Office of the
Milwaukee
Ombudsman
for Child Welfare

April 2009

To the Milwaukee County Community:

I am pleased to submit the 2008 Annual Report of the Office of the Milwaukee Ombudsman for Child Welfare. This report is intended to complement other quality assurance and evaluation information to assess the delivery of child welfare services in Milwaukee County.

2008 has seen a number of changes in leadership for the State of Wisconsin and Milwaukee as it pertains to children and families. On July 1, 2008, the new Department of Children and Families (DCF) began its operation under the leadership of Secretary Reggie Bicha. In December 2008, the Director of the Bureau of Milwaukee Child Welfare (Bureau), Denise Revels Robinson, submitted her resignation effective January 2009. These changes in leadership bring both opportunities and challenges as we move forward into 2009.

This report provides an overview of the activities of the Ombudsman Office for 2008 and our recommendations for systemic improvements based on three years of data analysis. The data suggests that the primary area for improvement is in the lack of quality supervision of front line staff. Also, for the third year in a row, the Ombudsman Office has identified documentation as needing additional attention. Clear measurable goals and improved communication are two further areas highlighted.

The Ombudsman Office appreciates the cooperation of the Bureau and its contracted private agency partners in our efforts to provide complainants with an independent and impartial review of their concerns. We look forward to continuing our work on behalf of the children and families of Milwaukee County.

Sincerely,

Pamela B. Matthews
Ombudsman Director

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Acknowledgements

We would like to thank the following individuals for their support and the ongoing success of the Office of the Milwaukee Ombudsman for Child Welfare (Ombudsman Office):

Governor Jim Doyle for his leadership and commitment to the children and families of Wisconsin;

Secretary Reggie Bicha, State of Wisconsin Secretary of the Department of Children and Families, for his steadfast dedication to responsible oversight of issues affecting Wisconsin families and their children and for his leadership and investment in caring for this critical population;

Cyrus Behroozi, Administrator, Division of Safety and Permanence, Wisconsin Department of Children and Families, for his long-standing efforts on behalf of Milwaukee County's abused children;

Dianne Jenkins, Office of Performance and Quality Assurance, Wisconsin Department of Children and Families, and Contract Administrator for the Ombudsman Office, for her support and dedication to the success of the Ombudsman Office;

The Board of Directors of the Planning Council for Health and Human Services, Inc. for their continuing commitment to the Ombudsman Office;

The Partnership Council members for their feedback on the work of the Ombudsman Office which has helped the Ombudsman Office to become more transparent; and

The staff of the Ombudsman Office and Planning Council for Health and Human Services, Inc., for their assistance so that those who contacted the Ombudsman Office were ably served in a timely, efficient, and professional manner.

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Executive Summary

The 2008 Annual Report is the fourth report on the yearly activities of the Office of the Milwaukee Ombudsman for Child Welfare (Ombudsman Office). This information is intended to complement other quality assurance and evaluation information to assess the delivery of child welfare services in Milwaukee County. The information in this report is not intended to make evaluative statements about the Bureau of Milwaukee Child Welfare (Bureau) services as a whole. Following are some highlights of the 2008 report.

Role of the Ombudsman

The Ombudsman Office is a neutral, independent office that reviews case-specific concerns regarding the safety, permanence, and well-being of children and families involved with the Bureau. The Ombudsman Office also provides education, information, and referrals to individuals contacting the office.

Key Areas for Improvement and Recommendations

The Ombudsman Office has identified four key areas from its observations of the complaints received and/or reviewed since it opened in June 2005 that need additional attention. The Ombudsman Office believes that the Bureau can increase both the safety of children and improve case management for families for each of these areas:

- Lack of Quality Supervision
- Lack of Accurate Documentation
- Lack of Clear Measurable Goals
- Lack of Adequate Communication

The Ombudsman Office makes six recommendations to assist in improving these areas and proposes that the Bureau:

1. Explore new policies and training methods for supervisors that emphasize the critical role a supervisor has in the development of skills in their staff and the supervisor's role as it relates to ensuring that the transfer of learning is occurring with new staff members;
2. Investigate methods that would ensure that supervisor oversight occurs with staff and that it results in good child welfare practice by their staff;
3. Review the methods by which its supervisors monitor documentation in the case record to ensure its thoroughness and accuracy, as previously recommended by the Ombudsman Office in 2007;
4. Scrutinize and develop methods to ensure that a supervisor's review of goals include ensuring that they match the parent's documented diminished protective capacities and that they incorporate behavioral, cognitive, or emotional changes that are clear and measurable;
5. Incorporate the need for adequate communication among program areas, with families, and with service providers into existing training to ensure that staff have and utilize necessary skills; and
6. Develop a form that would provide parents with written information from the case plan and/or case progress evaluation about needed changes in the parent's behavior, cognitive or emotional states that addresses the parent's diminished protective capacities for reunification.

Contacts for Services

Throughout 2008, the Ombudsman Office responded to a total of 242 new contacts for services. Contacts to the Ombudsman Office are classified as either a complaint or for information and referral. Complaints were up 50% compared to 2007 and contacts for information and referrals were up 200% from 2007.

There were 164 complaints received by the Ombudsman Office during 2008 covering a total of 447 issues. Twenty-seven complaints were resubmissions[1] and 103 complaints (62%) were referred to the Bureau's complaint resolution process (CRP), the internal review method the Bureau uses for resolving complaints. In seven complaints all issues were found to be outside the scope of Ombudsman Office after initial review.

Reviews: Findings and Recommendations

In 2008, the Ombudsman Office carried over four reviews from 2007 and screened in and began reviews of 31 separate complaints containing a total of 84 complaint issues. Of these, 25 reviews were completed in 2008 covering 64 complaint issues. The Ombudsman Office affirmed the actions of the Bureau 56 times, found two violations, six concerns, and 16 additional findings.

The Ombudsman Office made 38 recommendations from the 25 reviews that were completed in 2008; 29 were systemic in nature and nine were case-specific. Of the 29 systemic recommendations made, approximately one-half (15) involved reviewing existing standards, policies, or practices; just over one-third (11) related to areas lacking clarity in existing policies or practices; and the remaining addressed training (3).

Looking Forward to 2009

The Ombudsman Office looks forward to continuing our efforts to support children and families served by the Bureau of Milwaukee Child Welfare. The Ombudsman Office in 2009 will focus on:

- Cooperating with the State Department of Children and Families in their evaluation of the work of the Ombudsman Office;
- Working with the Bureau to improve the tracking of Ombudsman Office recommendations that the Bureau has agreed with and reporting progress made by the Bureau on a quarterly basis to the Partnership Council;
- Expanding on the quality of information conveyed in our finding letter to the complainant, particularly when the actions of the Bureau are affirmed;
- Exploring how the Ombudsman Office can be useful to the review process that takes place if a child dies in the care or custody of the Bureau;
- Assessing the efforts of the Ombudsman Office through the use of survey instruments in order to improve service to complainants and to target outreach efforts; and
- Receiving feedback on the content and structure of the Annual Report to ensure that stakeholder's expectations are being met.

[1] Complainants who had previously contacted the Ombudsman Office but were originally referred to the Bureau's Complaint Resolution Process.

2008 Annual Report

Introduction

The 2008 Office of the Milwaukee Ombudsman for Child Welfare (Ombudsman Office) Annual Report is the fourth annual report on the activities of the Ombudsman Office.

The Ombudsman Office was developed as part of Governor Jim Doyle's *KidsFirst* Policy Agenda, to strengthen the foster care and child welfare system in Milwaukee County. Oversight of the Ombudsman Office rests with the Secretary's Office of the Wisconsin Department of Children and Families (DCF). The Planning Council for Health and Human Services, Inc. was selected via a competitive bid process in 2004 to develop, implement, and manage an Ombudsman Office. The Ombudsman Office began accepting complaints on June 13, 2005.

In 2008, the Ombudsman Office responded to 242 new contacts resulting in 25 reviews being completed on 64 issues. This report examines the resolution of these contacts, as well as the four which carried over from 2007, and identifies key issues for further consideration.

What to Expect from this Report

The annual report produced by the Ombudsman Office contains information about the contacts for services that the Ombudsman Office has received in 2008. This includes overall observations and recommendations pertaining to key areas of practice, contacts for information and referrals, and complaints reviewed. The appendices provide additional detailed information on the work of the Ombudsman office including individual complaint reviews and their associated findings and recommendations. The information contained in this report is intended to complement other quality assurance and evaluation information collected by the DCF to assess the delivery of child welfare services in Milwaukee County. However, the Ombudsman Office cautions that the information in this report is not intended to make evaluative statements about the Bureau

of Milwaukee Child Welfare (Bureau) services, regardless of the number of reviews conducted. The report describes the concerns and experiences of a group of people who have self-selected to voluntarily register complaints about their interactions with the Bureau. The report does not claim or suggest that the information describing complaints and the findings related to those complaints are in any way representative of the experience of all of those who have had interactions with the Bureau or the service delivery system as a whole. At the same time, the Ombudsman Office believes that complaint-specific information can be useful in identifying areas for policy development, procedure refinement, and staff growth.

Background

Under contract with the DCF, Office of Performance and Quality Assurance, the Ombudsman Office is a neutral, independent office that reviews case-specific concerns regarding the safety, permanence, and well-being of children and families involved with the Bureau. The Ombudsman Office responds to citizen concerns regarding specific action or inaction of the Bureau to learn whether or not the Bureau followed policy, procedure, law, and practice standards in its decision-making. The Ombudsman Office also provides education, information, and referrals to individuals contacting the office.

The Ombudsman Office has the authority to accept and review complaints concerning actions or inactions of the Bureau or any of its partner agencies, when the partner agency is carrying out any public child welfare function performed under contract with the Bureau and within the scope of the Ombudsman Office. Child welfare services outside of the scope of the Ombudsman Office include 1) matters determined by a court of law, 2) issues related to foster and adoptive home licensing, 3) payment for foster care, or 4) issues related to non-court-ordered Kinship Care.

The function of the Ombudsman Office is to:

- Promote public confidence and integrity in the child welfare system in Milwaukee County through objective, thorough, and timely review of case-specific complaints;
- Respond to child protective services concerns and questions from citizens related to action or inaction of the Bureau;
- Provide independent reviews of case-specific concerns to assure that policies, procedures, laws, and practice standards are being followed appropriately and make recommendations for Bureau action as appropriate;
- Affirm correct actions of the Bureau when applicable;
- Make recommendations related to systemic issues that emerge as a result of reviews; and
- Regularly provide information on the Ombudsman Office’s activities in the community.

In keeping with the fundamental design and principles of a classical ombudsman program, the Ombudsman Office does not:

- Provide legal representation or bring legal action;
- Assign fault or blame to individuals;
- Have authority to impose its recommendations;
- Become involved in aspects of a case that is the province of the courts; or
- Share confidential information with anyone who is not authorized to have such access by statute, subpoena, or as is interpreted on a case-by-case basis under Wisconsin's Open Records Law.

Ombudsman Office recommendations are not binding on the Bureau, but are advisory in nature and directed at improving administrative process and service delivery. The Bureau may decide whether or not to take action on any recommendation it receives. If the Bureau disagrees with the review findings and/or the recommendations, either the Bureau or the Ombudsman Office may choose to advance the findings to the Secretary of the DCF for resolution.

Through fact-finding on case-specific issues, the Ombudsman Office monitors system performance and promotes policies, procedures, laws, and practices that improve the safety, permanence, and well-being of children in the care and custody of the Bureau. These issues are communicated to the Bureau as concerns and recommendations regardless of whether a violation is found.

Classical Ombudsman Model

The Ombudsman:

- Provides an independent and impartial format to review complaints;
- Examines laws and the facts of a complaint without having prejudged who is right and without taking one side or another;
- Makes findings about the complaint based on the facts and law and conclusions drawn on an analysis of them;
- Makes recommendations to an agency to remedy the situation where the Ombudsman determines a complaint is justified;
- Is not an advocate for any individual or group; and
- May advocate for recommendations, which in turn may benefit a complainant or improve the administration of government.

Staff

The 2008 Ombudsman staff consisted of the Ombudsman Director, an Associate Ombudsman, and a .5 FTE Administrative Assistant/Intake Coordinator. Consultation from an attorney is available for legal matters. The Ombudsman Office experienced turnover in 2008 that resulted in the Ombudsman position being staffed by an interim director from June 2008 through August 2008. See Appendix 1 for biographical details on the 2008 Ombudsman staff.

Outreach

The Ombudsman Office's outreach efforts in 2008 continued the focus of informing individuals and organizations who work with families involved in the Bureau. The Ombudsman Office also expanded its efforts to include professions that are not traditional child welfare agencies, but who may come into contact with families engaged with the Bureau. The Ombudsman Director and staff:

- Made 20 community presentations to approximately 258 attendees;
- Gave six presentations to approximately 149 new Bureau staff;
- Participated in two resource fairs throughout the year; and
- Explained the function and purpose of the Ombudsman Office to 12 Wisconsin State Legislators (or legislative staff).

