Independent Ombudsman

for the

Texas Juvenile Justice Department

First Quarter Report FY 14

September 1, 2013 to November 30, 2013

Introduction:

This report is the first Quarterly Report of FY 2014 to be submitted by this office under statute and is intended for the Executive Director of the Texas Juvenile Justice Department (TJJD), the Governor, Lt. Governor, Speaker of the House, members of the Texas Legislature, and the Auditor for the State of Texas. This report will serve to provide a description of the activities of the office during the first quarter of FY 14 spanning September 2013 through November 2013.

Overview of the Work of the Independent Ombudsman

The Independent Ombudsman (IO) was established for the purpose of investigating, evaluating, and securing the rights of the children committed to the Juvenile Justice Department, including a child released under supervision before final discharge. To fulfill the duties of the office, IO staff regularly visit all TJJD secure facilities, halfway houses, parole offices, all contract care programs as well as tracks Abuse, Neglect and Exploitation (ANE) incidents from all pre/post adjudication county facilities. Currently, TJJD operates 6 secure facilities, 8 halfway houses, and several parole district locations. Additionally, TJJD contracts with additional facilities to provide services to TJJD youth. While the IO seeks to address systemic problems with TJJD service delivery, the office has resolved numerous individual complaints, as well.

The office successfully visited and inspected secure TJJD facilities, as well as halfway houses, contract care facilities and parole offices to monitor for compliance with best practices for the safety and security of the youth. In addition, all ANE incident reports from county facilities have been reviewed and tracked for trends.

Facility Closure

As mandated by the 83rd Legislative Session, in July the TJJD staff recommended Corsicana as the facility to close due to its age, cost of repairs, difficulty in maintaining staff, youth access to self-harming materials and the high needs of the youth housed at that facility. The facility was slated to close in the Fall and the youth moved to the McLennan County Juvenile Correctional Facility. Resistance to the closure surfaced a few days after the initial recommendation from some Legislators, the Speaker of the House, and the Lieutenant Governor.

In light of the resistance, the Legislative Budget Board has not accepted the TJJD recommendation for closure and the relocation of the youth. The Ombudsman's Office has voiced concerns for the possible consequences brought on by the indecision.

The IO will continue to monitor this situation and make appropriate recommendations.

Special Report

A special site visit was conducted September 18 and 20, 2013, at the Phoenix Program in response to concerns raised while viewing a video of TJJD staff fighting with youth. The OIG was dispatched on Sept 18th following an IRC report of these incidents and made the determination the activities were "horseplay". The IO continued its investigation and found several issues of concern.

Agency Response:

On September 17, 2013 a Case Manager assigned to the Phoenix Program reported concerns to Mart Assistant Superintendent about the actions of several second-shift staff on the Phoenix Program and recommended that he review video on the unit. The Assistant Superintendent notified the Superintendent and both located instances of video reflecting staff engaged in inappropriate physical contact with youth on the unit.

This information was phoned into the IRC per policy and notification was submitted to Executive staff, the Office of Inspector General (OIG) and the Office of Independent Ombudsman (IO).

Review of video revealed additional incidents of concern regarding inappropriate physical contact between staff and youth. OIG officers were on site within two hours of the initial report. The IO responded the following day.

On September 18, 2013, the TJJD Administrative Investigations Division received notice from OIG regarding the allegations. AID opened multiple investigations and was on-site the same day the notice from the OIG was received.

ISSUES OF CONCERN	AGENCY RESPONSE
The activities viewed on the video occurred on two separate days, one in August and one in September. The video from August took place in the day area of dorm A. There were three staff and multiple youth visible on camera. One male staff would take youth one by one and pick them up slam them to the floor and lay on them, pinning them to the floor. The youth could be seen flailing his legs and arms. The staff would complete the "pinning" and then move on to another youth repeating the act. At no time did the other staff attempt to stop the act; they only watched. During the course of 15 minutes there were 6 youth who were slammed to the floor and pinned by the staff for an extended period of time. It was reported to the IO that two weeks prior to the IRC report the staff involved in the wrestling had been reprimanded by his supervisor for the behavior, but it appears to have continued. The second video, from September, shows two incidents where staff can be viewed entering a youth's room, closing the door behind them and then exiting a period of time after. Video from inside one of the youth's rooms shows the staff grabbing the youth and slamming him to the floor where the staff pins the youth and makes repeated punches to the youth's ribs. After a period of time the staff and youth get up. The staff exits the room and the youth can be seen holding his ribs. The camera inside the second youth's room could not be viewed due to the youth putting tissue over the camera. Before the staff entered that room he was seen giving the youth tissue. The youth in this	The agency has taken the immediate actions in response to the above incidents: The following personnel actions were taken as a result of the AID investigations: • The Dorm Supervisor over the Phoenix Unit was suspended without pay pending termination. • The JCO VI was suspended, placed on disciplinary probation and reassigned. • The two JCOs involved in inappropriate conduct with youth were suspended without pay and terminated. • Three JCO who failed to report the incident were placed on disciplinary probation and reassigned. Clear lines of responsibility have been established and formal oversight of the Phoenix Program has been placed under the Assistant Superintendent. Approximately 40 Phoenix staff were trained on the following policies: • PRS .02.09 Conditions of Employment: Staff Youth Relationship • GAP .07.03 Internal Reporting: Incident Reporting • GAP.380.9723 Security and Control: Use of

