12-14-05, a review of this case was held in District Court and both the foster parents and the paternal great aunt were present. The paternal great aunt advised the Family Court Judge she had been informed recently that her nephew was the father of the infant and she wanted custody of the child. The Family Court Judge advised the paternal great aunt to seek an attorney and for the Cabinet to notify her when a court date had been set for the TPR in Circuit Court. It was documented that the biological mother was lodged in the County Detention Center at the time of the hearing. On 12-20-05, a face-to-face visit was completed with the biological mother (in the Detention Center) to discuss the case plan. A case planning conference was held with the worker, FSOS, and the foster parents (the mother's attorney and the paternal great aunt were not present and the record does not state whether they were notified). Then, an MSW Consultation was held with only the SRCA and CHFS attorney present. According to the 02-17-06 TWIST report, the child was placed in foster care on 06-11-04 and the agency goal was changed to adoption on 12-29-05. The goal changed to adoption, in court, on 01-11-06. Although the paternal great aunt's desire for custody was documented in November 2005, the record does not reflect completion of a home evaluation on the paternal great aunt until five months later, on 03-17-06. The SSCL noted on 03-20-06 that the FSOS had advised the home study was favorable. SW #2 documented she had spoken with the FSOS and the SRCA in regards to placement of the child with the paternal great aunt. However, no visitations were set to begin until 05-12-06. SW #2 said she got the impression from the SRCA and the CHFS attorney that the paternal great aunt wanting custody was interfering with their plans to TPR.

The TWIST record indicates the biological mother either refused treatment or did not attend drug treatment. Neglect was substantiated based on the positive cocaine drug screen of the mother. The biological mother has not consistently (or for any amount of time) visited with the child, worked to be drug-free, or complied with any DCBS requirements. It is apparent, from the record and interviews with the SWs, she is not working to reunify with the child.

In March 2006, SW #2 was interviewed by OIG investigators and she expressed her concerns regarding children being adopted when there is a suitable relative available for placement. SW #2 said the Cabinet recommended the infant remain in a white foster home over being placed with her great-aunt, a 50-year-old African American woman. SW #2 said the Cabinet cited the length of time the infant was in foster care as the reason to not place her with the paternal great aunt. SW #2 stated she saw no reason why the infant should not be placed with her great aunt.

In June 2006, the paternal great aunt was interviewed by an OIG investigator and she stated she did not find out the infant was her niece until November 2005, after obtaining the DNA results for her nephew. The paternal great aunt said she had been attempting to obtain custody of the infant since then. She said she contacted several attorneys and learned their fee was $3,000-$4,000. She found an attorney for $1,000 and she borrowed the money from her landlord to pay the fee.

The paternal great aunt is disabled but works part time at a local ice cream shop. She is currently taking care of 2-3 other young children and appears to be doing an adequate job. Her home was observed to be clean, neat, and free of any odors. The paternal great aunt feels it is not her fault she did not find out about the infant until she was almost 2 years old. The paternal great aunt said she had one visit, was told it went "Great", and that her future visits would be on Sundays and would unsupervised. The next Friday, at 3:00 p.m., she received a call advising her visitation had been stopped and no reason was given. She believes the lack of visitation was intentionally done to separate her from the child. She said she has been advised the foster parents will be permitted to adopt the child. She said the mother's rights have not been terminated, yet. The paternal great aunt said when she appeared at a court hearing, on 01-11-06, she was told she had nothing to do with the case

and was not permitted to let the court know she wanted the child (during this hearing, the permanency goal was changed to adoption). The paternal great aunt stated she believes either the foster parents are using "pull" to prevent her from obtaining custody, or the Cabinet has delayed action on her request for custody because this child was pre-determined to be adopted.

A review of the TWIST contacts revealed the FSOS entered five records, as SW #3 (a former employee) in March 2006, for negative home visits that reportedly occurred during the months of June, July, August, September, and October 2005. Additionally, the CHFS Office of the Ombudsman has a justified complaint in this case because the child was not placed with the relative, per policy. SW #2 admitted to the CHFS Office of the Ombudsman that there are several records she has not entered and does not feel comfortable entering yet, for fear of retaliation. The FSOS has stated, now that the SRCA is gone, she is "trying to do the right thing." The FSOS stated during a conference call, on 06-16-06, she believed the paternal great aunt should have visitation and the child should be transitioned into her home. The SRA and three Legal Office staff argued for adoption, and the conclusion of the meeting was that the child will be adopted by the foster parents because the child has been in the foster home since birth and is bonded to the foster parents.

During a review of hard copy case files, in the Hardin County DCBS Office, OIG investigators located original documents from this case in another client's case file.

Client Case #7

Three children were removed by DCBS after a three-year-old child was observed walking down a sidewalk unattended on a Monday morning at the end of April 2004. The biological mother had a previous history with DCBS, as a child and as a parent.

At the time of this incident, the family consisted of the biological mother, her oldest son (5), her daughter (3), and an infant (2 months). The biological mother married her long-time boyfriend, and father of the two oldest children, in November 2005.

Interview with SW #1:

SW #1 was notified by SW #2 that a Hardin County Police Department had been called to the home after the child wandered down the street to the Fire Department, wearing a short sleeved shirt, sweat pants, no underwear or diaper, and untied shoes. After an initial investigation by the police, it was determined which house she came from and she was returned to her home. The police found the biological mother's brother sleeping in a back bedroom. He was staying with his sister because he was home on leave from the military. According to SW #1, when awakened he denied he was watching the children. SW #2 located the infant in an upstairs bedroom awake in his crib. He reported to SW #1 that the house was in a state of disarray and smelled strongly of cats.

SW #1 reports, in the CQA (Continuous Quality Assessment), when she arrived at the home she found the biological mother, present, with her mother, brother, and the two youngest children. When SW #1 asked the biological mother what happened and how the child came to be left home, unattended, the biological mother assured her she had left the children under the care of her eighteen-year-old brother. SW #1 said she spoke with the biological mother's brother and he denied his sister had asked him to watch the children. SW #1 informed the biological mother that she was substantiating neglect, due to the two youngest children being left unattended. As SW #1 was preparing to leave, she reported the biological mother became very upset and began raising her voice. After the biological mother raised her voice, SW #1 said she was going to re-enter the house as soon as the police could return.

Upon the return of the police, SW #1 entered the house and walked through it, to observe the condition of the household. SW #1 said she found it to be unclean and cluttered, as well as having a strong odor of cat urine. SW #1 reported the room where the children slept smelled of cat feces and urine and was cluttered with large piles of clothing. Upon looking into the infant's crib, SW #1 reported she observed the crib to be full of numerous items, including clothes, a lunch box, bottles, and diapers. SW #1 discussed this with the police officers on the scene and with the biological mother, who, SW #1 stated, refused to take responsibility for the condition of the home. SW #1 reports she had concerns about the safety and overall supervision of the children.

According to SW #1, she called the FSOS and was instructed to contact the judge, directly, to obtain an emergency removal order, by telephone. Around 9:00 or 10:00 on this Monday morning, SW #1 spoke with a Hardin County Family Court Judge and was granted a "verbal order" to remove the children, including the oldest child, who was with his father at the time of this incident. SW #1 denied taking these actions because the biological mother had angered her by "talking back" to her and stated said she thought the children were in imminent danger, and an emergency removal was necessary. The CQA reports that the biological father had a substantiated abuse complaint from 2003 for slapping the daughter and, therefore, would not be a proper caregiver. No other appropriate family members were identified, so the children were taken into foster care and placed in the foster/adoptive home, where they still reside today.

After the children were removed, the goal was changed from family reunification to adoption. SW #1 said the biological mother has not worked on her case plan. The biological mother was offered services through a mental health agency and given a case plan that included being able to provide financially for the children. She was to attend domestic violence classes, due to several reports of domestic violence reported between her and her boyfriend. SW #1 later stated this requirement was for a domestic violence assessment, instead of classes. A Hardin County Family Court Judge ordered the family into a family preservation program in June 2004 and the biological mother has not completed this yet. SW #1 admitted she has yet to make this referral, because the family preservation program is not involved with the family until 30 days prior to the return of the children. Since the case goal is now adoption, the referral will not be completed. SW #1 said this is still a fair item to list as uncompleted by the parents because it is not the caseworker's fault and she cannot do anything until 30 days before the children are to be returned.

<u>Interview with the biological mother and the biological father:</u>
The biological mother said she has no problems with her current caseworker, SW #3. She believes the previous caseworker, SW #1, removed her children solely because she angered SW #1.

The biological mother said she had left the house that morning to attend an appointment at the DCBS office to complete forms requesting 4-Cs childcare assistance. Her two youngest children were still asleep when she left. The other child was with the biological father at the grocery store. The biological mother said her brother was home on leave from the Marine Corps and she awakened him and told him she was going out for a while and he needed to watch the children. She said they argued because he wanted to go back to sleep, but she made sure he was awake before she left. While she was gone, the daughter awakened, dressed herself, unlocked the deadbolt, then wandered out and down the street to the Fire Department on the corner. The Fire Department contacted DCBS and SW #1 came to her house when the child was returned. According to the biological mother, SW #1 became defensive when she "got smart" with her and asked why DCBS was never there to help when needed. This angered SW #1, who then called the judge and the police to have all three of the children removed from the home. The biological mother said although it was early on a weekday morning, she was not provided any court documentation and was told SW #1 had a 'verbal order' from the judge to remove her children.

The biological mother said SW #1 advised the court the house was a "mess," with dirty clothes on the floor and groceries on the counter-top. She said there was a hole in one wall. She said a Family Court Judge stated that the children could go home when the hole was fixed. The biological mother was given a case plan and,

according to her, she completed everything but fixing the hole in the wall, and she was told the landlord would repair it. She said the case plan included domestic violence assessment and classes, mental health assessment and counseling, and a CATS assessment, court-ordered on 12-28-04. When she finished the case plan, the biological mother was given more tasks to complete. Included in one case plan was the requirement to work with a family preservation program, but no one would give her a referral. The biological mother said SW #1 told her father, from the onset, that DCBS' plan was to have her parental rights terminated and change the goal to adoption. She said SW #1 talked to her father in full detail, prior to her signing a release in the late spring/early summer of 2005. The biological mother said, after 16 months, the CATS assessment still has not been scheduled, although SW #1 claimed she requested it in February 2005. She said now that SW #3 is her caseworker, SW #3 has told her she does not know what to do to have the assessment completed. The biological mother said SW #1 required her to attend parenting classes in another area knowing she did not have transportation to the class. The biological mother said SW #1 stated she could not use a community transportation agency or her medical card to obtain the transportation, and DCBS could not provide transportation to parenting classes. Since SW #3 has assumed the case, the classes have been scheduled in her town. The biological mother provided DCBS with a report advising she had completed a domestic violence assessment and was determined not to need domestic violence services. The biological mother completed a mental health assessment, but SW #1 wanted her to do more. She said a family preservation program had been working with her, but they have been pulled out because DCBS changed the goal to adoption.