See Appendix 2 for a complete list of outreach efforts.

The Ombudsman Office Process: An Overview

All contacts with the Ombudsman Office are categorized as either complaints, or information requests and referrals. Information requests and referrals may include an individual asking for information about Ombudsman Office services or a request for services that are outside the scope of the Ombudsman Office.

Contacts that are determined to be complaints go through a screening process to determine if the issues complained about meet the criteria for the Ombudsman Office to review and to determine if the Bureau Complaint Resolution Process (CRP) has been utilized. The Ombudsman Office encourages individuals to follow the Bureau CRP; however, exceptions may occur.

The Ombudsman Office's target for completing the screening process and determining if the Bureau CRP has been followed is 14 calendar days from the date of initial contacts. For 99% of contacts in 2008, this process was completed within the established timeline. (See Appendix 3-"Process Overview" and Appendix 4-"Processing Guidelines" which illustrate the work flow of the Ombudsman Office.)

The Ombudsman Office communicates the decision as to whether or not a review will be conducted with the complainant. If a review will be conducted, the Ombudsman Office will communicate the status of the review with the complainant approximately every 30 days throughout the review process.

Bureau Complaint Resolution Process (CRP)

- Contact your assigned program staff member, tell him/her about the problem you are having. If the problem is not resolved to your satisfaction, ask that the complaint be sent to the supervisor;
- If the program staff person has had an opportunity to resolve the complaint and you are still not satisfied, the complaint becomes a dispute. The supervisor will contact you within 48 hours and will help resolve the dispute;
- If the supervisor cannot resolve the dispute, he/she will take it to upper levels of administration until you are satisfied with the resolution;
- If the Bureau cannot resolve the dispute, you may contact the Milwaukee Ombudsman for Child Welfare at (414) 224-1347 who may be able to help.

Upon completion of the review, the Ombudsman Office communicates the findings and any recommendations to the Bureau and requests a response. After receipt of the Bureau's response to its findings, correspondence is sent to the complainant regarding the Ombudsman Office review, review findings, recommendations (if any), and the Bureau's response.

Areas for Improvement and Recommendation

This section focuses on key areas identified as a result of Ombudsman Office's observations and its recommendations to assist with improving them. The four areas identified for improvement include significant issues that are interrelated and highlight the inter-dependency each has on the other for successful child welfare outcomes. The areas identified for improvement are primarily the result of specific reviews and from the overview of all contacts made with the Ombudsman Office in 2008. However, the Ombudsman Office also considered contacts and reviews from prior years.

The following areas are those that the Ombudsman Office has identified as being particularly relevant to the public's interest and critical to continued improvement within Milwaukee's child welfare system:

1. **Lack of Quality Supervision**

   The data analysis suggests that the primary area for improvement is a lack of quality supervision of front line staff. Supervisors are responsible for ensuring that their staff is appropriately managing their work according to relevant policies, procedures, and state statutes in order to keep children safe. Constructive feedback from supervisors is necessary for new staff to learn good child welfare practice and for all staff to continue developing their skills. The lack of quality supervision can put the safety of children at risk.

   Bureau policy requires supervisors to review and sign off on certain documents (i.e., case plans, case progress evaluations, permanency plans) prepared by staff under their supervision. However, these documents often lack clarity, do not accurately represent the current conditions of the family, or lack professional standards of performance.

   In a review of one specific case, the majority of a year's Case Progress Evaluations (CPE) were repeatedly approved by the supervisor even though they did not contain any new additional information since the prior report or reflect any efforts to work with the family. However, case notes did reflect changes and efforts to work with the family, which indicates that the CPEs were inaccurate and did not reflect the current condition of the family.

   In a separate review, Coordinated Service Team meetings (CST) were neither conducted nor attempted every three months as required. The Ombudsman Office noted in several reviews that CSTs appeared to be approached on a set schedule regardless of whether meetings were successfully completed or when there was an identified need, which suggests that CSTs are approached to meet compliance and not as a means to work with the family.

   Lack of quality supervision is a significant concern because the Bureau is a supervisory driven system. If staff are not appropriately supervised it is less likely that they will learn and exhibit good child welfare practices.

   Quality supervision of front line staff is crucial to the overall performance of the Bureau and has an impact on all program areas and activities. Therefore, the Ombudsman Office recommends that the Bureau:

Recommendation #1: Explore new policies and training methods for supervisors that emphasize the critical role supervisors have in the development of skills in their staff and the supervisor's role as it relates to ensuring that the transfer of learning is occurring with new staff members.

Recommendation #2: Investigate methods that would ensure that supervisor oversight occurs with staff and that it results in good child welfare practice by their staff.

2. Lack of Accurate Documentation

This is the third year in a row that the Ombudsman Office has identified the lack of accurate documentation as an area needing additional attention. The Ombudsman Office recognizes that the Bureau has taken steps to work on this area of concern; however, we continue to see frequent weakness in documentation in the Bureau record.

Frequently noted in reviews is that documentation does not clearly include what is known about client needs and history, which results in a "starting over" process each time the case changes hands and prevents the communication of crucial information. Lack of specific descriptive information is often not included in case notes, which prevents communication of essential information and interferes with informed decision-making.

In a recent review the Ombudsman Office found no case notes in the Bureau record regarding the use of a CST meeting as a strategy to assist the family. In addition, no case notes were found regarding court hearings that may have clarified the court conditions for reunification. Ongoing staff acknowledged the observations of the Ombudsman Office that legal and CST case notes had not been entered at that time, but confirmed that the actions of conducting CSTs and attending court hearings were completed.

High turnover rates of ongoing case management staff makes documentation that reflects the current condition of the family vital. Without proper documentation of these events the information and insight of what has taken place will be lost if a case is turned over to another staff person. Missing, inaccurate or unclear documentation of one staff can hinder the efforts of any staff that may follow which can negatively impact on the safety or well-being of the child(ren) and family.

Information about the process through which critical decisions are made and the content that contributes to the decision is not documented (as noted under lack of supervision). In most reviews conducted, it was observed that monthly summary case notes were not documented or directions resulting from case staffings with a supervisor. In a review of one specific case, none of this documentation occurred within a span of one year.

Finally, staff members are guided by their supervisors as to what is expected of them, including proper documentation of their activities. When documentation is either not occurring or lacks clarity, supervisors need to provide constructive feedback. Without it staff is left to assume that that their documentation efforts meet the Bureau's expectations and its policies.

Accuracy in documentation is essential to good child welfare practice, particularly when a case crosses program areas or must transfer from one worker to the next. Therefore, the Ombudsman Office recommends that the Bureau:

Recommendation #3: Review the methods by which its supervisors monitor documentation in the case record to ensure its thoroughness and accuracy.

3. Lack of Clear Measurable Goals

The third key issue identified is the need for clear measurable goals. The Ombudsman Office received a number of complaints where the parent had a fundamental lack of understanding regarding what was expected of them for reunification to occur. In reviewing case planning complaints, goals for reunification were often found to lack a focus on what behavioral, cognitive or emotional change must occur in order to enhance the identified diminished protective capacities of the parent and/or the goals were not defined in measurable terms.

Three components of the case planning process include: focusing on what behavior must change through enhancing the parent's protective capacities that were identified as lacking; creating realistic, measurable and specific goals that the parent agrees with and understands; and developing change strategies that may include providing services that will assist the parent in changing behavior, cognitive or emotional states. Each component is needed to increase a parent's likelihood of successfully increasing their protective capacities and ultimately reunification with their child(ren).

When goals are described in vague terms without any qualifier as to how the goal can or will be measured it makes it difficult for parents to know what is expected of them. One example from a review included the goal, "Parents becoming involved with their children's school." This goal is vague in that it does not articulate what constitutes involvement or how progress for reaching the goal will be measured.

A high number of complaints made where a lack of progress in visitation was reported appear to be associated with an overall lack of case progress due to the parent's reported lack of understanding of how their behavior impacted on the change in visitation. In one review, the only identified goal was, "Supervised visitation twice a week with the children will allow the parents an opportunity to spend quality time with them. It will also give insight into the interaction that the parents have with the children." The first part of this goal may be measurable, but it does not express what sort of behaviors must be exhibited in order for visitation to progress to unsupervised. Here again, quality supervision could mitigate this concern because supervisors have to sign off on the case plan where these goals are expressly stated.

Goal development that addresses the parent's diminished protective capacities that resulted in the removal of the children from their custody ought to be clear to parents regarding what must change and they have to be measurable in order for progress to be made. Therefore, the Ombudsman Office recommends that the Bureau:

Recommendation #4: Scrutinize and develop methods to ensure that a supervisor's review of goals include ensuring they match the parent's documented diminished protective capacities and that the goals incorporate behavioral, cognitive, or emotional changes that are clear and measurable.

4. Lack of Adequate Communication

The final area the Ombudsman Office noted for consideration is the need for improved communication. The majority of the individual systemic recommendations made by the Ombudsman Office in 2008 were related to basic lack of communication. Communication problems between Bureau program areas, with parents and families, and with third parties were identified. In the absence of this critical skill all other efforts are diminished and put good child welfare practices at risk.

Due to the fragmented nature of the Bureau, communication within and between program areas is essential. When staff does not either provide or utilize information available it can hinder case progress. For example, newly assigned staff need to adequately review a case's history. In one review the Ombudsman Office found that the case documentation noted that an agreed upon plan of action was developed for use if a disruption in placement occurred. After the case transferred to a new worker and a subsequent disruption in placement occurred, the parent was aware of the plan while the newly assigned staff was not. Because staff was unprepared it resulted in a complaint being filed with the Ombudsman Office.

The Ombudsman Office also heard from many parents who expressed frustration or made complaints regarding inadequate communication with Bureau workers. Of the 28 complaints received in 2008 regarding case planning, only a few reported having ever seen a written case plan or case progress evaluation. Another frequent complaint included unreturned phone calls.

Poor communication with/between third party service provider was also observed. Third party providers have information about the child or family they are working with or providing services to that staff need in order to understand the current condition of the family. If information from a third party provider is not conveyed in a timely manner or is never conveyed, the value of that service may be diminished.

In one review, the Ombudsman Office found that a father was working with a mental health service provider as recommended by Bureau staff, but the mental health service provider was not invited to CST meetings, three of which were within the timeframe of the Ombudsman Office review. No efforts were made to invite the mental health service provider until after the Ombudsman Office completed its review.

A specific case example was when a mother requested that the Bureau release case notes from the supervised visitation worker. The mother was directed by Bureau staff to obtain the case notes from the supervised visitation worker's agency as this was considered a third party provider. At a later date, the mother

reported to Bureau staff that the supervised visitation worker's agency denied her request for case notes and was not offered any assistance in obtaining them.

Without adequate communication Bureau staff cannot effectively meet the needs of the children and families they serve. Therefore, the Ombudsman Office recommends that the Bureau:

Recommendation #5: Incorporate the need for adequate communication among program areas, with families, and with service providers into existing training to ensure that staff have and utilize necessary skills.

Recommendation #6: Develop a form that would provide parents with written information from the case plan and/or case progress evaluation about needed changes in the parent's behavior, cognitive or emotional states that addresses the parent's diminished protective capacities for reunification.

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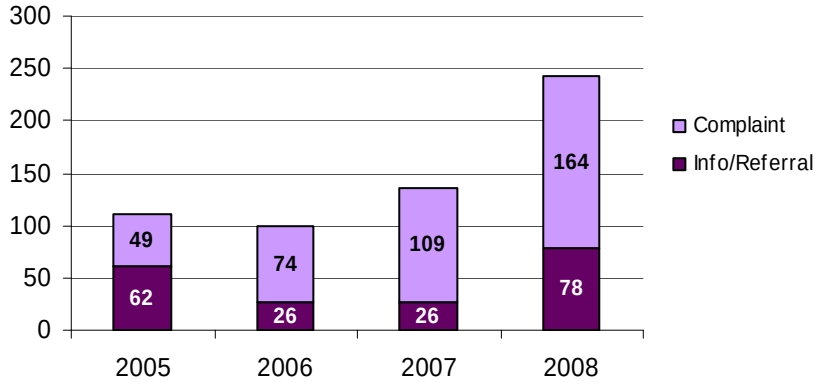
Contact Information for 2008

Contacts

Throughout 2008, the Ombudsman Office responded to a total of 242 new contacts for services. Contacts for information and referrals were up 200% from both 2007 and 2006 as shown in Figure 2. Contacts by phone (223) continue to be the most frequent method of contacting the Ombudsman Office. The Ombudsman office also responded to e-mail (12), mail (2), and walk-in contacts (5). While referrals by fax are accepted, as in 2007, none were received in 2008.

Figure 2

Annual Contacts to the Ombudsman Office



The number of requests made of the Ombudsman Office as well as the types of information and referrals provided by the Ombudsman Office can be found in Appendix 5.