incident was interviewed by the IO at which time the youth reported that the staff entered his room with the intent of engaging the youth in a fist fight. There was no "horseplay" involved in this situation. The staff member and the youth reportedly exchanged multiple punches and both parties suffered injuries to their faces before the supervising JCO entered the room and broke up the fight. The youth suffered a bloody nose and a black eye, and the staff member suffered a cut over his left eye. Youth and staff interviews conducted during the site visit indicate the practice of wrestling with youth on the Phoenix dorm was common on the second shift. Youth commented that they like the behavior and this is just the staff "being friendly with them." The youth stated that the practice was for the staff and youth to trade punches in the ribs until one or the other gave up. Some youth claimed they did not want to participate but felt they would be made fun of if they refused. The practice could be tracked back to at least May of 2013 with an incident involving a youth who complained to the IO that the staff had become angry with him after exchanging punches to the ribs, and the situation escalated from recreational to a fist fight inside the youth's room. The youth claims that the staff filed a 225 (youth incident report) on the youth after the fight in an attempt to get the youth in trouble. The youth reported the case was dismissed. The IO obtained a copy of the 225 which indicates the youth threatened the JCO and told him that he wanted to "catch a cell" to beat him. According to the 225, the youth did not receive a Level III or Level II hearing for the incident. "Catch a cell" is a term used to indicate a fight in a youth's room per the youth.	Force A DVR monitoring schedule was implemented on 9/25/13 to ensure routine monitoring of the Phoenix Unit. The Mart Superintendent, Assistant Superintendent and Phoenix Dorm Supervisor are also responsible for DVR monitoring. A comprehensive corrective action plan has been developed and is being implemented The TJJD OIG concluded its criminal investigation into the allegations on 9/30/13 and presented the facts in the case to the Special Prosecutions Unit Chief Juvenile Prosecutor and SPU Executive Director on 10/15/13. The SPU presented the case to a McLennan County Grand Jury on 10/23/13 and the grand jury "no billed" the charges
The Phoenix program was developed and implemented by the TJJD Director of Facility Operations and the Director of Rehabilitation Services, both administrative staff out of Central Office. It was originally created as a result of extremely aggressive and assaultive youth operating in the Giddings facility. According to the Phoenix Program manual for operations released at the onset of the program, July 25, 2012, Phoenix was designed to be a more structured self-contained behavior treatment program for the most assaultive youth at TJJD. The staff for the program were to be seasoned staff who had experience dealing with assaultive youth and who had demonstrated proficiency at working with this particular culture. These staff were to receive additional hours of training for dealing with assaultive behavior and the specific program to be administered in Phoenix.	The Phoenix Program does operate as a self-contained behavior treatment program and houses many of the most aggressive and assaultive youth assigned to the agency. The program was developed by the agency primarily under the leadership of the former Director of Facility Operations and Director of Rehabilitation Services but in concert with treatment, education and correctional staff at the Mart Unit as well as from Central Office. Staff design included seasoned staff with experience dealing with assaultive youth but in light of staffing configurations and personnel-related issues there will occasionally be staff assigned to the Phoenix Unit who may be newer to the agency. Regardless of tenure, all Phoenix staff are trained in motivational interviewing, skill building, and non-suicidal self-injury, among others.