The biological mother said SW #1 lied to the court. SW #1 kept changing the visitations, and changed the location of the visitations to the park in the summer months. The biological mother complained to SW #1 because the daughter is allergic to pollen and the heat was sometimes overbearing. The biological mother had water bottle fights with the children to help cool them off. When the biological mother needed to take one of the children to the restroom, she would ask SW #1 to keep an eye on the other children while she was away. The next time they were in family court, SW #1 told the court that the biological mother left the children in the park unattended. SW #1 told the court that the biological mother and her children were emotionally unattached, which the biological mother strongly disagrees with. The biological mother's son had a surgery scheduled but it was cancelled due to his illness. The biological mother was also sick that day. SW #1 then advised the court that she was not present for the surgery. The biological mother advised the court this was not true, the surgery was cancelled, due to the child's illness.

The biological mother said SW #1 was unreliable. SW #1 would make an appointment for a home visit and she would take off work to be home. Then, SW #1 would not show up. SW #1 would not respond to a phone call or an e-mail, unless she also sent it to someone else. The biological mother gave the children's birth certificates and social security cards to SW #1, to give to the foster mother, so the children could be enrolled in school. SW #1 neglected to give the cards to the foster mother, so the biological mother had to provide another set. SW #1 refused to allow the biological mother to breastfeed the infant, which the biological mother said is permitted by DCBS and recommended by doctors.

The biological mother said the daughter has a habit of running away from caretakers and she took off from the biological mother during a visit at a restaurant. SW #1 told the biological mother it was her fault, but the biological mother said the foster mother complains about the child doing the same thing to her.

A former DCBS employee made a home visit one morning at approximately 11:00 am. The biological mother worked third shift, got off work at 06:00 am, and told DCBS they needed to come later in the day, after she had time to get some rest. The former DCBS employee left without entering the home, but later testified that during this home visit, she had entered the house and it was filthy.

The biological mother said the maternal grandmother is a former 4-Cs certified childcare operator, who offered to take the children, but SW #1 did not contact her. The biological mother's father lives in another state and he

also offered to take the children. A home evaluation was never completed on either parent. The biological mother's boss, who owns a restaurant, offered to take the children, but DCBS refused to consider him for placement of the children because he was not a relative.

The last court appearance was April 16, 2006, but the court-appointed attorney arrived too late. The case was continued. The biological parents' visits have been cut from once a week to once every two weeks because the Cabinet tells her there are not enough workers to supervise the visits. The biological mother is grateful to the foster parents, but she has missed many of her children's "firsts" and the children get angry because they want to come home. The biological mother said she has recently begun to attend church again.

Client Case #8

The biological mother lived with her paramour and her two children. Her youngest child is the child of her paramour, but the oldest son is not. In April 2004, an investigation was initiated after pictures were developed by a local business showing the youngest child smoking marijuana. Both children were removed from the biological mother's home and placed in the custody of DCBS. The biological mother's paramour was questioned by the police and subsequently arrested after admitting to allowing the child to smoke the marijuana. The biological mother admitted to participating and taking most of the pictures. There was also an allegation of obscenities involving the youngest child. The paramour was indicted for Use of a Minor in a Sexual Performance (2 counts) and Unlawful Transaction With a Minor (2 counts). The biological mother was indicted on 2 counts of Use of a Minor in a Sexual Performance and Unlawful Transaction with a Minor in the 3rd degree. Both were incarcerated for the crimes.

The paternal grandfather of the oldest child started visiting his grandson in August 2004, shortly after he learned the child was in foster care. He advised DCBS that he was interested in adopting his grandson. According to a CQA, in August 2004, the paternal grandfather and his wife attended visitations with the child. The paternal grandfather and his wife were observed at the visitation and both were reported to have appropriate interaction with the child. In October 2004, the biological father of the oldest child stated he wanted to voluntarily terminate his parental rights to his son. A favorable home evaluation was completed on the paternal grandfather and his wife's home and they inquired about visiting the child in their home.

The CHFS Office of the Ombudsman reviewed the case in January 2006, after a complaint was initiated by the biological grandfather of the oldest child. The TWIST file reflected the paternal grandfather had his first visit with the child in August 2004, four months after he went into foster care. In early October 2004, the Cabinet approved a home evaluation on the biological grandfather and his wife. A contact in the file by SW #1, on 11-18-04, stated: "The child will be transitioned into his paternal grandfather's home soon. He is doing well with the visitation with his grandfather." The representative of the Office of the Ombudsman reviewing the case stated, after this contact, it was very vague in TWIST why the child was not transitioned into his grandfather's home. The representative of the Office of the Ombudsman stated once the biological grandfather of the oldest child became aware the child was in foster care, he became involved, was approved and was waiting for his grandson to be placed in his home. The representative of the Office of the Ombudsman noted there was no documentation in the case file of the visits between the paternal grandfather and his grandson, or of any bonding between the two. The representative of the Office of the Ombudsman also discovered there was nothing documented in TWIST, as of January 11, 2006, regarding whether the social service worker had considered all the factors surrounding the attachment of the siblings to each other, to the foster parents and to the paternal grandfather. This was later documented in TWIST, on January 25, 2006, after the representative of the Office of the Ombudsman had spoken with the FSOS and had justified the paternal grandfather's complaint.

The Ombudsman's report resulted in responses from two different FSOS', SW #2, and the SRCA, each requesting the CHFS Office of the Ombudsman revise their finding to unjustified. In the SRCA's response, she

stated the biological grandfather of the oldest child waited "9 months before making a decision regarding placement." The TWIST file reflects the paternal grandfather had his first visit with the child four months after the child went into foster care and the home evaluation was completed 6 months after the child entered foster care.

In March 2006, the biological grandfather of the oldest child was interviewed and he stated he wanted to adopt his grandson, but DCBS wanted the foster parents to adopt the child. He said the Cabinet did not want to separate the siblings. The paternal grandfather feels the Cabinet is standing in his way of the adoption because they want him to adopt both siblings and feels he should not have to adopt his grandson's half-sibling. The paternal grandfather has obtained an attorney to assist him with the adoption procedure. The termination of parental rights (TPR) process is pending and the paternal grandfather understands he will not have any rights if the TPR is finalized. The paternal grandfather said he was initially permitted to visit the child once a week, but the visitation has now been reduced to every other weekend. The paternal grandfather said SW #2 told him the FSOS had instructed her to change the visitation. The paternal grandfather said he realized there is now a bond between the child and his half-brother and has agreed to continue visits between the two siblings if he is permitted to adopt his grandson, to maintain the sibling bond.

In March 2006, SW #2 said this case was discussed several times with other workers and supervisors. She said the SRCA asked if the paternal grandfather's wife was a 'mail order bride" and if she was 'legal'. SW #2 said the SRCA was willing to permit the paternal grandfather to adopt his grandson and his grandson's half-sibling, but not just his grandson. SW #2 said the paternal grandfather did not want to adopt both children. SW #2 said the paternal grandfather had to hire an attorney to fight for custody of his grandson. She felt he should have been given custody of the child, from the start. She stated there was a definite bond between the biological grandfather and the child. She said at the time the paternal grandfather's home was initially approved, the bond between the siblings was not significant. SW #2 said she even mentioned the visitations between the paternal grandfather and the child on the home evaluation so their bond would be obvious. SW #2 said she felt the child was being used as a "bargaining tool" to coerce the paternal grandfather into also adopting the child's half-brother.

The TPR regarding this case is still pending. The paternal grandfather is continuing to fight for custody of the child. According to SW #1, SW #2, and SW #3, the paternal grandfather is a suitable relative placement for the child, although the Cabinet decision is to permit the foster parents to adopt both children. DCBS has established a goal of adoption for the children and both children currently reside in the same foster home

Client Case #9

In November 2004, five male siblings were removed from the home of their paternal aunt after she contacted DCBS and advised that her doctor told her she needed to set limits and she was no longer able to care for her nephews. She said she requested to be permitted to say good-bye to the children, but DCBS refused and removed the children from daycare. The paternal aunt said she did not know until appearing in court, two days later, that she was accused of neglect due to an allegation she was attempting to have the nephews adopted by daycare staff. The paternal aunt had just received permanent custody of the children one week earlier. The paternal aunt questioned why, if she was neglectful, did DCBS not also remove her two biological children. The paternal aunt claimed the children were treated the same and if she was neglecting one, she was neglecting all of them. One FSOS advised OIG investigators that during the investigation into this allegation, statements were obtained from three workers at the daycare indicating they were planning to adopt three of the nephews. Reportedly, one of the daycare workers was even referred to as "mommy" by one of the children. OIG investigators did not locate copies of these statements in the hard case file. A review of Inv-4 indicates statements that the initial allegation was received on 11-15-04 and the conclusion of this report is dated 02-28-05. The allegation that the paternal aunt intended to "sell" her nephews cannot be proven. The FSOS believed

the paternal aunt intended to place two of her nephews with daycare staff. During the course of the investigation, it was determined her former caseworker had advised the paternal aunt that when she obtained permanent custody, she had the right to seek out others to adopt the children. The paternal aunt produced a tape recording of the social service worker's statements. He had also advised her that an adoption would cost about $1,500 for each child. Although the Inv-4 was dated 02-28-05, it included information on events occurring over two weeks later. It stated the paternal aunt admitted to dependency at the adjudication hearing on 03-16-05 and that the biological parents signed the voluntary termination of parental rights forms on 03-10-05.

The paternal aunt had a previous DCBS case for dependency, in 1999, after the birth of her first child. She was living with her mother and her mother was given temporary custody until she could establish her own residence. That case was successfully closed in 2001. The case file indicates both the paternal aunt and the biological father suffer from mental illness.