Referral Sources

The Ombudsman Office continues to track information regarding referral sources in order to inform and target outreach efforts. At first contact, individuals are asked how they heard about the Ombudsman Office. The most frequent source of referrals to the Ombudsman Office in 2008 came from persons who had had previous contact with the office (27%), followed by Bureau or Agency staff (13%), and Resubmissions (11%). See Appendix 6 for a complete list of referral sources.

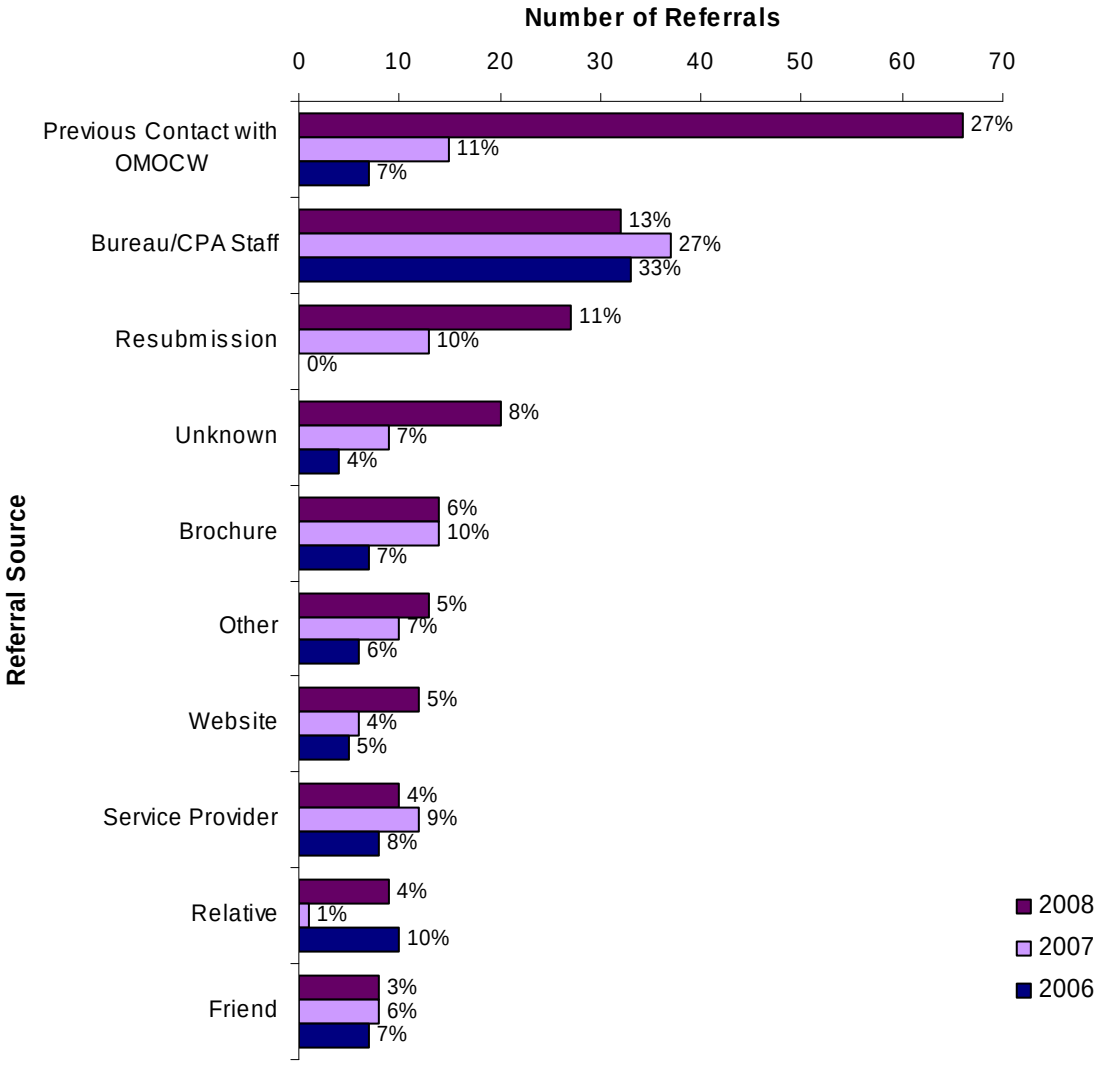
In 2008, nine of the top ten referral sources were the same as those for 2007, and eight were the same as those found in 2006. The one category found in 2007's top ten not found in 2008 was calls to the Department of Health and Family Services (currently, DCF), and public officials and advocacy groups made the top ten in 2006.

Previous contact with the Ombudsman Office was the number one referral source in 2008 (27%), second in 2007 (11%), and fourth in 2006 (7%). Similar differences in

ranking are found among the remaining nine top ten categories. Figure 3 shows how the 2008 top ten referral sources compare by percentage to those made in 2006 and 2007.

Figure 3

Top Ten Referral Sources in 2008



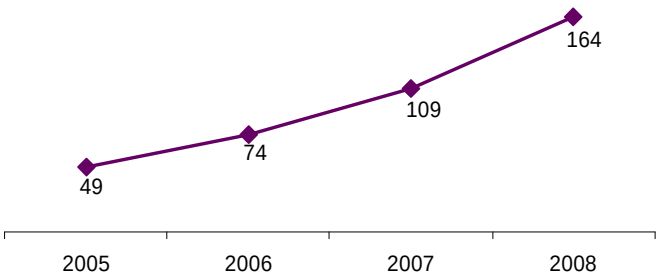
Complaint Information for 2008

Complaints

The number of complaints made to the Ombudsman Office rose from 109 in 2007 to 164 in 2008, which includes 27 complaints that were resubmitted from previous contacts. Complaints made were up 50% compared to 2007 and 122% compared to 2006 as shown in Figure 4.

Figure 4

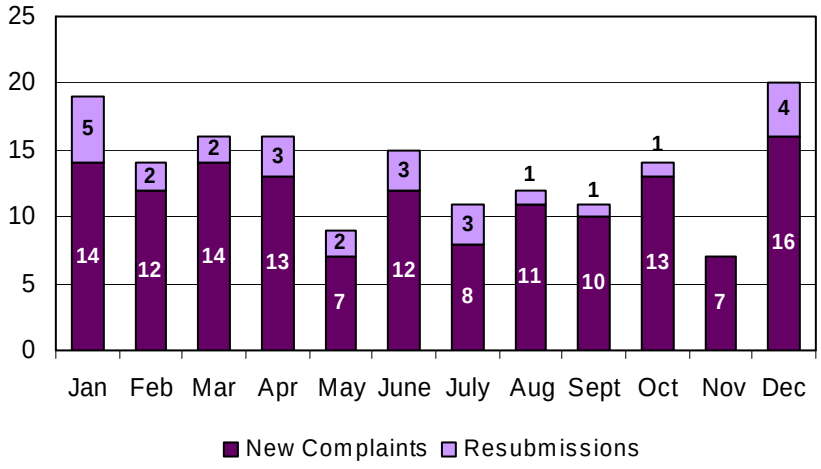
Annual Complaints to the Ombudsman Office



The number of complaints received per month by the Ombudsman Office in 2008 varied from a high of 20 in December to a low of seven in November. The monthly average was 14. Figure 5 illustrates the number of new complaints and resubmitted complaints received by the Ombudsman Office each month during 2008.

Figure 5

Complaints Received in 2008

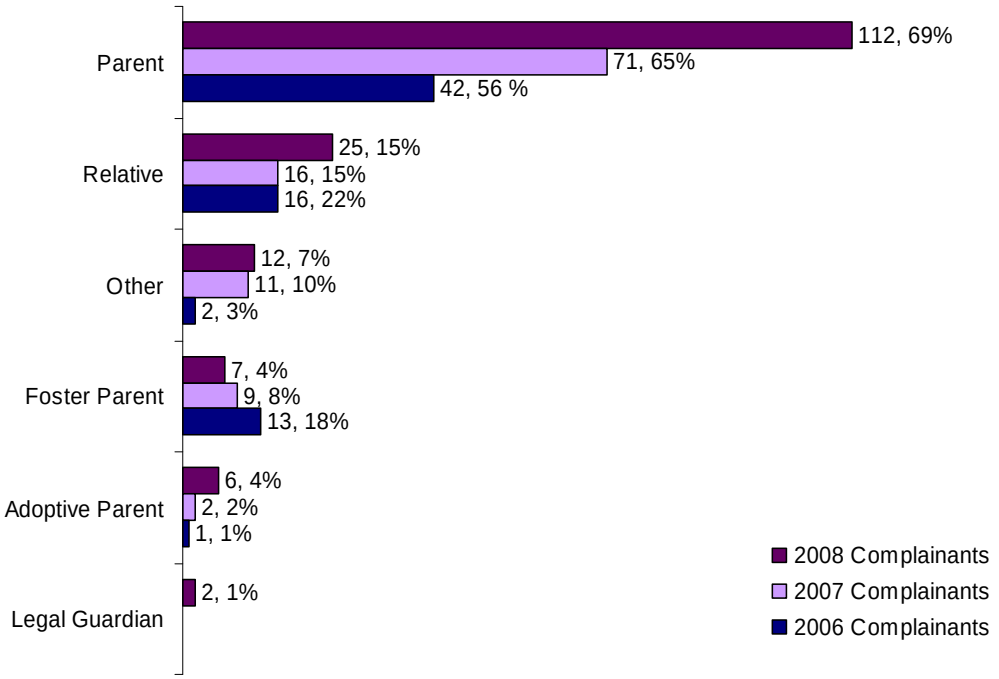


Complaint Sources

Of the 164 complaints received in 2008, 112 (69%) were made by birth parents of the child for whom the complaint was being made, 25 (15%) were made by other relatives, seven (4%) were made by foster parents, and six (4%) were adoptive parents. While parents and relatives remained the top two groups making complaints against the Bureau, the percentage of foster parents making complaints was slightly lower than in 2006 and 2007. See Figure 6 for a year-by-year comparison.

Figure 6

Complaint Sources by Relationship to Child
2006 - 2008



Children Involved in Complaints

The Ombudsman Office tracked data on the ages of the children involved in the complaints received in 2008 and the number of children per complaint. The Ombudsman Office identified 435 children in 157 of the 164 complaints.[2] For 408 of these children, the Ombudsman Office was able to obtain dates of birth.

[2] In seven complaints, the Ombudsman Office was unable to obtain information regarding both the dates of birth and the number of children involved in the complaint.

Of the 408 children identified and for whom a date of birth was obtained, 39% were four years old or younger, 41% were between five and eleven years old, 14% were between 12 and 15 years old, and 6% were ages 16 and older. Figure 7 provides a breakdown of the ages of children involved in these 157 complaints and Figure 8 shows the number of children involved in them.

Figure 7

Ages of Children Involved in Complaints
(n=408)

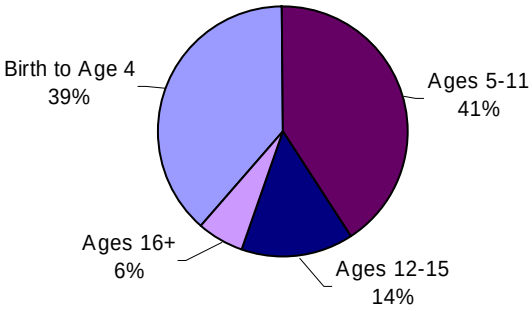
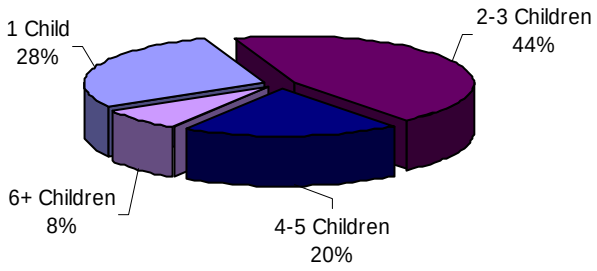


Figure 8

Number of Children Involved per Complaint
(n=157)



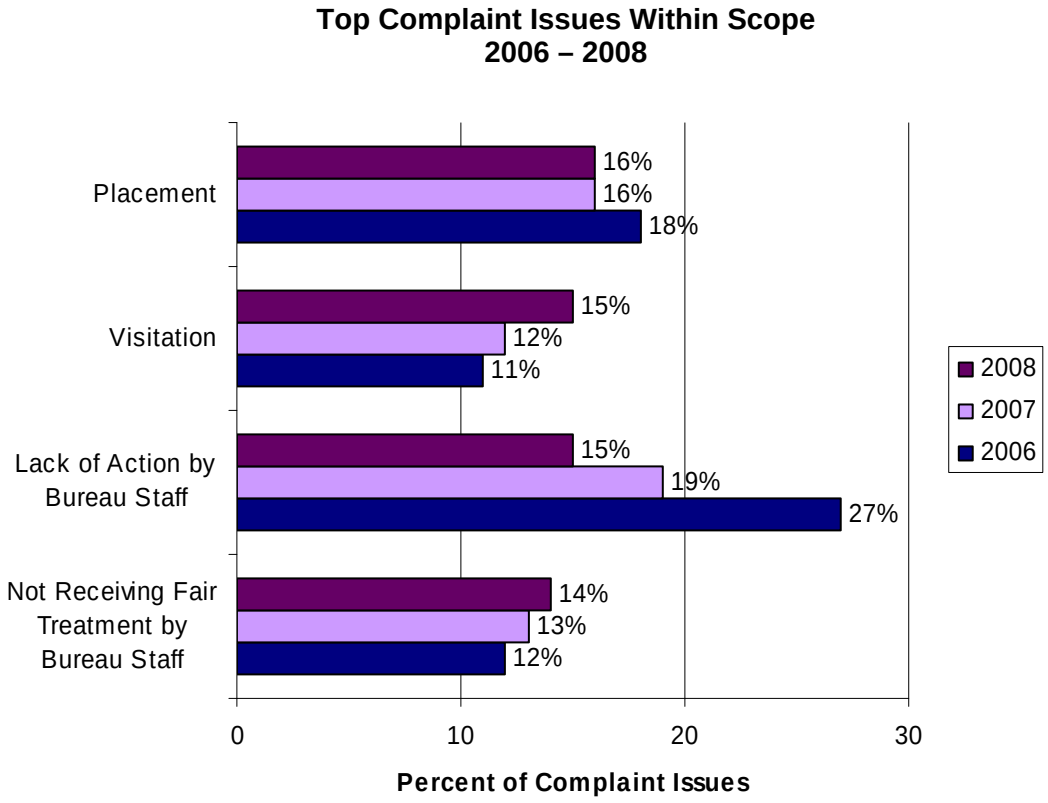
As shown in Figure 8, 28% of the complaints identified one child, 44% of the complaints identified two to three children and 20% of the complaints identified four or five children. Complaints with six or more children comprised eight percent of the total number of complaints.