The day to day operations of the program were overseen by the TJJD's Director of Facility Operations, who had an office outside the Mart facility, from the program's start date in July of 2012 until the time of his retirement in November of 2012. Interviews with staff at Mart indicate that the current Superintendent is a more frequent presence on the Phoenix dorm, but no Phoenix specific training was provided regarding the design and operation of the program. On the Job Training (OJT) records for the Mart Superintendent were provided to the IO as part of this inquiry. The curriculum for superintendent OJT does not contain any training related to the Phoenix program other than the process to refer a youth to the program, and this portion of the OJT has not been completed with the current Superintendent.	TJJD agrees that changes in leadership over the program had created a lack of focus and requires corrective action. Prior to the current administration there was no written plan for OJT training for any position other than Juvenile Correctional Officers. The Director of Secure Operations developed a comprehensive OJT plan for Superintendents and Assistant Superintendents. As a result of this incident, the Director of Secure Operations along with the Director of Integrated State Operated Programs have set training dates at Phoenix to review the original program design, policy and other relevant training with program staff. The first training is scheduled for November 2013.
The JCO VI in the Phoenix Program was described in interviews as being an effective supervisor. However, concerns were expressed that he was never scheduled to work any shifts other than first shift and was rarely in the Phoenix Unit to provide direction past 2 or 3 o'clock in the afternoon. This is concerning as the most vulnerable times for situations to occur in these types of settings are after normal business hours. The person the Superintendent most heavily relied on for his expertise was the Dorm Supervisor in charge of the day to day operations of the Phoenix program. The Dorm Supervisor was described as being "very non-confrontational" with his staff and not good at holding people accountable for their actions.	The Senior Director of State Programs and Facilities has directed the Phoenix Dorm Supervisor to work the 2-to-10 p.m. shift on an intermittent basis along with the normal day shift schedule. Additionally, the JCO V shift supervisor or JCO VI will be present on every evening shift. TJJD leadership was aware of performance issues with the Dorm Supervisor and, beginning in May 2013, began progressive discipline to improve his performance. When this incident occurred, the Dorm Supervisor was suspended without pay pending termination.
A review of records and interviews with agency staff indicates that staff from Central Office and the Mart facility worked in collaboration to provide a five to six day training block in June of 2012 to the staff specially selected to work in the Phoenix program. This training was specific to the program and covered teambuilding, tactical response and post orders, reviews of the Anger Control Cycle, Mental Health 101, and teaching Social Skills. Phoenix staff also received training in communication and de-escalation skills, Phoenix specific paperwork, conducting Check-in Groups and processing thinking reports. The Phoenix supervisory staff also received Motivational Interviewing training and additional skills trainings prior to the program beginning operations. Agendas provided to the IO show follow up training on Motivational Interviewing, a 2nd round of program training, and an on-site coaching were scheduled in one day sessions in July and August of 2012. An additional training agenda was provided for a 3 day block training that was held for new Phoenix staff in October of 2012. This training also appears to have been a collaborative effort as the training was delivered by personnel from Central Office and the Mart facility. This appears to be the last documented formal training for Phoenix staff even though there are very few of the original staff still	Training records of the 37 staff assigned to the Phoenix Program were reviewed in response to this report. Four of the 37 staff had less than one year's experience in their position. The most tenured staff had 17 years' experience with 25 of the staff (73 percent) having more than three years' experience. The average tenure of staff assigned to Phoenix is 5.7 years. The following training was conducted with Phoenix staff in 2013: • January 9, 2013 – The Director of State Integrated State Operated Programs met with Phoenix staff to review findings of Internal Audit dated December 2012, review policy, case management standards and audit findings. Additionally, the CCF-410 on youth behavior to be specific to Phoenix was revised. • March 2013 – All Phoenix staff received training on the administration of OC spray. • July 29, 2013 – Director of State Integrated State Operated Programs met with Phoenix staff at Mart to review new case

assigned to the program. It appears that any significant new hire training or on-going skills development training has not continued. This is concerning as many of the current JCO staff are new hires with limited experience in corrections let alone experience dealing with assaultive youth. TJJD management has acknowledged the lack of training provided to the staff working in this specialized program. A September 30, 2013, email was circulated by the Director of Secure Facility Operations to the Mart facility administration acknowledging the training deficiencies and requesting that an 8 hour block training be scheduled for the Phoenix staff.	management standards to be effective 8/1/13.
Several action plans were put together detailing strategies and action steps for the development of curriculum for the initial required block of staff training for the Phoenix Program. According to the project description the training would be designed to equip staff affiliated with the Phoenix Program with the tools, methodologies and techniques to successfully perform their job duties. The most recent action plan obtained by the IO is a detailed 49 step plan that was started in July of 2012 and was projected to be completed in February of 2013 with the result being a 24 hour, or 3 day curriculum that the TJJD Training Academy would have available to be delivered as needed to new staff working in the Phoenix Program. Work on this project appears to have stopped in October or November of 2012.	TJJD agrees that various personnel changes have affected staff training efforts at the Phoenix Unit. The agency has instructed the training department to bring the modules to completion and implement the training on a routine schedule in the immediate future.
The Phoenix Program Manual describes the program oversight and evaluation measures in detail. One of the oversight and evaluation methods described in the manual is a periodic assessment of the program implementation by the Director of Facility Operations. To the IO's knowledge this has not been done. The manual also states that the division responsible for quality and risk management will conduct an annual formal review of the program. The Monitoring and Inspections Department conducted a comprehensive review of the Phoenix Program April 15-17, 2013 and identified a number of deficiencies relating to policy (CMS.03.75) which outlines programming for the youth in this program. TJJD disputed a majority of these finding even though they contradict policy and offered limited action plans for correcting undisputed claims that do not address the actual problem. The manual also describes a series of outcome measures to evaluate the overall success of the Phoenix Program. Interviews conducted by the IO revealed that the process to gather this data has not begun.	Since December 1, 2012, the Director of State Operations has been on site at the Phoenix Program on the following dates: • January 28, 2013 – Mart/Phoenix monitoring visit • February 12, 2013 –Mart/Phoenix monitoring visit • March 25, 2013 – Mart/Phoenix monitoring visit • May 14, 2013 – Mart/Phoenix monitoring visit • May 30, 2013 – Phoenix visit with Mart Superintendent, just after being assigned as Interim Superintendent • June 6, 2013 – meeting on site with Mart Superintendent and Phoenix staff regarding findings and planned response to Comprehensive Audit of Phoenix by the Internal Audit Department • June 10 – 11, 2013 – Onsite at Mart with Director of Integrated State Operated Programs for Redirect training. Monitored Phoenix while on site. • July 8, 2013 – Mart Site Visit and Phoenix