The paternal aunt stated that she and several relatives, including a teacher, minister, and a social service worker, traveled to Frankfort to meet with the DCBS Commissioner on 02-18-05. An OIG investigator obtained the sign-in sheets for the CHFS complex for 02-18-05 and determined seven relatives signed into the building around 10:00 am that date. The paternal aunt stated she had contacted the CHFS Office of the Ombudsman and they justified her complaint, but the Commissioner still failed to take action. The paternal aunt said the Commissioner refused to meet with them and referred them to an official in his office. This official refused to meet with anyone but the paternal aunt. She said she provided the official with a copy of the audio tape of the former social services worker advising her on the possible adoption of her nephews. [The official advised OIG investigators that the paternal aunt played the tape for him, but did not provide a copy. A TWIST entry, dated 03-15-05, confirmed the tape included statements by the former social service worker advising the paternal aunt that she could locate homes for the children.] The paternal aunt said she later received a letter, signed by the Commissioner, apologizing for the misinformation provided to her about her being able to locate alternative homes for the children and for the conduct of the former worker. An OIG investigator requested a copy of the letter several times, but did not receive a copy.

The paternal aunt claims one of the relatives requesting the children is a cousin who is a social service worker in Indiana. She said the Commissioner's Office sent someone downstairs to obtain the names and addresses of all the relatives and they were advised home evaluations would be completed on all of them. To date, the paternal aunt reports none of them has been recontacted. The social service worker cousin reportedly wanted all the children, but the paperwork requesting a home study was never sent to Indiana. The cousin contacted the Lincoln Trail Region SRCA to determine the status of her home evaluation, and the SRCA told her that she must not be close to the family or she would have come forward earlier. Then, the cousin was advised the FSOS would send the paperwork to Indiana. OIG investigators did not locate any documentation to indicate the interstate home evaluation was ever requested.

The paternal aunt reported that after DCBS removed the five nephews from her home, they went to the biological parents' home and they agreed to sign the children over to the Cabinet because they could not pay the state child support for the children to be in foster care. The paternal aunt said the biological father told her that DCBS was going to make him pay child support and he could not afford it, so he had to sign away his parental rights.

The termination of parental rights hearing was set for 04-04-06. On 03-27-06, an OIG investigator contacted the biological father. He stated he was upset that his wife's 2005 tax refund was taken for the back child support and that DCBS are "the most dishonest people in the world." He said he has every intention of signing the boys over to the Cabinet because he is living in a hotel and may be going to jail for 2 years. He said he could not provide for the boys, cannot pay child support, and wants family members to have the boys or all the boys be adopted by the same home.

A review of the hard copy case file indicated at the time of the TPR, there were eight siblings: the five children removed from their paternal aunt, and three infants born after the others were placed in foster care. The biological parents were asked several times to sign a voluntary TPR and they refused until being told the Cabinet was going to request child support. The older children had previously been in foster care, in the paternal grandmother's care, and were returned home in December 2003. In April or May 2004, the biological parents placed the children with the paternal aunt. The Cabinet filed a non-removal petition, which included recommendations by the SRA, SRAA, and the caseworker. The paternal aunt was advised that if she was unable to care for the children, she was to contact the caseworker and he would explore alternative placement with the paternal grandmother. The Cabinet did not assume custody of the children until 11-15-04, when the paternal aunt requested the children be removed due to her medical issues. The case file includes only one home evaluation completed on the paternal grandmother's home and, reportedly, Perry County DCBS found it to be a favorable home but, Hardin County DCBS did not. Reportedly, the paternal grandmother was denied due to a prior DCBS complaint, when the paternal aunt was a teenager. However, these same children were placed in the paternal grandmother's home, by DCBS, 10-24-03 to 12-09-03, well after the incident involving the paternal aunt. There were other relatives willing to take one or more of the children but were told, by the FSOS, that the children would not be split among the relatives. Nothing was located in the file to reflect the SRCA's conversation with the relative in Indiana or that the FSOS sent paperwork to Indiana to request a home study. There was a contact located in the file where two separate cousins called into the Hardin County office and talked to the FSOS, but, no home evaluation is in the record as having been completed on either home.

The paternal aunt claimed she was repeatedly told there was a court order requiring all the boys be kept together in the same home and that a relative had to take all the boys or they would remain in foster care. No such notation or court order was located in the file. This was used as the reason why the children could not be placed with the various relatives, including the two families who live beside one another and share a fenced yard. Together, these families wanted all the siblings.

The Office of the Ombudsman reviewed this case and justified the paternal aunt's complaints on 11-17-04 and 01-06-05. They also justified a complaint by the biological father on 03-09-05. The Ombudsman determined there was no indication proper attempts were made for reunification, for relative placements, or that the paternal aunt was provided any services to assist in the addition of five children into her household. It was noted that many decisions were apparently based on personal issues and not according to policy. The children were immediately placed in a foster home outside the Lincoln Trail Region and the family was permitted only limited visitation. The Ombudsman noted there were numerous contacts entered on 04-25-06, 04-26-06, and 04-27-06 weeks after the 04-04-06 TPR. Additionally, there were three other contacts entered excessively late, by the FSOS. When OIG investigators reviewed these entries, it was determined several of these late entries included statements by the biological father that he did not want the children, he did not want them living with his sister, and he wanted to voluntarily waive his parental rights. No TWIST entries entered before the TPR included this information.

Client Case #10

A child fatality occurred in March 2005 when a five-month-old infant died in a house fire. There were only two people in the house at the time of the fire: the infant and his grandmother. The child's mother and a cousin also resided in the home. The child's mother had taken the cousin to the local hospital emergency room, prior to the occurrence of the fire. When firefighters arrived on the scene, they entered the residence after learning the infant was still inside. After the fire was extinguished, the infant was found underneath a bed. It was reported the mattress was pulled over him and boxes were piled around the bed that would have prevented the infant from crawling under the bed. The coroner's report stated the infant died of smoke inhalation. The local police

department investigated the fire. Hardin County DCBS was also notified and SW #1 was assigned to investigate the incident.

Interview with the Coroner:
The county Coroner said the infant died of smoke inhalation and he has been working with SW #1 on this case. He said the grandmother was a suspect in the child's death, because the child was found underneath a bed in a position that was nearly impossible for a five-month-old infant to have reached, unassisted. He said the grandmother was suspected of Munchausen's Syndrome by Proxy. He said he recalls overhearing someone say DCBS wanted to set up a video camera in a hospital to try to catch the grandmother doing something to the child. He said the local police had a criminal investigation reference the child's death.

Interview with Detective:
The Detective with the local Police Department was contacted and advised the police were aware there was prior DCBS involvement with the family, specifically with the infant. The Detective said there was a previous complaint on the grandmother. According to a DCBS-115, a referral was made in October 2004 to the police. The form shows the child had stopped breathing and was brought to a hospital in Jefferson County. The report was taken by the FSOS and SW #2 was assigned to the case. In October 2004, a second referral was made regarding the infant. This referral stated the grandmother is believed to have Munchausen's Syndrome. The form mentioned the child had experienced numerous visits to hospitals. The grandmother said the child stops breathing, but the doctors reported the child was fine. DCBS had a breathing monitor attached to the child because it was suspected the grandmother might try to harm the infant. The Detective said the grandmother is a suspect and the case will be presented to the Grand Jury.

Interview with DCBS Employee SW #1:
SW #1 said, although she was not an Ongoing worker, she was involved in the investigation of the infant's death. She said she had been upset over this case and stated, "That child did not have to die. The child could have been placed with his mother." SW #1 said she did not know why the infant was placed with the grandmother, and she blamed the former caseworker for not doing a thorough job regarding the grandmother. SW #1 said when she started pulling records, she found the grandmother had been diagnosed with Munchausen's in 2000. She said the former caseworker had done a favorable home study on the grandmother, prior to placing the infant's cousin in the home. SW #1 said there were records showing the grandmother was addicted to drugs and suspected of having Munchausen's. She said there were at least eight social service workers and three supervisors involved in the case. SW #1 said, although they discussed that they suspected it, no one had pulled the records, and there was documentation showing the grandmother was suspected of Munchausen's, in black and white. She said if the Cabinet had done their job, when the home evaluation was done to place the cousin in the grandmother's home, then the Cabinet would have been aware she was not capable of being a caretaker for children. SW #1 said everybody that had their hand in this case is responsible for "dropping the ball."

Client Case #11
The biological mother lived with her paramour, her two children (Child #1-a male child and Child #2-a female child), along with her paramour's male child. DCBS investigated a referral on the home after Child #1 appeared at school with bruising. The three children were interviewed, at school, by a SW.[15] She determined Child #1 had lost a toy belonging to the paramour's child and the two boys had fought. The mother was not home at the time, but the paramour was. There was discrepancy on whether the paramour was in the room at the time of the fight and whether the boys were forced to fight or not. When the SW went to the home to interview the paramour, he was belligerent to the children and aggressive. The paramour made verbal threats

[15] Social Service Worker (SW).

that he was going to find out who was telling what occurred in their home. The SW felt the children should be removed for their protection, but was advised by her supervisors not to remove the children. After she persisted, the SW was advised she could contact the County Attorney, and file a petition, if she felt she had enough evidence. The SW filed the petition and the mother's children were removed and placed in the initial foster home.

While in the initial foster home, the children began to disclose physical and sexual abuse. The primary abuser was the mother's paramour and the mother denied she knew anything about the abuse. Child #2 acted out physically and sexually toward Child #1. Child #2 was in the home for a year, before being placed in a residential program, to address her behaviors. The initial foster home expressed they were interested in adopting both children, but did not want to adopt Child #2 until her behaviors were under control. Child #1 was also exhibiting aggressive behaviors. The parents' rights were terminated October 18, 2004. In November 2004, DCBS determined they were not ready to split the siblings, so in April 2005, they moved Child #1 to be near Child #2. Child #1 was later moved to another foster home and Child #2 was in a different home. The current foster home states they are willing to adopt both children, once they are released from treatment.

SW Interview:
After interviewing the children at school and contacting the parents at their residence, the SW believed the children were at risk. The SW met with the SRCA, the SRAA, and her FSOS and stated she believed the children were being abused and should be removed. The SRCA told her not to remove the child. The SRCA did not want the children removed because she felt the children were older, with issues, and were not adoptable. The FSOS said it was too much paperwork to put the children in foster care. Then, after the SW continued to disagree, the SRCA said if she thought she had enough to convince the County Attorney and the Judge, she should contact them. The SW contacted the County Attorney's office, filed a petition, and the children were removed. After the children revealed the extent of the abuse, the FSOS told the SW that her report was too detailed and gave the courts more information than they needed. The FSOS told the SW the children could be returned to the mother if the SW did not advise the court of everything she had found.