Complaint Categories

There were 447 issues involved in the 164 complaints received in 2008, of which 73 issues were in complaints (27) that were resubmitted during the year. This is an average of 2.7 issues per complaint. Of the 447 issues identified, 70 were outside the scope of the Ombudsman Office. For complete complaint issue detail for 2008 see Appendix 7.

For complaint issues within the scope of the Ombudsman Office (377), the most frequent complaint issues continue to be related to placement (16%), visitation (15%), lack of action by the Bureau (15%), and fair treatment (12%) concerns. However, in 2006 and 2007, lack of action by Bureau staff received the most complaints as illustrated in Figure 9.

Figure 9



Screened Out Complaints

Of the 137 contacts classified as new complaints[3] received in 2008, 16 did not meet the Ombudsman Office screening criteria for all issues and were screened out. There is frequently more than one reason for each complaint. Complaints are often screened out based upon more than one screening criteria. Table 2 presents the frequency by which complaints were screened out and the related screening categories (see Appendix 8-Screening Criteria for complete detail).

[3] Does not include the 27 complaints that were resubmitted.

Table 2

Reasons Complaints Screened Out

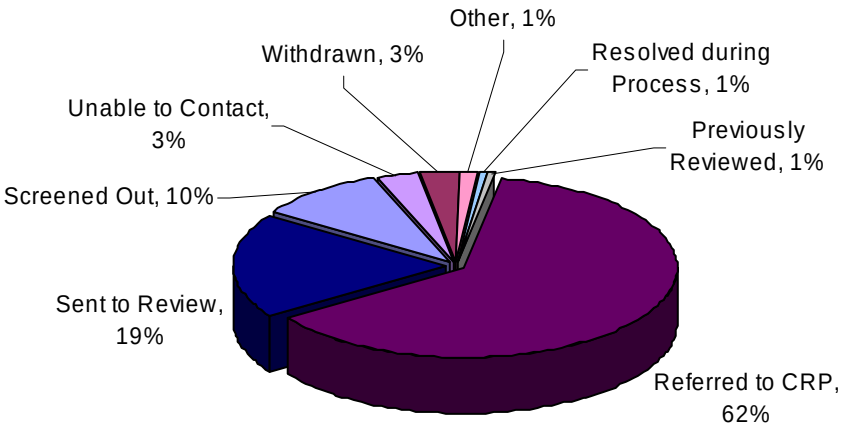
Screening Criteria	Number of Related Complaints
The complaint is not within the scope of issues the Ombudsman Office reviews.	8
The complaint does not involve a specific child and/or family involved with the Bureau (either currently or in the past 90 calendar days).	8
The complaint does not appear to be within the power and authority of the state agencies and/or private agencies serving children and families through the Bureau to control or resolve.	6
The issue(s) being complained about did not occur within the past year, or it is not clear at this time when the issue(s) occurred.	5
The complaint does not appear to be within the jurisdiction and/or responsibility of the Bureau.	4
The complainant does not appear to have direct substantive or procedural interest that is directly affected by the matter complained about.	2

Complaint Outcomes

The Ombudsman Office tracks the outcome for each complaint that is received. Of the 164 complaints received in 2008, 103 were referred to the Bureau's CRP (62%), 31 were sent to review (19%), and 16 were screened out (10%). The outcome for all 164 complaints is shown in Figure 10.

Figure 10

Outcome of 2008 Complaints



Complaints Referred to the Bureau Complaint Resolution Process

In 2008, the Ombudsman Office continued to focus a significant amount of time in seeking to empower individuals to clarify and articulate their concerns, so that they might take them forward to the Bureau in order to resolve their own issues. The Ombudsman Office asks each complainant if he or she is aware of the Bureau CRP and if they have attempted to resolve their issues by going through the CRP.

Of the 137 new complaints in 2008, 103 were referred to the CRP. For the fourth year in a row, the majority of complainants reported that they were not aware of the process and thus had not followed it. Some of these complainants, however, reported that they had gone through the first two steps (contacting the case manager and their supervisor) of the CRP. Community awareness and utilization of the CRP has become a focus of the Ombudsman Office's work and is an issue for which the Ombudsman Office has partnered with the Bureau and its contracted private agencies.

While completing the CRP is not mandatory, the Ombudsman Office encourages complainants to follow the existing process in order to attempt to resolve their issues. In cases where the complainant reports not being able to complete the process or the Ombudsman Office determines that the complainant is not able to complete the process, the Ombudsman Office may move the complaint forward to review.

The Ombudsman Office staff takes the time to listen to the complainant's concerns and helps them articulate their issues. The Ombudsman Office staff reviews the complainant's issues with them to ensure accuracy and thoroughness in the understanding of the issues. Then assists the complainant with understanding how they can successfully follow the CRP. The Ombudsman Office process can take between one hour and several days to complete, often times with multiple follow-up communications with the complainant as they navigate through the process.

Upon referring the complainant to the CRP, the Ombudsman Office staff provides the complainant with contact information in order to complete the CRP. Additionally, with the complainant's permission, the Ombudsman Office staff informs the Bureau that a complaint was received regarding a particular case and about the specific issues of the complaint.

Complainants Referred to Bureau CRP – Follow-up

If the complainant has not contacted the Ombudsman Office again to provide information and/or resubmit their complaint, the Ombudsman Office contacts complainants 30 days after their referral to the Bureau CRP to ascertain the outcome of the process. Follow-up contact is attempted by telephone and by letter if the Ombudsman Office is unable to reach a complainant by telephone. If a complainant is still engaged in the CRP at the 30 day follow-up, the Ombudsman Office will make an additional follow-up in 90 days. Of the 103 complainants referred to the Bureau CRP in 2008, 64 were able to be contacted and 14 awaited the 30-day follow-up contact timeline as of December 31, 2008. The outcomes for the 64 contacts are listed in Table 3.

Table 3.

Outcomes of Complaints Referred to Bureau Complaint Resolution Process

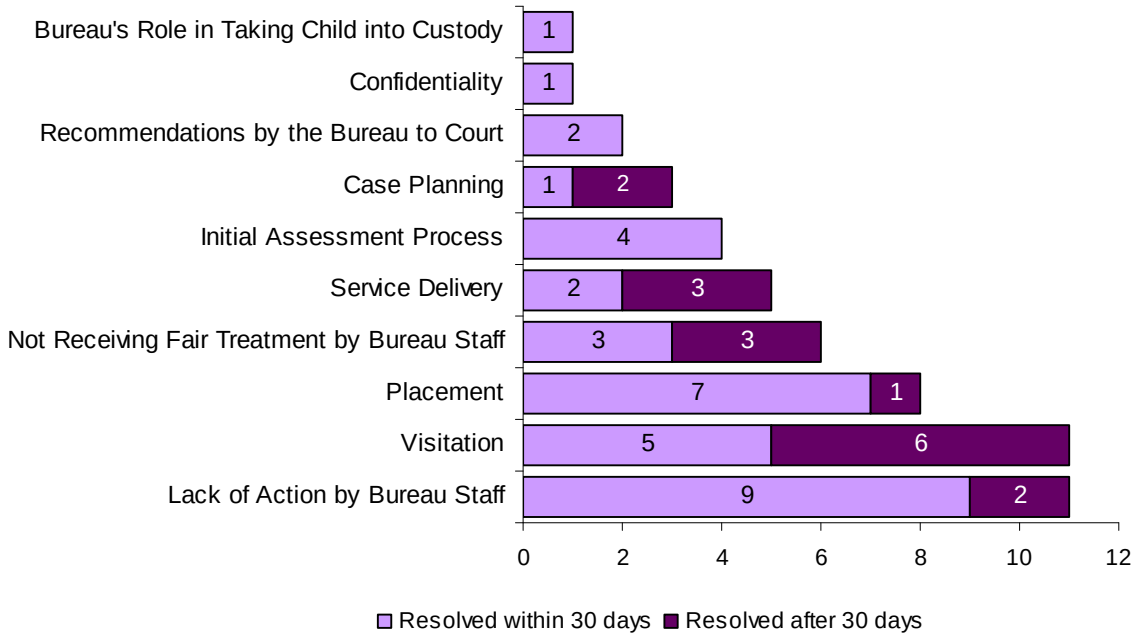
Outcome	Number
Successful Completion of CRP	26
Unsuccessful Completion of CRP-Resubmitted Complaint	16
Still attempting Completion of CRP	16
Unsuccessful Completion of CRP-Did Not Resubmit	2
CRP Not Followed	2
Circumstances that Prevented Completion of CRP	2
Total	**64**

Complaints Referred to Bureau CRP – Issues Resolved

There were 52 issues contained in the 26 complaints where the Bureau CRP was completed and the complainants reported that their issues had been resolved. Figure 11 provides an illustration of the complaint categories along with the number of issues resolved though the Bureau CRP in each category.

Figure 11

Issues Resolved Through the Bureau CRP



At the request of the Bureau, in June 2008, the Ombudsman Office started to ask complainants who had successfully completed the Bureau's CRP at what level their complaint was resolved. Of the 10 complaints that reached a successful resolution, we were able to get information from eight complainants. Three complaints were resolved at the case manager level, two at the supervisory level, and one each at the following levels: program manager, program manager with ongoing supervisor, and region manager. The Ombudsman Office will continue to collect this information when possible.

Case-Level Findings and Recommendations

Overview

The Ombudsman Office completed 25 reviews on 64 issues in 2008. The goal for the completion of an Ombudsman Office review is 60 calendar days from the time notice of review is sent to the complainant and the Bureau to the time that the Ombudsman Office sends the Bureau its findings of the review (see Appendix 4-"Timeline Goals"). For those complaints received in 2008, 20 (87%) reviews were completed within the 60 day timeline goal with the average completion time being 46 days.

For each of the reviews, findings and recommendations are communicated to the Bureau. These findings are categorized as: 1) affirmations of Bureau action; 2) violations of law, policy, or procedure; 3) practice concerns; 4) resolved; or 5) inconclusive.

The Ombudsman Office makes recommendations when appropriate if a finding is a violation, a concern, or is inconclusive. These recommendations reflect the Ombudsman Office's attention to these priorities: remedying violations and concerns whenever possible, shaping better future child welfare practice, and articulating the experiences of our complainants.

The term "additional finding" is used to describe a violation or practice concern found in the course of conducting the Ombudsman Office review that was not germane to the specific issues being complained about. The Ombudsman Office also makes recommendations regarding "additional findings".

The Bureau provides the Ombudsman Office with their response to the review findings and recommendations which includes any actions taken or planned. The Ombudsman Office continues to work with the Bureau in tracking all recommendations with which the Bureau agrees.

Violations

Practices that are observably out of compliance with existing policy, standard, or law.

Concerns

Practices that have been observed to be carried out in ways that are outside of what the Ombudsman Office considers to be optimal practice in the field and where there is no existing policy or law to address the issue.

Resolved

Complaint issues that reached resolution during the Ombudsman Office review.

Inconclusive

Complaint issues where the Ombudsman Office was unable to make a finding given the information available to the Ombudsman Office at the time of the review.

Additional Findings

Violations or practice concerns found in the course of conducting the Ombudsman Office review that were not germane to the specific issues being complained about.