	review • July 29, 2013 – Mart site visit and Phoenix review • September 10, 2013 – Mart/Phoenix Site visit, disciplinary letters issued • September 23-25, 2013 – Mart/Phoenix site visit, corrective action planning Additional action in FY 13 prior to this incident: • January 24, 2013 – Letter of concern and Performance Improvement Plan issued from Director of State Operations to former Mart Superintendent outlining expectations for improved facility operations which included issues on the Phoenix Unit. • January 30, 2013 – Former Superintendent met with Dorm Supervisor and JCO VI on Phoenix to review and train policy on Use of OC spray at the direction of Director of State Operations. Senior Director of State Programs and Facilities visited Mart and the Phoenix unit on the following dates: • December 20 -21, 2012 • January 9 -11, 2013 • May 9 -10, 2013 • July 12, 2013 • August 5, 2013 • September 26-27, 2013 TJJD agrees there were discrepancies as identified in the Monitoring and Inspection report. Once the report was finalized, corrective action was taken. A follow-up review was conducted by the Monitoring and Inspection Division in May 2013 this review reflected positively on the Phoenix Program showing improvements in documentation on the unit.
A review of Correctional Care System records indicates that the youth in the Phoenix Program may not be provided the level of services required by policy or outlined in the program manual. A sample of records for youth in the Phoenix Program on October 7, 2013 was selected for review through CCS. The youth selected had all been at Phoenix for at least 60 days. Policy (CMS.03.75) dictates that the Phoenix case manager make daily contact with each youth in the program and this contact should be summarized at	Based on earlier reports that identified ongoing issues, the agency has made and continues to make changes to the case management system at the Phoenix Program. Responsibility for the Phoenix case management system has been reassigned to the Director of Integrated State Operated Programs and Services. Additionally, the Performance and Accountability Specialist for Case Management from the State Programs and Facilities Division will conduct bi-monthly reviews of case management

least weekly on an automated chronological record, the CCF-520. The Phoenix case manager is also required to provide at least 30 minutes of individual counseling per week and conduct a daily Skills Development Group. CMS.03.75 calls for the Phoenix case manager to conduct the skills development groups in accordance with the daily schedule while the TJJD Phoenix Program Manual states that the youth attend groups facilitated by case managers five days per week. The following deficiencies were not in accordance with Case Management Standards: • The CCF 119 Group Log Summary shows that from July 1, 2013 through September 30, 2013 a total of 16 case manager led groups have been entered into the system. For a 3 month period this equals just over 1 group per week. Policy calls for groups to be conducted by the case managers 5 days per week. • Youth #1224311 has no chronological entries in the Correctional Care System since August 2, 2013. • Youth #1213404 has no chronological entries from August 2, 2013-September 3, 2013 or from September 9-30, 2013. • Youth #1223290 has no case manager chronological entries since August 15, 2013. • Youth #1205675 has had 2 case manager chronological entries from August 2, 2013 to date. This review indicates that either there has been a significant decrease in the frequency of services provided to the youth in the Phoenix Program compared to what is written in TJJD policy or multiple examples of services not being documented. The TJJD Internal Audit Department issued a report detailing an audit of the Phoenix Program in November of 2012. This report includes several findings that are worth noting as they appear to be part of a trend: • Individual counseling to the youth was not consistently provided. • Skill development and behavior groups were not consistently supported. The Internal Audit report goes on to state that oversight reviews could ensure better compliance with Phoenix programming. One of the official recommendations in the report states the following: • To assure compliance with the Phoenix Program, the Facility Superintendent should ensure oversight outlined in CMS 03.75 be completed to identify concerns and that proper	records at Phoenix to evaluate compliance with case management standards. The Behavioral Treatment Specialist from the State Programs and Facilities Division will conduct bi-monthly reviews of the Phoenix program to evaluate the behavior management program fidelity to the program design. Both staff will provide technical assistance, training, coaching and mentoring when appropriate

actions are taken to address them. TJJD management concurred with this finding and responded that their plan of action was implemented as of October 30, 2012. The plan of action detailed that the Facility Superintendent met with his management team to review CMS 03.75 to clarify roles, responsibilities and expectations. Documentation of service provision of program components-including behavior and skills group, individual counseling, mental status evaluations, program visits-was emphasized with the responsible staff. A review of the last seven IO reports of the Mart facility was conducted to specifically identify trends in the Phoenix portion of the report. In three of the seven reports, unstructured time for the youth was identified as a concern by the reporting Ombudsman. Structure was one of the many elements specified in the original design to provide continuous activity to maintain control of the culture and to educate youth on ways to control their behavior. Conclusion:	
Conclusion: The Phoenix program has detoured from its original design as a structured self- contained behavior treatment program. It is now a separate housing unit for difficult youth, providing little or no specialized programming. Many of the personnel specially selected for their knowledge, experience and training have been replaced with newly hired staff lacking training, knowledge and experience. Program oversight is minimal. Outcome measures, mentioned in the Phoenix Program Manual, have not been completed. If they had been, the data would be inaccurate due to a lack of program implementation. TJJD's failure to maintain and supervise this program has resulted in behaviors like the ones that instigated this review. It is noted that TJJD has been responsive and has begun addressing many of the issues identified by the IO during the course of this investigation.	TJJD agrees that the quality of programming and delivery of all services in the Phoenix Program merit close attention. A corrective action plan has been put into place and increased monitoring will occur. Documentation reflects that corrective action was taking place prior to the incident that resulted in this special report. Since its inception, 43 youth have completed the Phoenix Program with average stays of 104 days. Fourteen of the 43 youth have had no assaults following program completion, and 34 of the 43 have seen a significant reduction in the number of incidents following completion. Eleven (11) youth assigned to the Phoenix program in FY 13 have completed their GED while they were assigned to the Phoenix unit with one scoring a perfect score on the Math Section. Additionally, in the past year, the agency has improved outcomes specifically in the area of workers compensation related to youth aggression, something the Phoenix unit was designed (at least in part) to help address. The agency has experienced in FY 13 the lowest workman's compensation rates in its history and has reduced overall workman's compensation claims by up to 30% overall. The most recent report reflects again a continuing downward trend in