Child #1 was in the initial foster home for approximately two years, and Child #2 was there for one year. The initial foster home wanted to adopt Child #1, but had several incidents with Child #2 trying to physically and sexually abuse Child #1. The SRCA took the initial SW off the case and reassigned it to SW #2. Child #1 was very settled in the initial foster home, and appeared to be prospering. His grades were good and there were no behavioral problems. The initial foster home was willing to adopt both children, but DCBS refused to let them. Child #2 was placed in a treatment program and SW #2 later removed Child #1 from the home. The initial SW saw no reason for the removal. The initial SW said she entered contacts in the file that were not there later when she prepared to testify to them. There were several TWIST computer system entries in the file, attributed to the initial SW that she had not entered. Additionally, there were entries reflecting the biological mother had attended events that she had not attended. During the ASFA reviews, the FSOS and the SRCA told the initial SW not to include information in the file or the children would not be returned to the parents.

The initial foster mother's interview:
The initial SW was the social service worker that worked with both the initial foster home and the biological mother of the two foster children. The initial SW was taken off the case and replaced by another SW. The initial foster home had trouble getting the new SW to take any action regarding the children. The biological mother began having supervised visitation with the children and the children began acting out. The initial foster mother said she made several phone calls trying to get the initial SW reassigned to the case, but was told it would be impossible. The initial foster mother was frustrated and began to make phone calls to Frankfort, in an effort to get the initial SW back on the case, because the new SW was not doing anything. The initial foster mother attended a meeting with the SRCA, the new SW, and a private childcare agency representative where

the SRCA told the initial foster mother the names of all the people she had contacted at DCBS Central Office in Frankfort and told her she would never get the initial SW assigned to this case again.

In another meeting with the SRCA, the initial foster mother asked if they were going to prosecute the paramour for the sexual abuse perpetrated on these children. The SRCA asked her what made her think they had enough to get a conviction. The initial foster mother said she told the SRCA she would never know if they did not even try. The paramour was later arrested and charged with several crimes. The paramour ended up taking a plea bargain on charges that did not include sexual violations. The initial foster parents were planning to adopt one or both of the children when the TPR was completed. Then, SW #2 was assigned the case. The initial foster mother said SW #2 never smiled and she made inappropriate comments. Child #2 was sent to a residential facility in western Kentucky, for acting out. The initial foster parents' biological grandson was injured in a fall and the doctors diagnosed the injury as 'Shaken Baby Syndrome'. The child recovered and was placed with the initial foster parents, by the Cabinet, until any criminal actions were resolved. SW #2 visited the initial foster home and noticed the grandchild. She seemed surprised the baby was there, and asked why they had the baby. This seemed odd to the initial foster parents, because the Cabinet had placed the child in their home. In the next meeting, between SW #2, the initial foster mother, and the SRCA, SW #2 said she had just learned the baby was living with the initial foster parents. The initial foster parents had the child for eleven months before he was returned to his parents. In another meeting, SW #2 brought up the grandchild and said the initial foster parents were "unfit parents" because they did not know how to raise their own children (citing, as evidence, that a son had his child removed and placed with the initial foster home). SW #2, the children's therapist from a mental health agency, and other community partners were present when the initial foster mother gave the SRCA a letter from the children's school, in which the counselor and teachers had recommended the initial foster home for adoption. The SRCA refused to look at the letter or show it to anyone else at the meeting. Other professionals were also in favor of the initial foster home adopting Child #1. The SRCA and SW #2 were against the initial foster parents adopting one or both of the children. Child #1 remained with the initial foster home for approximately two months after this.

SW #2 transported Child #1 to visit Child #2 and whenever he learned he had to go anywhere with SW #2 he would start crying. On a couple of occasions, when SW #2 took him to respite or to visit Child #2, he returned upset saying SW #2 told him to forget about being adopted by the initial foster parents, and that he would never see the initial foster mother again. Child #1 told the initial foster mother, when he cried about having to leave her home, SW #2 told him to "Stop the Bullshit." The initial foster mother provided a copy of letters written by Child #1 about SW #2's comments.

The initial foster mother said SW #3 worked with SW #2 and would occasionally come by the house for visits. While there, she observed Child #1 was unhappy with leaving their home. SW #3 tried to help the initial foster home parents. Then, the initial foster mother received a phone call from SW #2 saying she was not permitted to speak to SW #3 or let her into the home again. The initial foster mother later received a card from SW #3 explaining she had been told to stay out of the case and apologizing for being unable to help.

SW #2 contacted the initial foster mother and instructed her to take Child #1 to a Sears store to have photographs taken for his adoption profile. Child #2 was there, along with many other children. The initial foster mother began talking to DCBS contract employee, who was completing the profile for Child #1 and Child #2. The DCBS contract employee was surprised to hear what was occurring in the case and stated that is not what she was told. The DCBS contract employee said she would contact the initial foster mother for more information. The initial foster mother did not receive a call from the DCBS contract employee and later learned she had been taken off the case. When she talked to the DCBS contract employee, again, she was asked not to tell anyone they had talked or she would be in trouble with the Cabinet.

Since he was removed, Child #1 had one failed adoption attempt. The last foster parent permitted Child #1 to phone the initial foster parents. Last December or January, the initial foster mother found out the children were transferred to another foster home and who their new caseworker was. When the initial foster mother contacted the caseworker to make sure she was aware the initial foster parents still wanted to adopt both Child #1 and Child #2, the caseworker became angry that she knew where the children were. She said the caseworker assured her that DCBS knew where the initial foster parents were and would contact them if they decided to let them adopt. The caseworker told the private childcare agency representative that she is aware the initial foster home wanted to adopt the children, but there is nothing she can do to help.

Hardin County no longer allows the initial foster home to have any foster children; however, the other regions have no problem placing foster children with them. Presently, they have a six-sibling group of children from another county, as foster children, and the initial foster parents are building onto their home to make room for Child #1 and Child #2, in case they are permitted to adopt them. The initial foster mother said she will continue in her efforts to adopt Child #1 and Child #2.

SW #2 Interview

SW #2 said Child #1 was removed from the initial foster home because they did not want to adopt both children. She denied making any inappropriate comments to Child #1. She denied telling him to "shut up" and has not spoken to any other child that way. She said she did not tell Child #1 not to talk about staying with the initial foster family. She stated Child #1 was emotional and cried back and forth on trips to see Child #2. SW #2 stated she would be surprised to know the reported reason Child #1 was crying was because of the way she was badgering him about moving him away from the initial foster home. SW #2 denied she ever told Child #1 the initial foster parents would never be able to adopt him.

Client Case #12

On 11-01-04, DCBS removed three children from the biological mother's home, after the 14-year-old son claimed to have had sex with his biological mother. The biological mother stated the son had raped her. She was incarcerated from 11-01-04 until 06-15-05, when she was acquitted of the charge of Incest in Hardin County Circuit Court. The 14-year-old son was placed in juvenile detention after he admitted to sexually abusing his youngest sister, twice. He also admitted to sexually abusing his older sister, who lives with a paternal aunt in Chicago, and the aunt's two children, while he was living with the aunt. On 04-21-05, the Hardin County Family Court found the younger children (ages 2 and 7) were neglected by the biological mother, because she failed to protect the daughter from the oldest son's abuse. Although the abuse did not occur while the biological mother was present in the home, DCBS alleged she should have been aware of it. Additionally, because the 15 year old claimed he had consensual sex with his mother, she was deemed to be a threat to the younger children. The biological fathers of the younger children live in another state and were not available or interested in obtaining custody of their child.

The biological mother was pregnant at the time of her incarceration and delivered a female infant on 01-04-05, while she was incarcerated. DCBS petitioned the court and the infant was placed in a different foster home than her siblings, upon release from the hospital. DCBS initially alleged the infant was a product of incest, but DNA proved the child's father was the mother's paramour.

Home evaluations were completed on the paternal grandmother, the maternal grandfather, and the mother's paramour. All three were denied placement of the children by DCBS, even while the biological mother was incarcerated, because the three relatives refused to state they believed the biological mother had raped her son. The biological mother lives with the maternal grandfather. Since the case was initiated, the mother's paramour has moved into the same residence and there have been two children born to them. In March 2006, the children

were placed with the youngest children's paternal grandmother. Currently, the biological mother has four children in foster/kinship care and is due to deliver a child in March 2007.

The initial foster home placement was willing to adopt the first two children. However, three months later, when the infant was born, and the foster parents expressed they were not willing to adopt the infant, too, the children were moved into a new foster home, in another county, and placed together. The new foster father complained to DCBS, about workers not complying with policy and the lack of quality in their documentation. After he complained to the CHFS Office of the Ombudsman and his complaint was justified, the fact that he contacted the Ombudsman was included on the foster home's annual review, to indicate he was uncooperative with DCBS. [The worker completing the annual review advised OIG investigators that she was instructed, by a regional supervisor, to re-do the favorable review, add the Ombudsman's contact, and complete a negative review of the home.] Social service workers made statements reflecting they believed the foster father was abusive, although there is no evidence or documentation to support this claim. A referral was received, alleging the foster parents were abusive to the children placed in their home. An investigation determined the allegations were unsubstantiated and proved some of the allegations were not possible. Two days later, and three days before Christmas, DCBS removed the children from the foster home and placed them in a foster home, outside the Lincoln Trail Region. Just over two months later, the children were placed with the youngest child's paternal grandmother. In sixteen months, the children were in four different placements.

The relationship between the children's relatives and DCBS has been combative. The DCBS employees claim the biological parents are unwilling to comply with the requirements of the case plan and have been threatening. The biological parents claim they cannot trust DCBS staff because they have been threatened, cursed, assaulted, lied to, lied about, and DCBS keeps changing what they have to do to have the family reunited.