Findings

There were 65 issues in 26 separate complaints reviewed and/or closed in 2008. Of these, there were 56 issues (86%) where the Ombudsman Office affirmed the actions of the Bureau; six issues (9%) where concerns were found; two issues (3%) where violations were found; and one issue (2%) that was resolved during the review. There were no inconclusive findings in 2008. Figure 12 provides a breakdown of the findings for the issues reviewed.

The Ombudsman Office identified 16 additional findings that were not part of the original complaint; six violations and 10 concerns. Four of the six violations were for accuracy in documentation, as were nine of the 10 concerns. Other areas in which findings were found include issues regarding communication between program areas and the conduct of staff and other professionals.

Figure 13 illustrates the inclusion of the additional findings and their effect on the affirmation rate of the Bureau's actions. See Appendix 9 for comprehensive information on Ombudsman Office findings.

Figure 12

Review Findings
Without Additional Findings

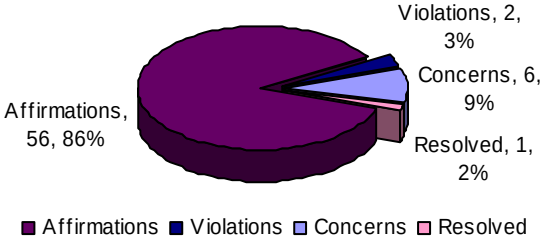
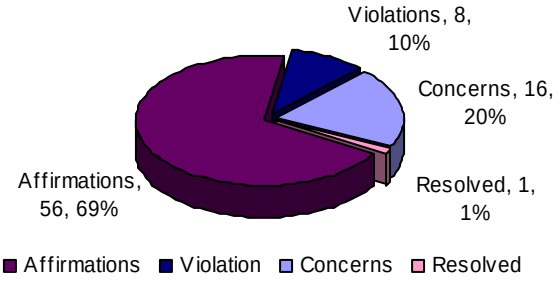


Figure 13

Review Findings
With Additional Findings



Recommendations

Ombudsman Office recommendations are made both as a result of conducting reviews and by observing trends and key issues from all of the contacts made to the Ombudsman Office. Additionally, the Ombudsman Office notes issues that have been presented in multiple years.

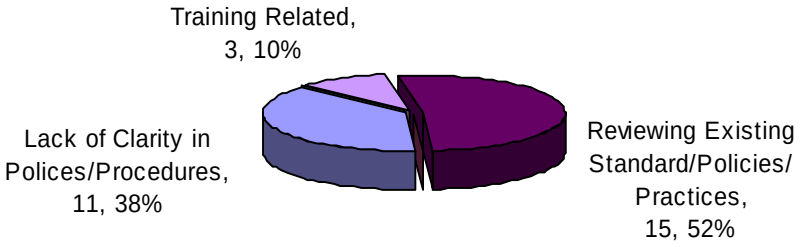
Recommendations from 2008 Reviews

The Ombudsman Office makes recommendations that are case-specific as well as systemic. In many individual complaints, the issue may not be able to be resolved because it involves an event or situation that has already occurred. In these instances, the Ombudsman Office focuses its recommendations on how to ensure that the event or situation does not occur again.

Based on the reviews conducted in 2008, the Ombudsman Office made 38 recommendations, 29 systemic and nine case-specific. Some of the recommendations made were the same for multiple reviews. Figure 14 illustrates that of the 29 systemic recommendations made, approximately half (15) involved reviewing existing standards, policies, or practices; over one-third (11) were related to areas lacking clarity in existing policies or practices; and the remaining addressed training (3).

Figure 14

Systemic Recommendations by Type



The Ombudsman Office found that in 52 percent (15) of its recommendations made to the Bureau, existing standards, policies, or procedures were in place, but in some cases were not utilized at all and in others were inadequately interpreted. This is notable because it reveals that the Bureau has appropriate child welfare practices in place. However, if they are not properly interpreted or followed the safety of children can be put in jeopardy or lead to barriers for reunification.

Of the 15 recommendations made, four (27%) related to poor documentation, four (27%) focused on Initial Assessment (IA) face-to-face contact expectations, and the remaining seven were associated with communication. A few fundamental practice areas or policies the Ombudsman Office recommended that the Bureau reinforce with staff and/or supervisors that touch on safety or communication include:

- Defining impending dangers, safety threats, and threshold criteria and their impact on safety planning;
- Communicating the notice and assignment of new cases to Initial Assessment Social Workers (IASW) to allow the IASWs to meet designated response times for face-to-face contact with children and families;
- Establishing face-to-face contact and re-attempts to establish face-to-face contact, particularly after receiving a referral of alleged child maltreatment in a timely fashion;
- Emphasizing the CST process in regard to goal development and service provider roles and responsibilities; and
- Communicating between program areas on cases with joint involvement.

Another 38 percent (11) of Ombudsman Office recommendations made to the Bureau were related to areas where current Bureau policy was either lacking clarity or was silent. In the absence of clear policy directives, child welfare workers' actions appeared to be incongruent with the best interests of the child(ren) or family. Of these, four (36%) recommendations related to insufficient documentation. The following are a few additional specific areas identified as areas of particular concern:

- Emphasizing relative involvement on case transfer forms and monitoring case transfers to ensure that case information in the BMCW record is updated by the appropriate staff *and* reviewed in full by the staff receiving the case prior to or in conjunction with a case transfer meeting;
- Reviewing and initiating actions to address when staff become aware of misconduct or suspected misconduct of other professionals working with children;
- Notifying parents of change of placements in pre-dispositional cases; and
- Increasing the involvement of service providers in the CST process, particularly with key professionals or individuals identified as critical related to their understanding of or involvement with changing the individual's diminished protective capacities, conditions impacting on child safety, and/or barriers of communication or cooperation that impact on case progress.

The final ten percent of Ombudsman Office recommendations (3) made to the Bureau related to training issues regarding:

- Engaging challenging youth;
- Providing and presenting information to the court; and
- Defining boundaries of practices to not only include the expectations of worker's roles and responsibilities but also limitations and management skills needed to cooperatively work with other professionals who have a defined expertise.

Communication Channels

Bureau and Contracted Private Agencies

The Ombudsman Office continues to meet with the Bureau and contracted private agency leadership to communicate information regarding Ombudsman Office activities, discuss and enhance protocols, and discuss any concerns as appropriate.

Partnership Council

The Partnership Council, established by Wis. Stats. Section 15.197(24), was created in 1995 to advise the DCF and the Legislature regarding child welfare services in Milwaukee County. The Ombudsman Office reports publicly at Partnership Council meetings on the Ombudsman Office's general activities. The Ombudsman Office Director presented the 2007 Annual Report to the full Partnership Council in April 2008 and began presenting quarterly reports in October 2008.

Brochure

The Ombudsman Office brochure provides information regarding ombudsman services and the process of the Ombudsman Office for individuals who have concerns about a child or family involved with the Bureau. Spanish and Hmong versions are available.

Poster

In December 2008, the Ombudsman Office had posters printed to help expand its outreach efforts in the community. Plans are to get them distributed in 2009 to government offices that serve families engaged in the Bureau of Milwaukee Child Welfare and in community settings throughout the county.

Committees and Associations

The Ombudsman Director actively participates in Milwaukee Child Abuse Prevention Services Coalition meetings and is a member of their Public Policy Committee. The Ombudsman Director is a member of the Wisconsin Child Welfare Committee and the United States Ombudsman Association (USOA).

Website

The Ombudsman Office developed a website (www.ombudsmanmilw.org) that allows members of the public to learn about ombudsman services, the Ombudsman Office, the complaint process, how to file a complaint, reports, and how to contact the Ombudsman Office. The complaint form can be downloaded from the website. Additionally, the complaint form may be emailed directly to the Ombudsman Office through the website.

The State of Wisconsin DCF and Bureau have a link on their website under the Bureau Complaint and Appeal Process to the Ombudsman Office (http://dcf.wisconsin.gov/bmcw/progserv/AboutBMCW/complaint-appeal/INDEX.htm).

For a complete list of communication activities please see Appendix 10.

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Looking forward to 2009

The Ombudsman Office looks forward to continuing all of its previous efforts to support children and families served by the Bureau of Milwaukee Child Welfare. The following are areas of additional focus for the Ombudsman Office in 2009.

Cooperating with the State Department of Children and Families (DCF) in their evaluation of the work of the Ombudsman Office

Working with families, the Bureau and other community groups, the Ombudsman Office helps to support quality services for children and families involved with the Bureau and looks forward to the opportunity to demonstrate its value to the Milwaukee community. Since the Ombudsman Office opened in June 2005, it has continued to develop to meet the needs of the community. The Ombudsman Office has made improvements upon the prior year's performance both in terms of the number of families served and the quality of the service we provide to all who contact the office.

Working with the Bureau to improve the tracking of Ombudsman Office recommendations that the Bureau has agreed with and reporting progress made by the Bureau on a quarterly basis to the Partnership Council

The Ombudsman Office is pleased to be able to expand on its efforts of making the work of the office more transparent. This will provide an opportunity for the community to learn and the Bureau to share what actions they have taken toward implementing those recommendations that the Bureau is in agreement with. Discussion on how best to track these recommendations will take place early in the second quarter of 2009 and the Ombudsman Office expects its second quarterly report of 2009 to reflect progress on recommendations made in 2009.

Expanding on the quality of information conveyed in our finding letter to the complainant, particularly when the actions of the Bureau are affirmed

For some complainants, the Ombudsman Office recognizes that the current information provided in its findings letter may lack sufficient information for them to comprehend how the finding was made. Through consultation with legal counsel and the Department of Children and Families, the Ombudsman Office will investigate how it can provide enough information for complainants to clearly understand the factors considered in determining the finding while respecting the confidentiality of the Bureau record.

Exploring how the Ombudsman Office can be useful to the review process that takes place if a child dies in the care or custody of the Bureau

After the tragic death of Christopher Thomas in November 2008, a number of people were surprised to learn that the Ombudsman Office does not currently have a role in reviewing the Bureau's actions or inaction if a child dies in its care or custody. The contract the Ombudsman Office has with the DCF clearly allows for its participation in the Child Abuse Review Team (CART) and the DCF has extended their desire for the

Ombudsman Office to be part of that team. The Ombudsman Office will revisit the past decision to not participate in the CART and whether that is the only or proper role for the Ombudsman Office to have if a child dies. Information is currently being gathered on what role other ombudsman offices in other jurisdictions have in order to make an informed decision.

Assessing the efforts of the Ombudsman Office, through the use of survey instruments, in order to improve service to complainants and to target outreach efforts.

In 2008, the Ombudsman Office developed a number of survey instruments to assess the performance of Ombudsman Office staff in their work with complainants and its outreach efforts. The Ombudsman Office will gather information anonymously from complaints through mailing a survey that include a self-addressed, postage-paid envelope for ease of return of the survey, after we have referred them to the Bureau's CRP or after a review has been completed. The survey asks the complainant to assess the service they received from staff and the value of the services received. A similar survey tool is used to evaluate presentations made in the community. This data will be shared in the 2009 annual report.

Receiving feedback on the content and structure of the Ombudsman Office's Annual Report to ensure that stakeholder's expectations are met.

The purpose of the annual report is to provide information that is useful, informative, and expected about the work of the Ombudsman Office to its various stakeholders. Constructive feedback from the users of this report will help to ensure that the report is meeting the needs of its intended audiences. To provide feedback on this report please contact the Ombudsman Director, Pamela Matthews, via email at pmatthews@ombudsmanmilw.org or by phone at 414.224.1347.

Appendices

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Appendix 1

Staff

The 2008 Ombudsman Office Staff consisted of the Ombudsman Director, an Associate Ombudsman, a .5 FTE Administrative Assistant/Intake Coordinator, and the consulting services of an attorney to confer with regarding legal matters.

Ombudsman Director

- Pamela Matthews began in the Ombudsman Office in September 2008. She has comprehensive experience in local, county, and state levels of government. She has expertise in child welfare policy analysis and development, and experience with diverse audiences and stakeholders. Matthews holds a bachelor's degree in Community Leadership from Alverno College.
- Lisa Drouin worked with the Ombudsman Office from March 2005 through June 2008. She has more than a decade of experience working in social services and child welfare. Drouin served in a senior management position as the Quality Assurance Manager in the child welfare system in Milwaukee, and holds a master's degree in Social Work from the University of Wisconsin-Milwaukee.

Associate Ombudsman

- David Scholl has been with the Ombudsman Office since November 2007. He has over seven years of experience working in child welfare, including roles as a trainer, case manager, CST Facilitator, and supervisor for Safety Services and Ongoing Case Management. Scholl holds a master's degree in Social Work from the University of Wisconsin-Milwaukee.

Administrative Assistant/Intake Coordinator

- Michelle Doneis has been with the Ombudsman Office since November 2007. She has six years of administrative experience and holds a bachelor's degree in Human Services Management from Cardinal Stritch University.