	injuries due to youth aggression. Costs and rates have decreased by 28% and 30% respectively, while the entire employee population has reduced by only 2% in the same time frame.
Recommendations: It is the opinion of the IO that TJJD should follow through and completely implement the Phoenix Program as described in July 2012. Staff must be properly trained from the beginning and receive regular periodic training while working in the Phoenix Program. It is recommended that outcome measures be defined and regularly checked. Issues and recommendations by oversight entities such as the IO, Internal Audits, and Monitoring and Inspections should be reviewed with action plans submitted for improvement.	The agency agrees with the IO's recommendations and has already taken steps to ensure staff is properly trained and a comprehensive training is being developed for all new Phoenix staff. The agency has been developing a method of performance tracking for each state facility. The Phoenix Program will have its own section in this performance report. The agency will continue to respond, as appropriate, to all IO, Internal audit and monitoring reports with corrective action plans. The Monitoring and Inspections Division will conduct both announced and unannounced on-site monitoring to ensure program compliance and progress

Accounting of Site Visits, Youth Contact and Individual Cases

	FY 2013	1st Quarter FY14	FY14 Total
Site Visits	236	52	52
Number of Youth Interviewed	1410	587	587
Number of Youth Interviews Conducted	2915	768	768
Closed Cases	256	60	60

Facilities visited by IO staff during the first quarter

Secure Facilities

Corsicana Residential Treatment Center (*Corsicana TX)*
Evins Regional Juvenile Center (*Edinburg TX)*
Gainesville State School (*Gainesville TX)*
Giddings State School (*Giddings TX)*
McLennan County State Juvenile Correctional Facility (Mart TX)
Ron Jackson State Juvenile Correctional Complex (*Brownwood TX)*

TJJD Halfway Houses

Ayres House-*San Antonio TX*
Brownwood Halfway House-*Brownwood TX*
Cottrell House-*Dallas TX*
Edna Tamayo House-*Harlingen TX*
McFadden Ranch-*Roanoke TX*
Schaeffer House-*El Paso TX*
Willoughby House-*Fort Worth TX*
York House-*Corpus Christi TX*

TJJD District Offices

Austin District Office
Dallas District Office
Fort Worth District Office
Houston District Office
San Antonio District Office

Parole Areas (Parole officers not working out of a district office)

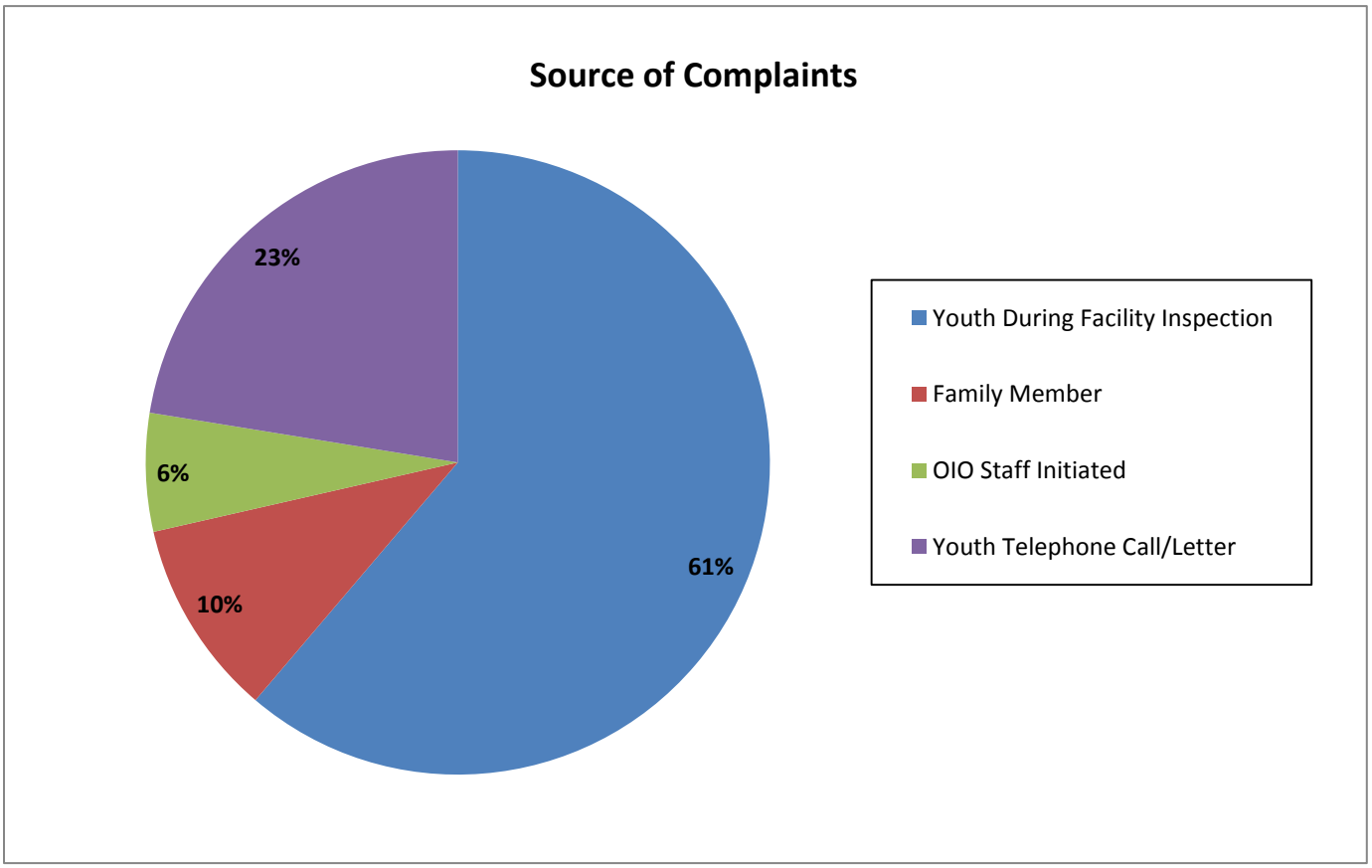
Amarillo Area Parole
Bell County Area Parole
Harlingen Area Parole
Lubbock Area Parole
Midland Area Parole
Tyler Area Parole