The biological mother has been described as a "sexual predator" (ONG-1) although SW #1 admitted the biological mother did not fit the definition of the term. SW #2 and the FSOS testified in Hardin County Family Court that the biological mother had prematurely delivered an infant in December 2005, because she failed to obtain prenatal medical care. The biological mother presented medical receipts of doctor/clinic visits on 9-12-05, 10-03-05, 9-21-05, 10-02-05, 10-08-05, 10-14-05, 11-10-05, and 12-01-05. SW #2 entered contacts in the case file, on 09-12-05 and 10-03-05, stating visitation was cancelled because the biological mother was at the doctor. On 10-18-05, the biological mother advised SW #2 she was 3 months pregnant. On 11-26-05, the biological mother was hospitalized for a medical condition related to the pregnancy and the infant was prematurely delivered on 12-17-05. This infant was also removed from the parents and placed in a foster home upon release from the hospital.

During one visitation, in January 2006, the biological mother became upset when she observed a bleeding rash on her infant's bottom and back. When she contacted SW #2 two days later and asked if the infant had seen a doctor, she was told she had. The biological mother obtained the medical records and said they reflect a doctor did not see the child until three days after the visitation. She was told the infant had diaper rash, but said the medical records indicated the rash was being treated as scabies. When she mentioned this to SW #2 and the FSOS, she was advised she was wrong and that the child had not been treated for scabies. OIG investigators located medical records in the case file, which indicated the child had been to a doctor four times from early January to early February. During the first visit, the doctor noted the rash on the child's back may be scabies. Two weeks later, and two days after the biological mother noticed the rash, the doctor diagnosed the condition as eczema. Two weeks later, the doctor instructed the foster mother to apply the prescription cream more often and the rash cleared up within three days.

On 10-11-05, SW #2 changed the social security number (SSN) listed in the TWIST computer system, from the biological mother's SSN to the number of another person, with the same name, residing in another state. This

SSN was used to enter the biological mother into the Kentucky Child Abuse and Neglect (CAN) database and was reported to the court for use in determining the biological mother's monthly child support obligation.

An incident that occurred during a Family Team Meeting was taped by the mother's paramour. The FSOS accused the mother's paramour of threatening to kill her. A review of the tape does not indicate this was said. An investigation was conducted by the Kentucky State Police and no charges were filed. This incident was brought to the attention of the Family Court Judge who issued an admonishment to the DCBS staff against threatening clients regarding not returning their children and requiring all contact between the family and DCBS to be audio or video-taped.

Client Case #13

The biological mother came into foster care with her infant child. She turned 18 in 2005 and left foster care a few days later on 08-27-05. She did not take her child with her, but was in contact with DCBS by 09-06-05, when it is documented that the FSOS would be contacted about "allowing the FM to supervise the visits between NM and CH."[16]

According to the service recordings, the biological mother contacted the worker on 09-13-05 and again requested visitation. On 09-14-05, the worker, the FSOS, and the SRCA discussed providing services to the biological mother. On 10-18-05, the foster mother reported the biological mother was calling every 2-3 days to check on the child. SW #1 reported, the first visit with the child was scheduled for 11-22-05, but the biological mother claims she was not told about this visit. SW #1 reported that she arrived at the biological mother's apartment with the child and a CATS assessor, but the biological mother was not home. The next documented contact with the biological mother was an office visit on 12-20-05, where a case plan and visitation schedule were developed (visits to start on 01-06-06). SW #1 was to make referrals for counseling and parenting classes. The next contact was in court on 01-04-06, when the goal was changed to adoption, just 4½ months after the biological mother left foster care. The mother visited with the child on 01-06-06 and gave her Christmas presents. The worker documented that she was unable to contact the biological mother to cancel the 01-13-06 visit, and there is no mention of another attempted or completed visit until 02-03-06 when the worker attempted to call the biological mother, again, to cancel the visit scheduled for that day. SW #1 claims she was unable to contact the biological mother and learned on 03-28-06 that the biological mother had recently moved.

When OIG investigators interviewed SW #1, on 02-23-06, she claimed she had no way of contacting the biological mother. OIG investigators contacted the biological mother within 30 minutes of trying to locate her. During a 7-11-06 interview with SW #1, she again claimed she was unable to locate the biological mother, and initially refused to accept the biological mother's stepfather's phone number until an OIG investigator wrote it down, handed it to SW #1, and stated for the benefit of the tape recording of the interview that she was doing so. An OIG investigator contacted the biological mother, again, and another OIG investigator e-mailed the biological mother's contact information to a DCBS Central Office supervisor on 08-11-06. On 09-11-06, the biological mother called OIG, again, and said she had also called the DCBS office and left phone numbers where she could be reached, but no one returned her calls. An OIG investigator forwarded the biological mother's contact information, again, and the FSOS responded that they contacted the biological mother that date and had set up a visit for the next day, 09-12-06.

The biological mother claimed DCBS will not return her calls and have reported she missed visits that were never scheduled (she thinks DCBS brought witnesses, such as a CATS assessor on 11-22-05, on purpose to indicate she was not interested in her child), and that she was present at visits that DCBS claims she missed. DCBS believed the former foster mother was permitting the biological mother to see the child and she was

[16] Foster Mother (FM), Natural Mother (NM), and Child (CH).

moved to another foster home. The biological mother believes DCBS is intentionally denying her access to her child and documenting that she has not visited. The biological mother stated she has not received any services and is unaware of any referrals completed, except the CATS assessment. The biological mother reported she is employed as an exotic dancer and is making a nice living. She claimed to be looking to purchase a house and does not use any drugs or alcohol. Although a case plan was established on 12-20-05, OIG investigators located another case plan established three months later, on 03-28-06 (the same day SW #1 determined the biological mother had recently moved). This case plan requires the biological mother to complete her GED, attend counseling, attend family counseling, remain in therapy, take all medications (none are prescribed), develop a financial plan, and complete drug assessment and drug screenings. The biological mother believes the case plan was intentionally made so difficult so that she could not complete it.

RECOMMENDATIONS

Based on the evidence and findings compiled during the course of the investigation, OIG makes the following seventeen (17) recommendations:

1. The cloak of secrecy that currently dominates the proceedings relative to the removal of children and the termination of parental rights is not in the best interest of Kentucky's children and must be removed as part of any material reform. Allowing the proceedings to be open, with exception only by court order, will provide the most fail-proof form of oversight, in turn, ensuring that the citizens of the Commonwealth believe in the integrity of the process and have full faith in the outcomes which it produces. Accordingly, the Cabinet should work with the Courts and the Legislature to implement such changes.

2. DCBS should implement Inspection Teams to periodically complete unannounced inspections of DCBS offices. This process should be modeled after such teams utilized by the Kentucky State Police to ensure agency integrity and compliance. The teams, at a minimum, should be responsible for ensuring that DCBS offices are operating in an effective and efficient manner and adhering to all applicable laws and regulations, as well as agency rules, regulations, policies, and procedures. Further, the teams should ensure that complaints made by staff, courts, advocates, law enforcement, clients, and citizens are evaluated and resolved when validated. The reviews should be conducted uniformly, objectively, free of personal opinions and real or perceived conflicts of interest. The team's written reports should be submitted to the DCBS Commissioner, Office of Inspector General, General Counsel and Cabinet Secretary. The DCBS Commissioner should sign such report to evidence his/her review and understanding of the team's findings.

3. The vagueness of the definitions of neglect, abuse, and a dependent child under KRS 600.020 makes it difficult to apply the statute in a fair and uniform fashion. Likewise, the statute's broad terms create the opportunity for findings of neglect, abuse, and dependency to be inappropriately applied. For example, as written, the statute can and, in some cases, has been applied to impoverished families as well as accidental injuries and deaths. The Cabinet should work with the Legislature to make any and all appropriate modifications to the statute to clarify the intent of the statute and, to the extent possible, eliminate the potential for misuse or over-application of the statute. Further, while KRS 620.040 requires a 'probable cause' standard before a judge may issue a search warrant to enable a law enforcement officer to enter a residence to evaluate the condition of a child, KRS 620.060 requires petitions for emergency custody to only meet a 'reasonable grounds' standard that one of three elements exists, in addition to a finding that the parents or other person exercising custodial control or supervision are unable or unwilling to protect the child. The second condition also includes the statement, "This condition shall not include reasonable and ordinary discipline recognized in the community where the child lives, as long as reasonable and ordinary discipline does not result in abuse or neglect as defined in KRS 600.020(1)." There are nine elements in KRS 600.020(1), adding to the confusion as to what substantiates abuse, neglect, or dependency.

4. In situations where parents are potentially threatening to social service workers, or deny entry to the social service worker, law enforcement should accompany the worker to assure the worker's safety. Since law enforcement may assume protective custody of a child, without prior approval of the court, workers should be required to contact law enforcement and request verification of the safety of any children in a home, whenever a parent denies access to a social services worker, prior to the worker contacting the court for an ECO. Based on the fact that, once an ECO is issued, even if the worker, upon entry to the residence, determines conditions in the home are safe, they have no recourse but to remove the children. Contacting law enforcement first would prevent the unnecessary removal of

children from a home simply because the parent denied the social service worker's request for access. Further, it will eliminate the perception, whether accurate or not, that children removed in such cases are being removed by social service workers for the purpose of punishing the parent for originally denying access.

5. DCBS record management processes and systems are inadequate and must be improved to ensure the integrity of the case reports and the recommendations and actions that flow from the same. Again, we recommend that Cabinet officials look to the Kentucky State Police for model processes while developing and implementing a records management system.

6. DCBS Permanency and Protection staff should receive consistent and repetitive training with regard to the elements required to substantiate abuse, neglect, or dependency. These elements should be standardized across the state and easily identifiable. For example, DCBS policy should mirror KRS (i.e. must have "physical injury" or "serious physical injury" to substantiate physical abuse) and define what elements are necessary to substantiate the abuse. Workers appear confused about what actually exemplifies abuse. For example, some social service workers have told parents it is "illegal" to spank their children.

7. The CHFS Office of the Ombudsman is a greatly underutilized resource in ensuring the integrity of the DCBS actions. Unfortunately, the Office of the Ombudsman has historically and is currently viewed by some individuals as an unnecessary intermeddler. DCBS and the Office of the Ombudsman should work together to develop and implement any and all necessary policy and procedures to better ensure that the two departments work cooperatively to ensure better oversight of the process and that quality control measures are in place to detect process failures and/or weaknesses. At a minimum, any complaint justified by the Office of the Ombudsman should result in a written action plan for the resolution of the issue, through the chain of command, from the SRA to the DCBS Commissioner's Office.