Legal counsel for the Ombudsman Office is Henry Plum, JD. He is a private attorney and consultant. Plum is a nationally recognized speaker and educator in the field of child abuse and neglect. As a former Assistant District Attorney in Milwaukee, he has extensive experience as a prosecutor in areas of child abuse and neglect, termination of parental rights, and child related litigation, and has a thorough understanding of Wisconsin Statutes.

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Appendix 2

2008 Outreach

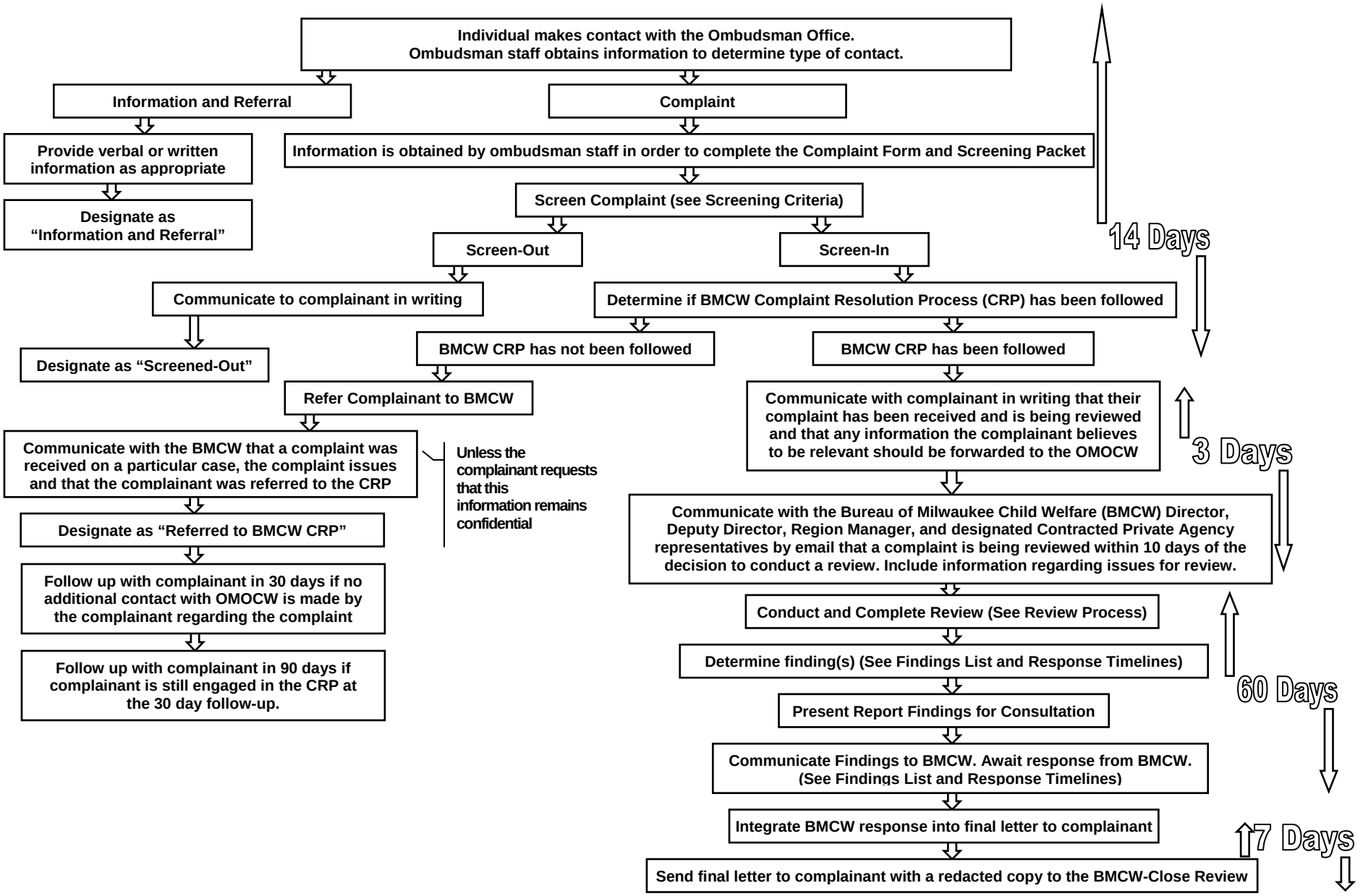
Presentations/Outreach	Date
Community – 20	
▪ Voices United, Adoption/Foster Parents – Presentation (6 attendees)	3/19/08
▪ Milwaukee Child Abuse Prevention Services (MCAPS) Coalition, Public Policy Committee (16 attendees)	5/12/08
▪ Rockwell United Way Employee Kick-off (hundreds)	10/6-7/08
▪ Agape Community Center, Executive Director	10/9/08
▪ Fatherhood Summit (# of attendees unknown)	10/11/08
▪ Adoption Resources of WI, Development & Communications Director	10/16/08
▪ Abri Health Plan Customer Service Staff Meeting – Presentation (23 attendees)	10/30/08
▪ Black Health Coalition of Wisconsin, Service Provider Meeting – Presentation (22 attendees)	11/12/08
▪ Aids Resource Center of Wisconsin, Program staff – Presentation (11 attendees)	11/13/08
▪ COA Youth & Family Center – Presentation (5 attendees)	11/20/08
▪ Kids Matter, Inc. – Presentation (5 attendees)	11/21/08
▪ CHIPS & TPR Attorneys – Presentation (22 attendees)	12/1/08
▪ Curative Care Network – Presentation (40 attendees)	12/8/08
▪ Parenting Network – Presentation (5 attendees)	12/8/08
▪ Esperanza Unida, Inc, staff (2 attendees)	12/9/08
▪ Fresh Start Family Service, Treatment Foster Care – Presentation (30 attendees)	12/12/08
▪ Lad Lake, Independent Living staff – Presentation (8 attendees)	12/15/08
▪ Aurora Family Counseling Clinic – Presentation (5 attendees)	12/16/08
▪ Brighter Futures Meeting – Presentation (51 attendees)	12/16/08
▪ Perez Pena Limited Inc. – Presentation (5 attendees)	12/17/08
BMCW Staff – 8	
▪ New BWCW Staff – Presentation (19 staff)	1/16/08
▪ Ongoing Staff – Region 3, Annual Outreach	3/4/08
▪ Safety Service Staff – Region , 3 Annual Outreach	3/6/08
▪ New BMCW Staff – Presentation (34 staff)	4/23/08
▪ New BMCW Staff – Presentation (32 staff)	6/4/08
▪ New BMCW Staff – Presentation (31 staff)	8/27/08
▪ New BMCW Staff – Presentation (29 staff)	10/8/08
▪ New BMCW Staff – Presentation (14 staff)	11/19/08

Continued

Presentations/Outreach	Date
Partnership Council – 9	
▪ Milwaukee Partnership Council Quarterly Meeting, Presented 2007 Annual Report	4/25/08
▪ Partnership Council member & community advocate, Mary Thomas	9/11/08
▪ Partnership Council member & State Senator, Spencer Coggs	9/17/08
▪ Partnership Council member & State Representative, Sue Jeskewitz	9/22/08
▪ Milwaukee Partnership Council Quarterly Meeting, Quarterly Report	10/24/08
▪ Partnership Council member & community advocate, Linda Davis	10/24/08
▪ Partnership Council member & Milwaukee County Board Supervisor, Willie Johnson, Jr.	10/31/08
▪ Partnership Council member & WI State Assembly, Office of Rep. Tamara Grigsby, JFC	11/18/08
▪ Partnership Council member & Presiding Children's Court Judge, Mary Triggiano	12/23/08
Legislative – 12	
▪ WI State Senate, Sen. John Lehman, Joint Finance Committee (JFC) Member	10/20/08
▪ WI State Assembly, Office of Rep. Scott Suder, JFC Member	10/20/08
▪ WI State Senate, Office of Sen. Luther Olsen, JFC Member	10/20/08
▪ WI State Senate, Office of Sen. Dave Hansen, JFC Member	10/20/08
▪ WI State Senate, Office of Sen. Judy Robson, JFC Member	10/20/08
▪ WI State Assembly, Rep. Mark Pocan, JFC Member	10/20/08
▪ WI State Assembly, Office of Rep. Dan Meyer, JFC Member	10/21/08
▪ WI State Assembly, Office of Rep. Jeff Stone, JFC Member	10/21/08
▪ WI State Senate, Office of Sen. Julie Lassa, JFC Member	10/21/08
▪ WI State Assembly, Office of Rep. Steve Kestell, JFC Member	10/21/08
▪ WI State Senate, Office of Sen. Lena Taylor, JFC Member	11/17/08
▪ WI State Senate, Office of Sen. Alberta Darling, JFC & Partnership Council Member	11/20/08

Appendix 3

Process Overview



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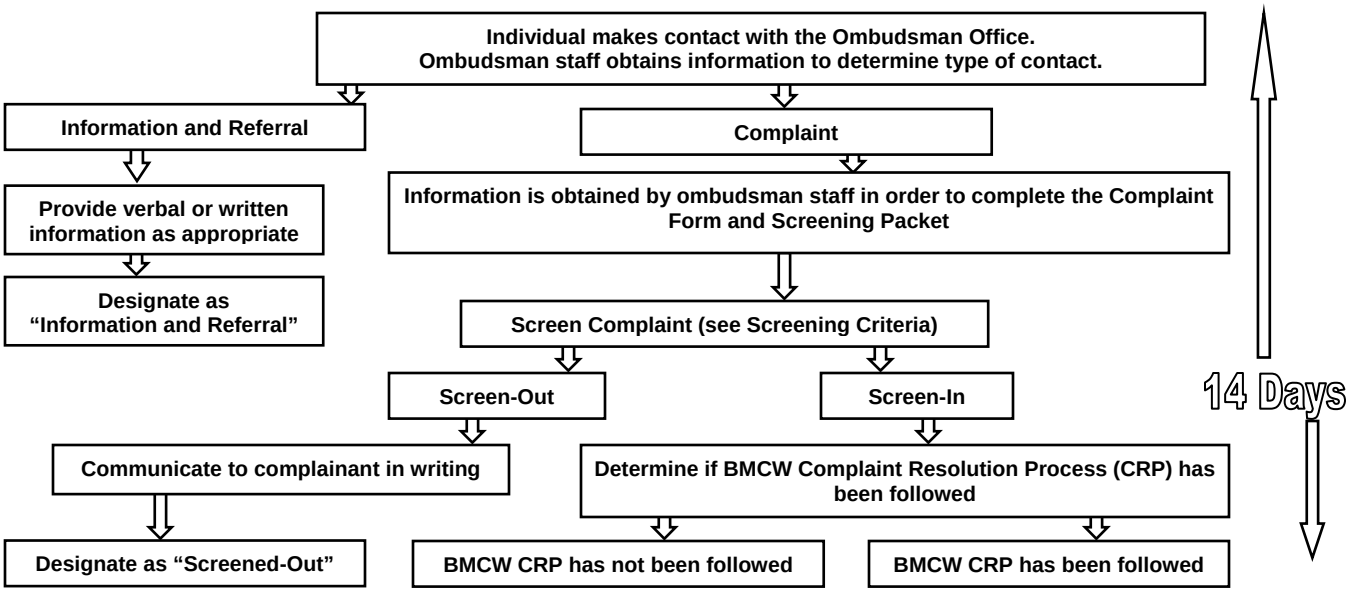
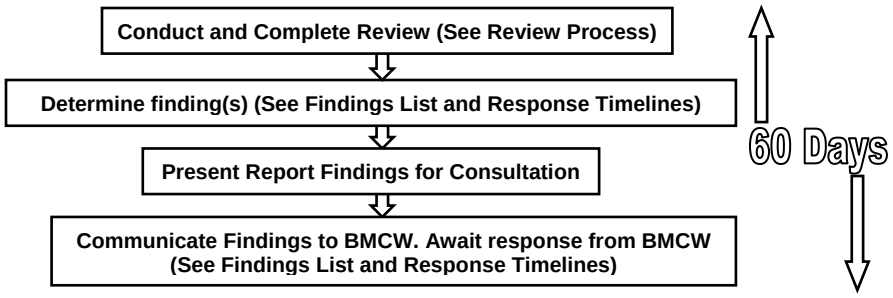
Appendix 4

Processing Guidelines



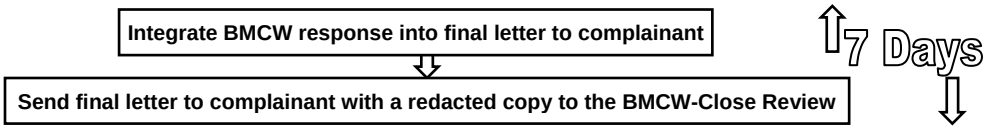
The Ombudsman Office's target for completing the screening process and determining if the Bureau CRP has been followed is 14 calendar days from the date the individual contacts us. For 99% of contacts, this process was completed within the timeline established. The average number of days this process took in 2008 was two. For 82 contacts (52%), this process was completed the same day the individual contacted the Ombudsman Office. Challenges in terms of making contact with the complainant to obtain information necessary to complete this process led to this timeline being exceeded for two complaints.