Contract Care Facilities

Amikids, dba Rio Grande Valley-*Los Fresnos TX*
Byrds Therapeutic Group Home-*Houston TX*
G4S Youth Services, LLC-*Brownwood*
Garza County Regional Juvenile Center-*Post TX*
Gulf Coast Trades Center-*New Waverly TX*
National Mentor Healthcare LLC, East Intermediate-*Houston TX*
Specialized Alternatives for Youth (SAFY)-Arlington TX
Terrell State Hospital
Unity Children's Home-*Houston TX (two locations)*

Anyone may file a complaint with the IO. Complaints can be made via telephone, mail, fax, email, or in person during a facility inspection. The IO received 49 complaints during the first quarter. The majority of these cases were received directly from the youth during facility inspections.

First Quarter-FY 14



Complaints Received by Facility-First Quarter FY 14*

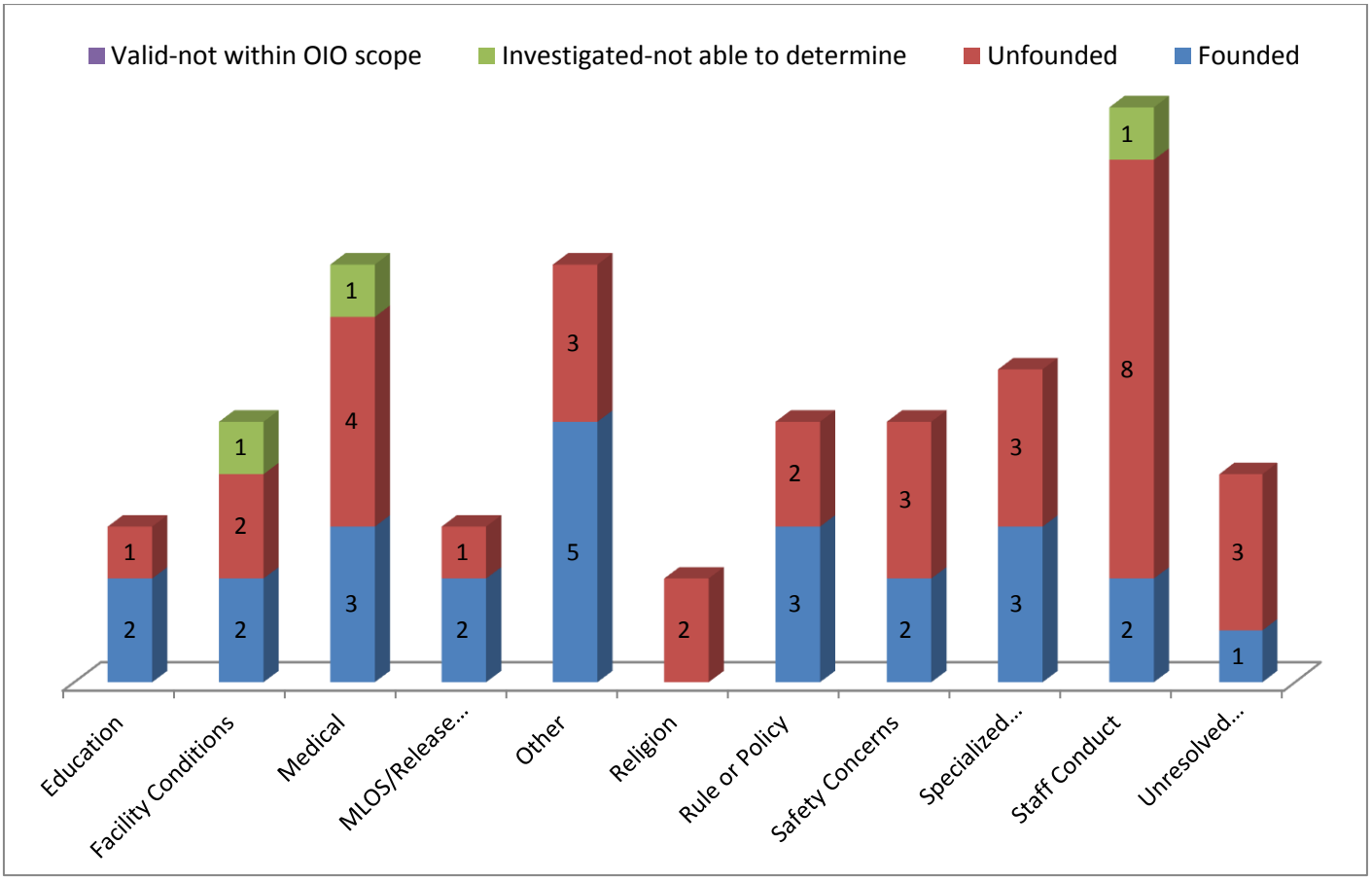
Facility	Total for Facility	Conextions	Education	Facility Conditions	Medical	MLOS Release Date	Other	Parole	Religion	Rule or Policy	Safety Concerns	Specialized Treatment	Staff Conduct	Unresolved Grievances
AYRES HOUSE	1										1			
CORSICANA RTC	1					1								
EVINS RJC	18		1	1	2	1					1	2	3	4	3
GAINESVILLE STATE SCHOOL	6			1			2		2			1			
GIDDINGS STATE SCHOOL	9		1	1	1		1					1	1	3	
GULF COAST TRADES CENTER	1														1
MCLENNAN COUNTY SJCF	5				1	1	2							1	
HARLINGEN PAROLE	1													1	
RON JACKSON SJCC	3			1	2										
SCHAEFFER HOUSE	2					1									1
YORK HOUSE	2				1		1								