8. Under the current process, the vast majority of TPR cases proceed to court based solely on a review conducted by DCBS regional staff and a Cabinet regional attorney. Based on the gravity of the action, we believe all TPR cases should be reviewed and approved by DCBS Central Office officials prior to petitioning the court for termination. This review should include not only the information contained in the TWIST computer system and the hard case file, but should include interviews with the biological parents and relatives attempting to obtain custody of the child, if any, as well as the social service worker(s) involved to assure the required services have in fact been offered/provided and not just documented as having been offered/provided and that the case is, in fact, appropriate for termination.

9. DCBS management and supervisory staff should follow an established organizational chain of command to ensure that the SRA does not inappropriately defer or abuse his/her management responsibilities within the region and that the SRA's management ability is reviewed by Central Office supervision, to assure accountability and compliance with applicable laws and regulations as well as with agency standard operating procedures. Additional training should be provided to all management and supervisory personnel on methods of supervision and accountability, as well as interacting with clients, community partners, law enforcement and the courts. This training should include the areas of constitutional law, perjury, falsification of records, and the integrity of the court system and penalties associated with non-compliance related to the same.

10. All TWIST records should identify any edits and the date/time of any approvals completed by supervisors. TWIST records should reflect the entry date and time, in addition to the reported date and time of the contact. Such efforts would prevent the occurrence of missing or altered documentation,

which several workers claim to have experienced. Additionally, these modifications would provide immediate access to the entry documentation information so readers could readily identify any discrepancies or delays in the documentation.

11. Client case information is presently contained in two locations, the TWIST computer system and the hard copy case file, requiring duplication of workers' efforts and limited access to all the information available in the case. All documents should be scanned and entered into TWIST, to eliminate the need for a hard copy case file. This would reduce the caseworker's workload, abolish the current need to duplicate records, and provide agency oversight into cases via the ability to access the entire record without traveling to the local office and reviewing a case file. This ability to provide oversight could eliminate the need to contact the case manager to determine what information is available and what documentation has been completed. Additionally, this would permit regional and Central Office supervisors to hold field and regional staff accountable for timely, accurate, and factual documentation.

12. Relatives are often not advised of termination of parental rights proceedings involving family members, since they are not legally an interested party. KRS 625.060 limits the parties to the petitioner, the Cabinet, and the biological parents in an involuntary termination of parental rights hearing. A legislative modification should be considered which would mandate that the Cabinet provide notice to the court of all relatives who have previously requested custody of the children, unless such relatives have been determined to be unsuitable for placement.

13. A reason initially offered for why DCBS would favor adoption over other permanency options was the federal incentive program. This argument does not stand up to scrutiny. Nonetheless, non-adoptive permanency options should be reviewed by Cabinet officials. Kentucky does receive federal funding when children are adopted. However, the amount of adoption subsidies paid to adoptive parents each year far exceeds the adoption incentives received from the federal government. The state may receive from $4,000 to $6,000 per adopted child, depending on the child's needs. Kentucky received just over $1 million in incentives in the 2005 federal fiscal year. During the state fiscal year 2005, the Cabinet paid families more than $37 million in adoption subsidies. These subsidies typically range from $600 to $1,200 per month per child. According to the December 2006 report from the Auditor of Public Accounts, 98% of the 876 children adopted in federal fiscal year 2005 qualified for adoption subsidies. Only 80% of those children were considered a special needs child, and 41% of the total amount was considered special needs due to being a member of a sibling group. The lowest amount paid to Kentucky foster parents is approximately $600 per child per month, but may be as high as $5,671, depending on the child's needs. The Adoption and Safe Families Act of 1997 encourages relative placement. However, it appears relatives are not the preferred placement option when children are removed from their parents' home, as evidenced by the 6.5%, statewide, who are placed with relatives.[17] Since Kinship Care, paid to a relative with temporary or permanent custody of a child in the Cabinet's custody, is typically $300 per month, it would be economically beneficial to the state and, obviously, emotionally beneficial to the child, to encourage relative placements. Accordingly, DCBS should develop and implement a formalized process to ensure relative placement is uniformly identified as the preferred placement, when appropriate.

14. DCBS should study the use of the CATS program to determine if program assessors are always provided accurate and complete information by DCBS staff and whether or not the findings are appropriately applied. The Cabinet should also develop written policy to address the situations for when it is appropriate to obtain additional assessments, outside the CATS program, in order to prevent the procurement of further assessments with the intent of obtaining a specific desired outcome.

[17] LRC: Foster Care Report, 2006.

15. DCBS should change its employee evaluation criteria to remove any performance criteria, whether real or perceived which contributes to any conflict of interest. At a minimum, evaluations should be based on factual performance measures, rather than specific outcomes such as the number of children adopted.

16. The Cabinet should develop a policy and procedure to assure the timely notice of investigative findings is completed and forwarded to subjects of DCBS investigations. This policy should include the identification of an individual responsible for assuring the completion of this task. Further, a letter, from Central Office, signed by an identified DCBS official, attesting the client's name has been removed from the Child Abuse and Neglect (CAN) database, should be forwarded to the client and all previously notified parties, whenever a client wins an appeal and obtains a reversal of the findings at a Child Abuse Prevention and Treatment Act (CAPTA) administrative hearing.

17. DCBS should continue to study innovative practices implemented by other states in an aggressive effort to develop and implement such best practices in Kentucky. Further, DCBS should work to expand the Parent Advocate Program, currently in place in Jefferson County, into other communities around the Commonwealth. Finally, whether part of a formal program or not, community partners should be more fully utilized to provide local and economical services to clients.

Appendix

KRS 600.020 Definitions for KRS Chapters 600 to 645.

As used in KRS Chapters 600 to 645, unless the context otherwise requires:

(1) "Abused or neglected child" means a child whose health or welfare is harmed or threatened with harm when his parent, guardian, or other person exercising custodial control or supervision of the child:

(a) Inflicts or allows to be inflicted upon the child physical or emotional injury as defined in this section by other than accidental means;

(b) Creates or allows to be created a risk of physical or emotional injury as defined in this section to the child by other than accidental means;

(c) Engages in a pattern of conduct that renders the parent incapable of caring for the immediate and ongoing needs of the child including, but not limited to, parental incapacity due to alcohol and other drug abuse as defined in KRS 222.005;

(d) Continuously or repeatedly fails or refuses to provide essential parental care and protection for the child, considering the age of the child; (e) Commits or allows to be committed an act of sexual abuse, sexual exploitation, or prostitution upon the child;

(f) Creates or allows to be created a risk that an act of sexual abuse, sexual exploitation, or prostitution will be committed upon the child;

(g) Abandons or exploits the child;

(h) Does not provide the child with adequate care, supervision, food, clothing, shelter, and education or medical care necessary for the child's well-being. A parent or other person exercising custodial control or supervision of the child legitimately practicing the person's religious beliefs shall not be considered a negligent parent solely because of failure to provide specified medical treatment for a child for that reason alone. This exception shall not preclude a court from ordering necessary medical services for a child; or

(i) Fails to make sufficient progress toward identified goals as set forth in the court-approved case plan to allow for the safe return of the child to the parent that results in the child remaining committed to the cabinet and remaining in foster care for fifteen (15) of the most recent twenty-two (22) months;

(2) "Aggravated circumstances" means the existence of one (1) or more of the following conditions:

(a) The parent has not attempted or has not had contact with the child for a period of not less than ninety (90) days;

(b) The parent is incarcerated and will be unavailable to care for the child for a period of at least one (1) year from the date of the child's entry into foster care and there is no appropriate relative placement available during this period of time;

(c) The parent has sexually abused the child and has refused available treatment;

(d) The parent has been found by the cabinet to have engaged in abuse of the child that required removal from the parent's home two (2) or more times in the past two (2) years; or

(e) The parent has caused the child serious physical injury;

(3) "Beyond the control of parents" means a child who has repeatedly failed to follow the reasonable directives of his or her parents, legal guardian, or person exercising custodial control or supervision other than a state agency, which behavior results in danger to the child or others, and which behavior does not constitute behavior that would warrant the filing of a petition under KRS Chapter 645;

(4) "Beyond the control of school" means any child who has been found by the court to have repeatedly violated the lawful regulations for the government of the school as provided in KRS 158.150, and as documented in writing by the school as a part of the school's petition or as an attachment to the school's petition. The petition or attachment shall describe the student's behavior and all intervention strategies attempted by the school;

(5) "Boarding home" means a privately owned and operated home for the boarding and lodging of individuals which is approved by the Department of Juvenile Justice or the cabinet for the placement of children committed to the department or the cabinet;

(6) "Cabinet" means the Cabinet for Health and Family Services;

(7) "Certified juvenile facility staff" means individuals who meet the qualifications of, and who have completed a course of education and training in juvenile detention developed and approved by, the Department of Juvenile Justice after consultation with other appropriate state agencies;
(8) "Child" means any person who has not reached his eighteenth birthday, unless otherwise provided;
(9) "Child-caring facility" means any facility or group home other than a state facility, Department of Juvenile Justice contract facility or group home, or one certified by an appropriate agency as operated primarily for educational or medical purposes, providing residential care on a twenty-four (24) hour basis to children not related by blood, adoption, or marriage to the person maintaining the facility;
(10) "Child-placing agency" means any agency, other than a state agency, which supervises the placement of children in foster family homes or child-caring facilities or which places children for adoption;
(11) "Clinical treatment facility" means a facility with more than eight (8) beds designated by the Department of Juvenile Justice or the cabinet for the treatment of mentally ill children. The treatment program of such facilities shall be supervised by a qualified mental health professional;
(12) "Commitment" means an order of the court which places a child under the custodial control or supervision of the Cabinet for Health and Family Services, Department of Juvenile Justice, or another facility or agency until the child attains the age of eighteen (18) unless the commitment is discharged under KRS Chapter 605 or the committing court terminates or extends the order;
(13) "Community-based facility" means any nonsecure, homelike facility licensed, operated, or permitted to operate by the Department of Juvenile Justice or the cabinet, which is located within a reasonable proximity of the child's family and home community, which affords the child the opportunity, if a Kentucky resident, to continue family and community contact;
(14) "Complaint" means a verified statement setting forth allegations in regard to the child which contain sufficient facts for the formulation of a subsequent petition;
(15) "Court" means the juvenile session of District Court unless a statute specifies the adult session of District Court or the Circuit Court;
(16) "Court-designated worker" means that organization or individual delegated by the Administrative Office of the Courts for the purposes of placing children in alternative placements prior to arraignment, conducting preliminary investigations, and formulating, entering into, and supervising diversion agreements and performing such other functions as authorized by law or court order;
(17) "Deadly weapon" has the same meaning as it does in KRS 500.080;
(18) "Department" means the Department for Community Based Services;
(19) "Dependent child" means any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child;
(20) "Detention" means the safe and temporary custody of a juvenile who is accused of conduct subject to the jurisdiction of the court who requires a restricted environment for his or her own or the community's protection;
(21) "Detention hearing" means a hearing held by a judge or trial commissioner within twenty-four (24) hours, exclusive of weekends and holidays, of the start of any period of detention prior to adjudication;
(22) "Diversion agreement" means an agreement entered into between a court-designated worker and a child charged with the commission of offenses set forth in KRS Chapters 630 and 635, the purpose of which is to serve the best interest of the child and to provide redress for those offenses without court action and without the creation of a formal court record;
(23) "Emergency shelter" is a group home, private residence, foster home, or similar homelike facility which provides temporary or emergency care of children and adequate staff and services consistent with the needs of each child;
(24) "Emotional injury" means an injury to the mental or psychological capacity or emotional stability of a child as evidenced by a substantial and observable impairment in the child's ability to function within a normal range of performance and behavior with due regard to his age, development, culture, and environment as testified to by a qualified mental health professional;
(25) "Firearm" shall have the same meaning as in KRS 237.060 and 527.010;