The guideline for the completion of the Ombudsman Office review is 60 calendar days from the time correspondence is sent to the complainant and the Bureau that a review will take place until the time that the Ombudsman Office sends the Bureau its findings of

the review. For those complaints opened and closed in 2008, 20 (87%) reviews were completed within the 60 day process guidelines with the average completion time being 46 days. There were three reviews that went over the 60 day timeline goal; in one review an additional complaint issue was added to the review at the 30 day mark, and in two reviews court transcript requests caused delays.

For findings of affirmation, the Bureau is requested to respond to the Ombudsman Office findings within seven calendar days. For findings of violation, concern, and/or other findings, the Bureau is requested to respond to the Ombudsman Office within 30 calendar days. If subsequent correspondence is needed due to the Bureau providing additional information and/or disagreement with the Ombudsman Office findings, each correspondence is requested within 21 calendar days.



The process guideline for sending the final findings correspondence to the complainant upon receipt of the Bureau's response to the findings is seven days. For those complaints received in 2008, 100% of the final findings correspondences were completed within the seven day timeline goal with the average completion time being two days.

Process from Contact to Final Correspondence

For complaints received in 2008 and where the review was completed in 2008, the average length of time from the date of contact to the date the final findings correspondence was sent to the complainant was 79 calendar days. This accounts for time awaiting the Bureau's response to the Ombudsman Office findings and any additional correspondence that was needed.

The Ombudsman Office will adjust its processing guideline for making a screening decision from 14 days to seven days. In the past two years the Ombudsman Office has usually made this screening decision within two days.

Appendix 5

Information and Referral Categories

Information Requested	TOTAL
Legal Advice	15
CPS - Other Counties	13
Safety Threats (abuse/neglect)	10
Who to Contact at Bureau	10
Questions about Bureau	8
Court Process/questions	7
Child Support	5
Information about OMOCW Office	4
Advocacy	3
Contact Information for Bureau Personnel	3
Foster Care - Licensing/Becoming a Foster Parent	3
Health Insurance	3
How to Obtain Bureau Records	3
Kinship	3
W-2	3
Other Ombudsman Programs (non-child welfare)	2
Visitation Questions	2
Bureau - General Information	1
Employment after Incarceration Information	1
Foster Care Payment	1
MPS	1
Starting a Group Home	1
Rent Assistance	1
TOTAL REQUESTS*	**103**

* There were a total of 78 contacts for information in 2008 with an average of 1.32 requests per contact.

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Appendix 6

Referral Sources

Referral Source	TOTAL	Number of Referrals	
		Complaints	Info/Referral
Previous Contact with Ombudsman Office	66	45	21
Bureau/Contracted Private Agency Staff	32	27	5
Resubmission	27	27	0
Unknown	20	3	17
Brochure	14	11	3
Other*	13	9	4
Website	12	5	7
Service Provider	10	7	3
Relative	9	8	1
Friend	8	6	2
Child Advocacy Group	5	3	2
Community Resource Guide	5	1	4
Attorney	4	3	1
DCFS	4	1	3
Social Worker	3	1	2
Madison – Unspecified State Office	2	2	0
Public Official	2	2	0
Court	2	1	1
Child Protective Services	2	1	1
Milwaukee Journal Sentinel	2	1	1
TOTAL		**164**	**78**
TOTAL COMBINED	**242**	**242**	

*Other includes one each of: Guardian ad Litem, Health Care Professional, Adopt Us Kids Adoption Network, Badger Care State Office, Directory Assistance, DWD, Hope Network Book, Legal Action, Maximus, National Child Abuse Number, Ombudsman Office, Parent Support Group, and Social Services in Seattle.

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Appendix 7

Complaint Categories

Complaint Category	Number
Placement ▪ Relative placements not sought (20) ▪ Disagreement with a change of placement (8) ▪ Safety of a child's placement (7) ▪ Conduct of a caregiver (6) ▪ Siblings are not placed together (4) ▪ Placement not being appropriately monitored (4) ▪ Appropriateness of the placement (4) ▪ Child has had multiple placements (1) ▪ Other: o Siblings will be separated through adoption process (1) o Relative placement ruled out without adequate reason (3) o Disagree with choice of relative placement (1) ▪ Placement outside of Milwaukee (1)	**60**
Visitation ▪ Visits should be unsupervised (9) ▪ Visitation with parent is not occurring (7) ▪ Bureau is canceling/suspending visits (7) ▪ Visitation is not progressing (7) ▪ No visitation plan is in place (5) ▪ Child is missing visits (4) ▪ Visits should be supervised (1) ▪ Lack of understanding of why visitation is supervised (1) ▪ Siblings are not able to visit with each other (1) ▪ Other: o Inappropriate person allowed visitation (2) o Visitation changed from unsupervised to supervised (2) o Changes in visitation and location (2) o One instance each of the following: location of visitation, specific instance of visitation should not occur, visitation with spouse is not occurring, denied assistance for food resources needed an extended visit, timeliness of first visit after taking child into custody, management of visitation plan, and visitation regressed without justification	**55**

Continued

Complaint Category	Number
Lack of Action by Bureau Staff ▪ Inadequate assistance from staff (19) ▪ Lack of return contact (10) ▪ Lack of follow-up on a report of child abuse or neglect on an open case (7) ▪ Information withheld by staff (7) ▪ Lack of follow through by staff regarding concerns (5) ▪ Lack of contact with parent for consent for medical treatment (5) ▪ Other: o Lack of action taken to control for safety (2)	**55**
Not Receiving Fair Treatment by Bureau Staff ▪ Disrespectful treatment/lack of professionalism from staff (17) ▪ Bias against mother (14) ▪ Staff giving misinformation (8) ▪ Bias against father (6) ▪ Retaliatory/threatening behavior by staff (4) ▪ Bias against other family members (1) ▪ Other: o Conflict of interest (1) o Staff implemented inappropriate techniques in handling child (1) o Not following a prior agreement reached through the CRP (1) o Not accounting for conditions affecting mother (1)	**54**
Service Delivery ▪ Lack of timeliness of service delivery (7) ▪ Not addressing mental health needs of a child (6) ▪ Not addressing mental health needs of a parent/caregiver (6) ▪ Service providers (3) ▪ Not addressing needs as requested (3) ▪ Not addressing educational needs of a child (3) ▪ Not addressing basic needs of a parent/caregiver (2) ▪ Conflict between recommendations of service provider and Bureau (2) ▪ Not addressing needs as court ordered (2) ▪ Not providing services (2) ▪ Bias against mother (1) ▪ Not addressing medical needs of a child (1) ▪ Other o Not addressing AODA concerns of child (3) o Conflict of interest with interpreter (1)	**42**

Continued

Complaint Category	Number
Case Planning ▪ Conditions for return of the children (18) ▪ Case plan does not address a particular need (5) ▪ Not involving relatives with case planning (1) ▪ Other: o Disagreement between foster parent and Bureau regarding permanency plan (1) o Coordinated Service Team (CST) excludes service providers (1) o Expectations to achieve case closure (1) o Parent not involved in case planning or addressing special needs of the child (1)	**28**
Bureau Recommendations to the Court ▪ Inaccurate information provided to court (16) ▪ Concern/disagreement with recommendations made (4) ▪ Other: o Not complying with Adoption and Safe Families Act (ASFA) (1)	**21**
Initial Assessment Process ▪ Lack of timeliness in beginning initial assessment (4) ▪ Lack of interviewing parents (2) ▪ Lack of timeliness in completing initial assessment (1) ▪ Other: o Lack of interviewing children appropriately (2) o Reporter of maltreatment did not receive follow-up contact (1) o Investigation did not include alleged coercion of children (1) o Inaccurate information was obtained through investigation, contained in the Bureau record, & used in decision-making (1) o Lack of action to address alleged physical abuse (1) o Lack of thoroughness in an investigation led to substantiation of maltreatment (1) o Lack of interviewing children (1) o Lack of consideration of Child Protective Services (CPS) history (1) o Assessment of persons not in custody of the parent (1) o Lack of action taken to address alleged safety concerns (1) o Maltreatment decision not based on available information (1) o Lack of follow-up on a report of child abuse or neglect (1)	**20**

Continued

Complaint Category	Number
Bureau's Role with Taking a Child into Custody ▪ Concern that a child was taken into custody and should not have been (8) ▪ Concern that a child should have been taken into custody and was not (5) ▪ Disagreement with a Screen-Out decision (2) ▪ Lack of follow-up on a report of child abuse or neglect (1) ▪ Incorrect assessment that resulted in the removal of a child (1) ▪ Other: o Lack of information gathered on child's dietary needs (1)	**18**
Notification Issues ▪ Not receiving proper notification regarding a change of placement (7) ▪ Not receiving proper notification regarding taking a child into custody (4) ▪ Other: o Not receiving notification of change of worker (1) o Not receiving notification of change of worker during incarceration (1) o American Indian Tribe not notified (1)	**14**
Confidentiality Concerns ▪ Inappropriately releasing confidential information (4) ▪ Name of the reporter of maltreatment was released (1) ▪ Other: o Address released to parent when other parent had domestic violence concerns (1) o Inappropriately requested signed consent to obtain information (1)	**7**
Other - Within Scope ▪ Parent not consulted regarding child's picture being taken (1) ▪ Case Manager instructed child to make allegations against parent (1)	**2**
Bureau Record ▪ Information missing (1)	**1**

Continued

Complaint Category	Number
Issues Outside the Scope of the Ombudsman Office Attorney Related Concerns (15) ▪ Attorney not providing adequate services (11) ▪ Attorney not providing information (1) ▪ Other: o Guardian ad Litem actions/inactions (2) o Interpreter not provided at court (1) o Guardian ad Litem conflict of interest (1) Court Related Concerns (19) ▪ Disagreement with court decisions (8) ▪ Other: o Family Court (3) o Judges actions (2) o One instance each of the following: Lack of understanding regarding court process, Interpreter not provided, Refused to release transcript, Change of court date not received, and Not producing/noticing an incarcerated parent Licensing Concerns (8) ▪ Foster home licensing concerns (1) ▪ Adoption home licensing concerns (5) ▪ Treatment foster home licensing concerns (2) Payment Related Issues (4) ▪ Lack of payment for care of a child (2) ▪ Other: o Kinship usage (1) o Licensing pay rate dispute (1) Other (24) ▪ Actions/Inactions of Milwaukee Public School (6) ▪ W-2 (2) ▪ Previously reviewed by the Ombudsman office (2) ▪ Inactions of Milwaukee Police Department (2) ▪ One instance each of the following: Law enforcement report inaccurate, Kinship process, Family Court, Use of federal money, Adult Services, Barriers to community supports, 10-year old BMCW case, Actions of child, Child's doctor not providing adequate services, Juvenile in Need of Protective Services (JIPS) not providing adequate services, Choice of psychiatric treatment, and CPS outside of Milwaukee County	**70**

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Appendix 8

Screening Criteria

The Ombudsman Office uses the set of criteria below to determine if a complaint is screened in or out. If all of the following criteria can be answered in the affirmative, then the complaint will be screened in:

1. The complaint is within the scope of issues the Ombudsman Office reviews.

   The Ombudsman Office does not review complaints regarding concerns about attorneys, court related decisions, licensing concerns, personnel related issues, or payment related issues.

2. The complaint involves a specific child and/or family involved with the Bureau (either currently or in the past 90 calendar days).

3. The issue(s) being complained about occurred within the past year (or has substantial impact on a current issue), or it is not clear at the time of the complaint when the issue(s) occurred.

4. The complaint appears to be within the jurisdiction and/or responsibility of the Bureau (safety, permanency, well-being).

5. The complaint appears to be within the power and authority of the state agencies and/or private agencies serving children and families through the Bureau to control or resolve.

6. The complainant appears to have direct substantive or procedural interest which is directly affected by the matter complained about.

7. Other-may include conflict of interest with the Ombudsman Office.

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Appendix 9

Complaint Issues Reviewed
Findings and Related Information

Findings Affirming the Actions of the Bureau (56)

Visitation (10)

- **Visitation with parent is not occurring-**A complainant reported that the father had been denied visitation with his son despite his desire to have visits with his son.
- **Lack of providing resources needed for extended visitation-**A complainant reported that the Bureau denied assistance for food resources needed for an extended visit.
- **Visitation should be unsupervised-**A complainant reported that at a Coordinated Service Team (CST) meeting, it was decided to initiate unsupervised visits but then two days later this decision was reversed without explanation and visits remained supervised.
- **Visitation should be unsupervised-**A complainant reported that the mother was cleared of alleged physical abuse allegations and consistently attended scheduled supervised appointments, but visits did not change back to unsupervised.
- **Visitation should not have been changed from being unsupervised to being supervised-**A complainant reported that the decision to change visitation from being unsupervised to being supervised was based on unsubstantiated allegations of maltreatment and as retaliation for the parent not providing consent to release confidential information regarding the child to a biased service provider.
- **Concern that the Bureau is canceling/suspending visits-**A complainant reported that half of the father's visits with his children had been canceled over the prior three months.
- **Visitation with the parent is not occurring-**A complainant reported that there was not a functioning visitation plan, resulting in the father not having a visit with his child in the past two weeks.
- **Visitation should be unsupervised-**A complainant reported that visitation with the mother was not progressing in relation to general case progress.
- **Visitation should be in-home to accommodate the medical needs of the mother-**A complainant reported that due to the mother's pregnancy resulting in a medical need, in-home visitation with her children should be provided.
- **Visitation with a parent is not taking place-**A complainant reported that six children were in foster care and were not having visitation with the mother, with no just cause provided.