* Facilities without complaints are not listed

The IO closed 60 cases in the first quarter of fiscal year 2014. Cases are closed in one of four ways: Founded, Unfounded, Investigated-unable to determine, and Valid-not within IO scope.

Closed Cases

First Quarter FY 14

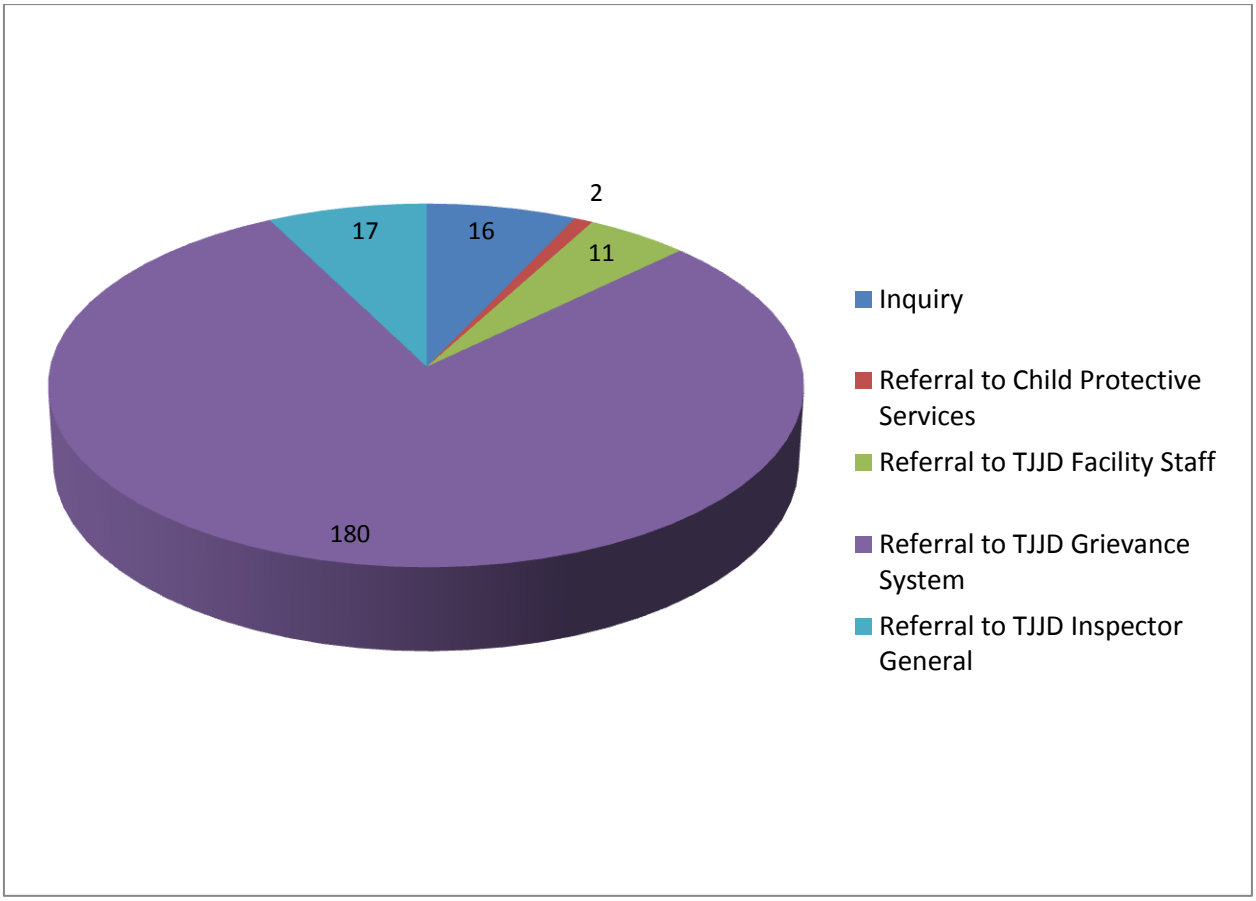


** Note: The Independent Ombudsman generally does not make findings regarding the quality or appropriateness of the care delivered. Unless otherwise noted, the medical cases in this report involve only issues of access to health care services.