(26) "Foster family home" means a private home in which children are placed for foster family care under supervision of the cabinet or a licensed child-placing agency;
(27) "Habitual runaway" means any child who has been found by the court to have been absent from his place of lawful residence without the permission of his custodian for at least three (3) days during a one (1) year period;
(28) "Habitual truant" means any child who has been found by the court to have been reported as a truant as defined in KRS 159.150(1) two (2) or more times during a one (1) year period;
(29) "Hospital" means, except for purposes of KRS Chapter 645, a licensed private or public facility, health care facility, or part thereof, which is approved by the cabinet to treat children;
(30) "Independent living" means those activities necessary to assist a committed child to establish independent living arrangements;
(31) "Informal adjustment" means an agreement reached among the parties, with consultation, but not the consent, of the victim of the crime or other persons specified in KRS 610.070 if the victim chooses not to or is unable to participate, after a petition has been filed, which is approved by the court, that the best interest of the child would be served without formal adjudication and disposition;
(32) "Intentionally" means, with respect to a result or to conduct described by a statute which defines an offense, that the actor's conscious objective is to cause that result or to engage in that conduct;
(33) "Intermittent holding facility" means a physically secure setting, which is entirely separated from sight and sound from all other portions of a jail containing adult prisoners, in which a child accused of a public offense may be detained for a period not to exceed twenty-four (24) hours, exclusive of weekends and holidays prior to a detention hearing as provided for in KRS 610.265, and in which children are supervised and observed on a regular basis by certified juvenile facility staff;
(34) "Juvenile holding facility" means a physically secure facility, approved by the Department of Juvenile Justice, which is an entirely separate portion or wing of a building containing an adult jail, which provides total sight and sound separation between juvenile and adult facility spatial areas and which is staffed by sufficient certified juvenile facility staff to provide twenty-four (24) hours per day supervision;
(35) "Least restrictive alternative" means, except for purposes of KRS Chapter 645, that the program developed on the child's behalf is no more harsh, hazardous, or intrusive than necessary; or involves no restrictions on physical movements nor requirements for residential care except as reasonably necessary for the protection of the child from physical injury; or protection of the community, and is conducted at the suitable available facility closest to the child's place of residence;
(36) "Motor vehicle offense" means any violation of the nonfelony provisions of KRS Chapters 186, 189, or 189A, KRS 177.300, 304.39-110, or 304.39-117;
(37) "Near fatality" means an injury that, as certified by a physician, places a child in serious or critical condition;
(38) "Needs of the child" means necessary food, clothing, health, shelter, and education;
(39) "Nonsecure facility" means a facility which provides its residents access to the surrounding community and which does not rely primarily on the use of physically restricting construction and hardware to restrict freedom;
(40) "Nonsecure setting" means a nonsecure facility or a residential home, including a child’s own home, where a child may be temporarily placed pending further court action. Children before the court in a county that is served by a state operated secure detention facility, who are in the detention custody of the Department of Juvenile Justice, and who are placed in a nonsecure alternative by the Department of Juvenile Justice, shall be supervised by the Department of Juvenile Justice;
(41) "Parent" means the biological or adoptive mother or father of a child;
(42) "Person exercising custodial control or supervision" means a person or agency that has assumed the role and responsibility of a parent or guardian for the child, but that does not necessarily have legal custody of the child;
(43) "Petition" means a verified statement, setting forth allegations in regard to the child, which initiates formal court involvement in the child's case;
(44) "Physical injury" means substantial physical pain or any impairment of physical condition;

(45) "Physically secure facility" means a facility that relies primarily on the use of construction and hardware such as locks, bars, and fences to restrict freedom;
(46) "Public offense action" means an action, excluding contempt, brought in the interest of a child who is accused of committing an offense under KRS Chapter 527 or a public offense which, if committed by an adult, would be a crime, whether the same is a felony, misdemeanor, or violation, other than an action alleging that a child sixteen (16) years of age or older has committed a motor vehicle offense;
(47) "Qualified mental health professional" means:
(a) A physician licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties;
(b) A psychiatrist licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the practice of official duties, and who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc.;
(c) A psychologist with the health service provider designation, a psychological practitioner, a certified psychologist, or a psychological associate licensed under the provisions of KRS Chapter 319;
(d) A licensed registered nurse with a master's degree in psychiatric nursing from an accredited institution and two (2) years of clinical experience with mentally ill persons, or a licensed registered nurse with a bachelor's degree in nursing from an accredited institution who is certified as a psychiatric and mental health nurse by the American Nurses Association and who has three (3) years of inpatient or outpatient clinical experience in psychiatric nursing and who is currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a regional comprehensive care center;
(e) A licensed clinical social worker licensed under the provisions of KRS 335.100, or a certified social worker licensed under the provisions of KRS 335.080 with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a regional comprehensive care center;
(f) A marriage and family therapist licensed under the provisions of KRS 335.300 to 335.399 with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth, a psychiatric unit of a general hospital, or a regional comprehensive care center; or
(g) A professional counselor credentialed under the provisions of KRS 335.500 to 335.599 with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, or a regional comprehensive care center;
(48) "Residential treatment facility" means a facility or group home with more than eight (8) beds designated by the Department of Juvenile Justice or the cabinet for the treatment of children;
(49) "Retain in custody" means, after a child has been taken into custody, the continued holding of the child by a peace officer for a period of time not to exceed twelve (12) hours when authorized by the court or the court-designated worker for the purpose of making preliminary inquiries;
(50) "School personnel" means those certified persons under the supervision of the local public or private education agency;
(51) "Secretary" means the secretary of the Cabinet for Health and Family Services;
(52) "Secure juvenile detention facility" means any physically secure facility used for the secure detention of children other than any facility in which adult prisoners are confined;
(53) "Serious physical injury" means physical injury which creates a substantial risk of death or which causes serious and prolonged disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily member or organ;
(54) "Sexual abuse" includes, but is not necessarily limited to, any contacts or interactions in which the parent, guardian, or other person having custodial control or supervision of the child or responsibility for his welfare, uses or allows, permits, or encourages the use of the child for the purposes of the sexual stimulation of the perpetrator or another person;

(55) "Sexual exploitation" includes, but is not limited to, a situation in which a parent, guardian, or other person having custodial control or supervision of a child or responsible for his welfare, allows, permits, or encourages the child to engage in an act which constitutes prostitution under Kentucky law; or a parent, guardian, or other person having custodial control or supervision of a child or responsible for his welfare, allows, permits, or encourages the child to engage in an act of obscene or pornographic photographing, filming, or depicting of a child as provided for under Kentucky law;
(56) "Social service worker" means any employee of the cabinet or any private agency designated as such by the secretary of the cabinet or a social worker employed by a county or city who has been approved by the cabinet to provide, under its supervision, services to families and children;
(57) "Staff secure facility for residential treatment" means any setting which assures that all entrances and exits are under the exclusive control of the facility staff, and in which a child may reside for the purpose of receiving treatment;
(58) "Status offense action" is any action brought in the interest of a child who is accused of committing acts, which if committed by an adult, would not be a crime. Such behavior shall not be considered criminal or delinquent and such children shall be termed status offenders. Status offenses shall not include violations of state or local ordinances which may apply to children such as a violation of curfew or possession of alcoholic beverages;
(59) "Take into custody" means the procedure by which a peace officer or other authorized person initially assumes custody of a child. A child may be taken into custody for a period of time not to exceed two (2) hours;
(60) “Valid court order” means a court order issued by a judge to a child alleged or found to be a status offender:
(a) Who was brought before the court and made subject to the order;
(b) Whose future conduct was regulated by the order;
(c) Who was given written and verbal warning of the consequences of the violation of the order at the time the order was issued and whose attorney or parent or legal guardian was also provided with a written notice of the consequences of violation of the order, which notification is reflected in the record of the court proceedings; and
(d) Who received, before the issuance of the order, the full due process rights guaranteed by the Constitution of the United States.
(61) "Violation" means any offense, other than a traffic infraction, for which a sentence of a fine only can be imposed;
(62) "Youth alternative center" means a nonsecure facility, approved by the Department of Juvenile Justice, for the detention of juveniles, both prior to adjudication and after adjudication, which meets the criteria specified in KRS 15A.320; and
(63) "Youthful offender" means any person regardless of age, transferred to Circuit Court under the provisions of KRS Chapter 635 or 640 and who is subsequently convicted in Circuit Court.

KRS 610.127 Parental circumstances negating requirement for reasonable efforts to reunify child with family.