*

In addition to the cases that are investigated by IO staff, the office also receives numerous inquiries and complaints that are referred to the appropriate authority. The IO received 226 inquiries and referrals during the first quarter of fiscal year 2014.

Inquiries and Referrals

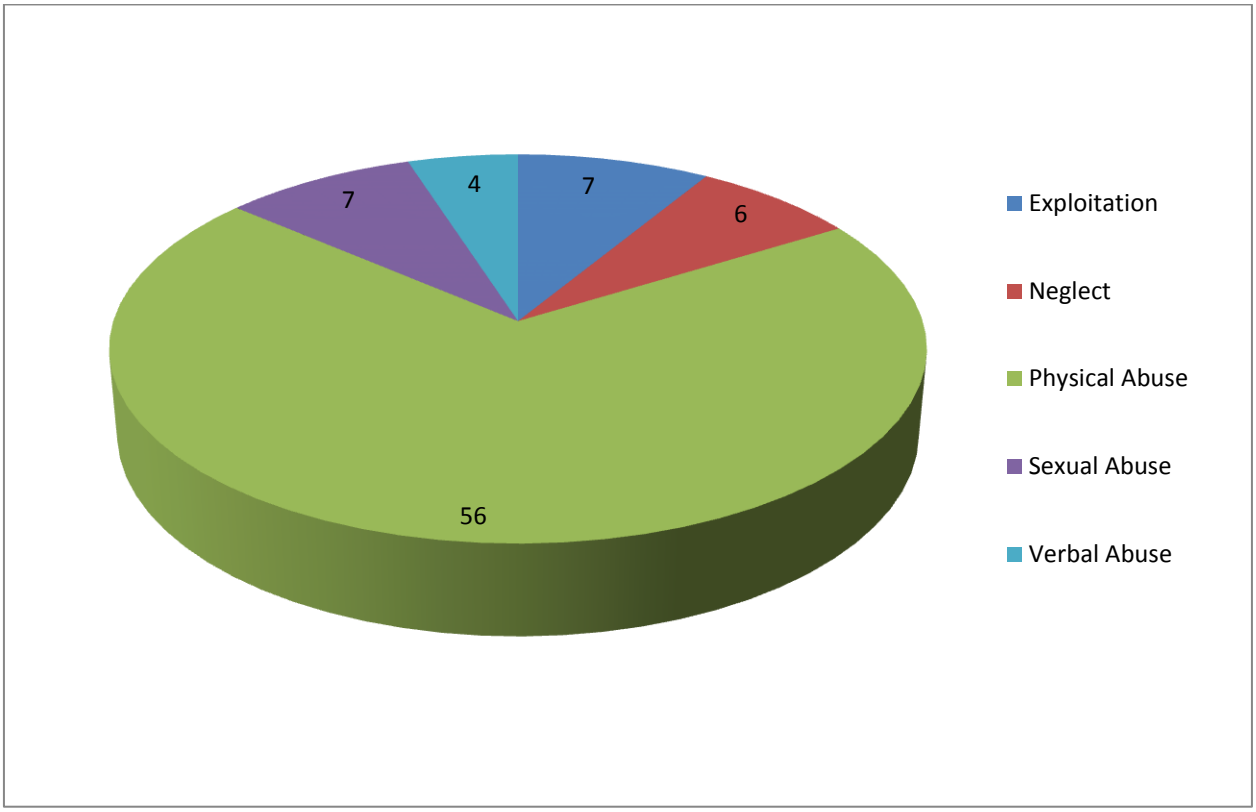
First Quarter FY14



The IO reviewed 80 ANE reports in the first quarter of fiscal year 2014.

Reports of Abuse, Neglect and Exploitation from County Operated Facilities*

First Quarter FY 14



*These reports are reviewed by the IO, but there is no investigation or determination of findings made by the office. The IO tracks these incidents for indications of systemic issues and trends.