Reasonable efforts as defined in KRS 620.020 shall not be required to be made with respect to a parent of a child if a court of competent jurisdiction determines that the parent has:
(1) Subjected the child to aggravated circumstances as defined in KRS 600.020;
(2) Been convicted in a criminal proceeding of having caused or contributed to the death of another child of the parent;
(3) Committed a felony assault that resulted in serious bodily injury to the child or to another child of the parent;
(4) Had their parental rights to another child terminated involuntarily;
(5) Engaged in a pattern of conduct due to alcohol or other drug abuse as defined in KRS 222.005 for a period of not less than ninety (90) days that has rendered the parent incapable of caring for the immediate and ongoing needs of the child, and the parent has refused or failed to complete available treatment for alcohol or other drug abuse;

(6) Mental illness as defined in KRS 202A.011 or mental retardation as defined in KRS 202B.010 or other developmental disability as defined in KRS 387.510 that places the child at substantial risk of physical or emotional injury even if the most appropriate and available services were provided to the parent for twelve (12) months; or
(7) Other circumstances in existence that make continuation or implementation of reasonable efforts to preserve or reunify the family inconsistent with the best interests of the child and with the permanency plan for the child.

KRS 620.060 Emergency custody orders.
(1) The court for the county where the child is present may issue an ex parte emergency custody order when it appears to the court that removal is in the best interest of the child and that there are **reasonable grounds** to believe, as supported by affidavit or by recorded sworn testimony, that one (1) or more of the following conditions exist and that the parents or other person exercising custodial control or supervision are unable or unwilling to protect the child:
(a) The child is in danger of imminent death or serious physical injury or is being sexually abused;
(b) The parent has repeatedly inflicted or allowed to be inflicted by other than accidental means physical injury or emotional injury. **This condition shall not include reasonable and ordinary discipline recognized in the community where the child lives, as long as reasonable and ordinary discipline does not result in abuse or neglect as defined in KRS 600.020(1**); or
(c) The child is in immediate danger due to the parent's failure or refusal to provide for the safety or needs of the child.
(2) Custody may be placed with a relative taking into account the wishes of the custodial parent and child or any other appropriate person or agency including the cabinet.
(3) An emergency custody order shall be effective no longer than seventy-two (72) hours, exclusive of weekends and holidays, unless there is a temporary removal hearing with oral or other notice to the county attorney and the parent or other person exercising custodial control or supervision of the child, to determine if the child should be held for a longer period. The seventy-two (72) hour period also may be extended or delayed upon the waiver or request of the child's parent or other person exercising custodial control or supervision.
(4) Any person authorized to serve process shall serve the parent or other person exercising custodial control or supervision with a copy of the emergency custody order. If such person cannot be found, the sheriff shall make a good faith effort to notify the nearest known relative, neighbor, or other person familiar with the child.
(5) Within seventy-two (72) hours of the taking of a child into custody without the consent of his parent or other person exercising custodial control or supervision, a petition shall be filed pursuant to this chapter.
(6) Nothing herein shall preclude the issuance of arrest warrants pursuant to the Rules of Criminal Procedure.

KRS 620.080 Temporary removal hearing.
(1) Unless waived by the child and his parent or other person exercising custodial control or supervision, a temporary removal hearing shall be held:
(a) Within seventy-two (72) hours, excluding weekends and holidays, of the time when an emergency custody order is issued or when a child is taken into custody without the consent of his parent or other person exercising custodial control or supervision; and
(b) In cases commenced by the filing of a petition, within ten (10) days of the date of filing.
(2) At a temporary removal hearing, the court shall determine whether there are **reasonable grounds** to believe that the child would be dependent, neglected or abused if returned to or left in the custody of his parent or other person exercising custodial control or supervision even though it is not proved conclusively who has perpetrated the dependency, neglect or abuse. For good cause, the court may allow hearsay evidence. The Commonwealth shall bear the burden of proof by a **preponderance of the evidence** and if the Commonwealth should fail to establish same, the child shall be released to or retained in the custody of his parent or other person exercising custodial control or supervision.

KRS 620.120 Criminal charges tried separately.
In cases where criminal charges arising out of the same transaction or occurrence are filed against an adult alleged to be the perpetrator of child abuse or neglect, such charges shall be tried separately from the adjudicatory hearing held pursuant to this chapter.

KRS 620.130 Alternatives to removal from custody.
(1) In any proceeding under this chapter, when the court is petitioned to remove or continue the removal of a child from the custody of his parent or other person exercising custodial control or supervision, the court shall first consider whether the child may be reasonably protected against the alleged dependency, neglect or abuse, by alternatives less restrictive than removal. Such alternatives may include, but shall not be limited to, the provision of medical, educational, psychiatric, psychological, social work, counseling, day care, or homemaking services with monitoring wherever necessary by the cabinet or other appropriate agency. Where the court specifically finds that such alternatives are adequate to reasonably protect the child against the alleged dependency, neglect or abuse, the court shall not order the removal or continued removal of the child.
(2) If the court orders the removal or continues the removal of the child, services provided to the parent and the child shall be designed to promote the protection of the child and the return of the child safely to the child's home as soon as possible. The cabinet shall develop a treatment plan for each child designed to meet the needs of the child. The cabinet may change the child's placement or treatment plan as the cabinet may require. The cabinet shall notify the committing court of the change, in writing, within fourteen (14) days after the change has been implemented.

KRS 625.020 Circuit Court jurisdiction.
The Circuit Court shall have jurisdiction of proceedings under this chapter.

KRS 625.043 Termination orders.
(1) If the Circuit Court determines that parental rights are to be voluntarily terminated in accordance with the provisions of this chapter, it shall make an order terminating all parental rights and obligations of the parent and releasing the child from all legal obligations to the parent and vesting care and custody of the child in the person, agency, or cabinet the court believes is best qualified to receive custody.
(2) Upon consent by the Cabinet for Health and Family Services, the child may be declared a ward of the state and custody vested in the cabinet or in any child-placing agency or child-caring facility licensed by the cabinet or in another person if all persons with parental rights to the child under the law have had their rights terminated voluntarily or involuntarily. If the other person is not excepted by KRS 199.470(4) or (5), a grant of permanent custody shall be made only if the proposed custodian has received the written approval of the secretary or the secretary's designee for the child's placement.

KRS 625.060 Parties to action.
(1) In addition to the child, the following shall be the parties in an action for involuntary termination of parental rights:
(a) The petitioner;
(b) The cabinet, if not the petitioner; and
(c) The biological parents, if known and if their rights have not been previously terminated. It shall not be necessary to make the putative father a party if he is exempted by KRS 625.065.

(2) Any party other than the child who is not the petitioner shall be a respondent.

KRS 625.090 Grounds for termination.

(1) The Circuit Court may involuntarily terminate all parental rights of a parent of a named child, if the Circuit Court finds from the pleadings and by clear and convincing evidence that:

(a) 1. The child has been adjudged to be an abused or neglected child, as defined in KRS 600.020(1), by a court of competent jurisdiction;

2. The child is found to be an abused or neglected child, as defined in KRS 600.020(1), by the Circuit Court in this proceeding; or

3. The parent has been convicted of a criminal charge relating to the physical or sexual abuse or neglect of any child and that physical or sexual abuse, neglect, or emotional injury to the child named in the present termination action is likely to occur if the parental rights are not terminated; and

(b) Termination would be in the best interest of the child.

(2) No termination of parental rights shall be ordered unless the Circuit Court also finds by clear and convincing evidence the existence of one (1) or more of the following grounds:

(a) That the parent has abandoned the child for a period of not less than ninety (90) days;

(b) That the parent has inflicted or allowed to be inflicted upon the child, by other than accidental means, serious physical injury;

(c) That the parent has continuously or repeatedly inflicted or allowed to be inflicted upon the child, by other than accidental means, physical injury or emotional harm;

(d) That the parent has been convicted of a felony that involved the infliction of serious physical injury to any child;

(e) That the parent, for a period of not less than six (6) months, has continuously or repeatedly failed or refused to provide or has been substantially incapable of providing essential parental care and protection for the child and that there is no reasonable expectation of improvement in parental care and protection, considering the age of the child;

(f) That the parent has caused or allowed the child to be sexually abused or exploited;

(g) That the parent, for reasons other than poverty alone, has continuously or repeatedly failed to provide or is incapable of providing essential food, clothing, shelter, medical care, or education reasonably necessary and available for the child's well-being and that there is no reasonable expectation of significant improvement in the parent's conduct in the immediately foreseeable future, considering the age of the child;

(h) That:

1. The parent's parental rights to another child have been involuntarily terminated;

2. The child named in the present termination action was born subsequent to or during the pendency of the previous termination; and

3. The conditions or factors which were the basis for the previous termination finding have not been corrected;

(i) That the parent has been convicted in a criminal proceeding of having caused or contributed to the death of another child as a result of physical or sexual abuse or neglect; or

(j) That the child has been in foster care under the responsibility of the cabinet for fifteen (15) of the most recent twenty-two (22) months preceding the filing of the petition to terminate parental rights.

(3) In determining the best interest of the child and the existence of a ground for termination, the Circuit Court shall consider the following factors:

(a) Mental illness as defined by KRS 202A.011(9), or mental retardation as defined by KRS 202B.010(9) of the parent as certified by a qualified mental health professional, which renders the parent consistently unable to care for the immediate and ongoing physical or psychological needs of the child for extended periods of time;

(b) Acts of abuse or neglect as defined in KRS 600.020(1) toward any child in the family;

(c) If the child has been placed with the cabinet, whether the cabinet has, prior to the filing of the petition made reasonable efforts as defined in KRS 620.020 to reunite the child with the parents unless one or more of the

circumstances enumerated in KRS 610.127 for not requiring reasonable efforts have been substantiated in a written finding by the District Court;
(d) The efforts and adjustments the parent has made in his circumstances, conduct, or conditions to make it in the child's best interest to return him to his home within a reasonable period of time, considering the age of the child;
(e) The physical, emotional, and mental health of the child and the prospects for the improvement of the child's welfare if termination is ordered; and
(f) The payment or the failure to pay a reasonable portion of substitute physical care and maintenance if financially able to do so.
(4) If the child has been placed with the cabinet, the parent may present testimony concerning the reunification services offered by the cabinet and whether additional services would be likely to bring about lasting parental adjustment enabling a return of the child to the parent.
(5) If the parent proves by a preponderance of the evidence that the child will not continue to be an abused or neglected child as defined in KRS 600.020(1) if returned to the parent the court in its discretion may determine not to terminate parental rights.
(6) Upon the conclusion of proof and argument of counsel, the Circuit Court shall enter findings of fact, conclusions of law, and a decision as to each parent-respondent within thirty (30) days either:
(a) Terminating the right of the parent; or
(b) Dismissing the petition and stating whether the child shall be returned to the parent or shall remain in the custody of the state.