Service Delivery (10)

- **Not addressing medical needs of a child-**A complainant reported that Bureau staff did not address the medical needs of a teen mother's pregnancy while she was placed at a group home.
- **Not addressing mental health needs of the parent-**A complainant reported that the mother had not been on medication for her mental health condition due to the Bureau not assisting with insurance barriers and access to services.
- **Not addressing the basic needs of a parent-**A complainant reported that the mother's basic needs were not addressed regarding income resources, health insurance resources, and energy assistance.
- **Not addressing the mental health needs of a child-**A complainant reported that the child was given medication not recommended for his age and without a diagnosis; in contrast to the child's psychological evaluation, visitation with the mother was suspended and therapy with the mother was not implemented.
- **Bureau Staff not addressing needs as requested-**A complainant reported that Bureau staff was not assisting with needs requested by the complainant for housing, transportation, mental health services, and recommendations for community resources to assist with child advocacy issues.
- **Service provider not addressing needs as requested-**A complainant reported that the service provider was not involved or assisting the complainant with locating housing.
- **Not addressing mental health needs of a parent/caregiver-**A complainant reported that the Bureau of Milwaukee Child Welfare did not address the mother's mental health needs or assist the mother with locating psychiatric services.
- **Not addressing needs as court ordered-**A complainant reported that the case manager did not implement services as outlined in the court order for reunification.
- **Conflict between recommendations of service provider and Bureau-**A complainant reported that mental health professionals reported that the mother did not need psychiatric medications but that Bureau staff continued to insist on the need for psychiatric medications.
- **Lack of timeliness of service delivery-**A complainant reported that family therapy involving the mother and children had not been implemented.

Placement (8)

- **Siblings are not placed together-**A complainant reported that two siblings continue to be placed in separate foster homes despite an opportunity to have them placed together.
- **Placement not being appropriately monitored-**A complainant reported that the children have been in and removed from four different placement providers due to issues of alleged maltreatment that lacked investigation.

- **Child's safety in the biological mother's home-**The Ombudsman Office was originally unable to make a finding due to unclear documentation of safety threats. After further review, this was modified to affirm the actions of the Bureau given the agreement of selected safety factors. But based on the lack of clarity highlighted in resolving this complaint, the Ombudsman Office found an additional concern.
- **Conduct of a caregiver-**A complainant reported that the father, who has placement of the child, did not meet the child's medical and educational needs or cooperate with the visitation plan.
- **Safety of a child's placement-**A complainant reported concerns with the child's safety with the relative caregiver due to the cohabitation of other relatives in the home with alleged mental health issues.
- **Disagreement with a change of placement-**A complainant reported that the maternal grandmother did not receive adequate assistance from the Bureau to sustain the placement of a child.
- **Disagreement with a change of placement-**A complainant reported that the child was removed from a placement without just cause and placed in a facility that is not appropriate for the child's age or special needs. Furthermore, the Bureau did not provide a reason as to why the child was moved.
- **The appropriateness of the level of care-**A complainant reported that the teen was placed in a group home in Milwaukee County after placement with a relative was disrupted. This was contrary to a prior agreement for the teen to be placed in a residential facility or in a placement outside of Milwaukee County as a strategy to meet the teen's special needs.

Case Planning (7)

- **Conditions for reunification-**A complainant reported that the Bureau has not provided the parent with a clear explanation of the case plan containing measurable goals to assess progress for reunification.
- **Regarding conditions for return of children-**A complainant reported that there were no clearly expressed safety threats, expectations of change, or measurable outcomes to reach reunification; that a TPR petition was filed despite the reported strong bonds between the children and the mother, the mother's completion of court conditions, and absence of identified safety concerns.
- **Case plan does not address a particular need-**A complainant reported that the schedule of services and appointments interferes with the mother's work hours needed to sustain the family's basic needs.
- **Concerns about conditions for return of children-**A complainant reported that domestic violence counseling is not a needed service and was recommended without a justified reason.
- **Conditions for return of children-**A complainant reported that the mother believes that she has cooperated with required services but there has not been progress for reunification. Additionally, the mother reportedly does not

- **Bureau staff not involving the father in case planning regarding reunification conditions and meeting the child's special needs-**A complainant reported that Bureau staff has not included the father in plans to address the child's special and long-term needs or in plans for reunification.

- **Case plan does not address a particular need-**A complainant reported that the mother is seven months pregnant but the Bureau has not addressed the unborn child's needs or assisted the mother to prevent the detainment of the child upon its birth.

Lack of Action by Bureau Staff (7)

- **Inadequate assistance from staff-**A complainant reported that Bureau staff is not assisting to obtain beds, furniture, and clothing for a teen mother.

- **Lack of follow-up on a report of child abuse or neglect on an open case-**A complainant reported that a contact to 220-SAFE regarding a concern of maltreatment was inappropriately screened out without an investigation. Additionally, 220-SAFE re-directed the reporter to contact the police.

- **Lack of contact with parent for consent for medical treatment-**A complainant reported that a child was prescribed medication where increases in the dosage were made without the mother's consent.

- **Lack of follow-up on a report of child abuse or neglect on an open case-**A complainant reported that Bureau staff did not follow up on maltreatment concerns reported by the complainant to the case manager.

- **Lack of follow-up on a report of child abuse or neglect-**A complainant reported that despite confirmation with the maltreater regarding the use of a belt that caused bruising to the child as a form of discipline practice, the Bureau took no further action.

- **Information withheld by staff-**A complainant reported that the mother requested a copy of the case plan which has not been provided.

- **Lack of action taken to control for safety-**A complainant reported that the alleged maltreater had access to the child at the time of the complaint and during the investigation which placed the child in danger.

Not Receiving Fair Treatment by Bureau Staff (4)

- **Retaliatory/threatening behavior by staff-**A complainant reported that Bureau staff threatened a teen mother with the removal her child from her care if she did not comply with Wraparound services.

- **Bias against the mother-**A complainant reported that a prior case manager demonstrated a trend of undermining case progress which continues to impact case progress; that the prior case manager disrupted plans for reunification, reversed visitation progress, reported inaccurate information to court, and

blamed the mother for the behavior of the father and maltreatment concerns raised by the mother.

- **Staff being rude and/or disrespectful, displaying unprofessional behavior-**A complainant reported that the case manager told the father that he would not get his children back unless he admitted to sexually abusing them.

- **Other-**A complainant reported that Bureau staff was disrespectful to her while following the Bureau's Complaint Resolution Process.

Bureau's Role With Taking A Child Into Protective Custody (3)

- **A child should have been taken into custody and was not-**A complainant reported that on or about a particular date a telephone referral of alleged maltreatment regarding observations of cuts on the child's arm/wrist was made to 220-SAFE but the child was not placed in protective custody.

- **A child should have been taken into custody and was not-**A complainant reported that in a particular month, a telephone referral of alleged maltreatment by the primary care provider who had threatened the child with a gun was made to 220-SAFE but the child was not placed in protective custody.

- **A child was taken into custody and should not have been-**A complainant reported that the child was taken into protective custody from the father without just cause.

Bureau Recommendations to the Court (3)

- **Inaccurate information provided to the court-**A complainant reported that the Bureau wrote untrue statements about the father which were presented to the court.

- **Inaccurate information provided to the court-**A complainant reported that the incoherent state of the mother, status of the mother's cognitive functioning, and the home lacking diapers and food was inaccurate information provided at the emergency detention hearing.

- **Inaccurate information provided to the court-**A complainant reported that the case manager provided inaccurate information to the court regarding the mother's follow-through with the medical and educational needs of the child.

Confidentiality (2)

- **Inappropriately releasing confidential information-**A complainant reported that confidential information about the child's placement and case progress was released to a non-relative without consent.

- **Inappropriately releasing confidential information-**A complainant reported that the mother's address information was not protected, allowing the child's father with known domestic violence issues to obtain the family's address.

Notification (1)

- **Not receiving proper notification regarding a change of placement-**A complainant reported that the mother did not receive appropriate notification regarding the change of a child's placement.

Other Within Scope (1)

- A complainant reported that the case manager instructed the child to blame the mother of alleged physical abuse that was reported to the Bureau of Milwaukee Child Welfare.

Findings of Violations (2)

1. Violation

Issue-Initial Assessment Process—lack of timeliness in beginning initial assessment-A complainant reported that a call to 220-SAFE was made regarding alleged physical abuse of a child and that the time it took for the Initial Assessment Social Worker to respond was not adequate to assess the alleged injuries or to ensure for the child's safety.

Findings-The Ombudsman Office review found a violation regarding Initial Assessment process issues—lack of timeliness in beginning initial assessment related to the *Child Protective Services Access and Initial Assessment Standards Chapter Seven: The Timeframe for Response and the Bureau Policy and Procedure IA 7.00: Initial Assessment and Safety Assessment* (formerly CM 06).

The Ombudsman Office found that a report of alleged physical abuse was made to the Bureau and screened in with a 48-hour response time. In the Child Protective Service Report the reporter indicated that visible marks were noted on the child. Two days later the reporter again called the Bureau with concerns that the injuries reported two days earlier would continue to fade and not be documented. Four days after the original referral, when the response time was identified as not being met, a coverage Initial Assessment Social Worker (IASW) was contacted and attempted to meet the children at school and contact the alleged maltreater. Initial Assessment staff clarified with the Ombudsman Office that the response time was not met due to the assigned IASW being involved in a detention process on a separate case and that pagers are not used on 48 hour response times, only with same day and 24 hour response times.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau review the current communication process regarding the notice and assignment of new cases to IASWs and explore methods of practice to support the IASWs meeting designated response times for face-to-face contact with children and families.

Bureau's Response-The Bureau is in agreement with the Ombudsman office finding of a violation, but noted that the violation occurred due to the assigned IASW's involvement with a detention process on another case.

The Bureau was in agreement to review the current communication process regarding the notice and assignment of new cases to IASWs and explore methods to support the IASWs meeting assigned times.

Status of Recommendation: The Ombudsman Office was unable to receive additional information on this recommendation.

2. Violation

Issue-Initial Assessment Process—lack of interviewing children-A complainant reported that the investigation of the allegation of maltreatment did not include the children's reports of what occurred, nor did it consider the alleged coercion used by the parent to keep the children from disclosing information about maltreatment.

Finding-The Ombudsman Office found a violation related to the *Child Protective Services Access and Initial Assessment Standards Chapter Seven: The Timeframe for Response* and the Bureau Policy and Procedure *IA 7.00: Initial Assessment and Safety Assessment (formerly CM 06)* regarding an allegation of physical abuse reported to the Bureau.

The Ombudsman Office initially reviewed the Bureau case record and interviewed the Initial Assessment Social Worker (IASW) and the Region Manager and found no evidence of contact or attempted contact with the children 10 days after the report was received. The Ombudsman Office was then directed to an Access case note six months afterward that identified that the IASW "made two attempts to meet the children at their schools within the time, two consecutive days" and that the IASW "was informed that the children were not in school during those attempts."

The Ombudsman Office was informed by the first child's public High School that there was no record of an IASW signing in on the visitor's log on the specified days in question. The Ombudsman Office was informed by the second child's public High School that the visitor's log for the past year was no longer available. Furthermore, the Ombudsman Office was provided with attendance information for the second child attending which stated that they were not absent or late on either of the days in question.

The Ombudsman Office interviewed the IASW assigned to the case and their Supervisor. At this interview, the IASW reported that they did make an attempt to visit the first child on either of two consecutive days, but was informed that the child was on a field trip. The IASW indicated in two separate responses that there was not an attempt to contact the second child on either of the two consecutive days and that the first attempt to contact the child was five days after the designated response time; there was no prior attempted contact for the second child.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau review the *Child Protective Services Access and Initial Assessment Standards Chapter Seven: The Timeframe for Response* and the Bureau Policy and Procedure *IA 7.00: Initial Assessment and Safety Assessment* (formerly CM 06) with all Initial Assessment staff and explore methods of practice to support the IASW's

meeting designated response times for face-to-face contact with children and families.

Bureau's Response-The Bureau disagreed with the Ombudsman Office finding of a violation. The Bureau agreed in part to the recommendation made by the Ombudsman Office in that the Service Manager reviewed with the IASW the Child Protective Services Access and Initial Assessment Standards and Bureau Policy and Procedure in regard to meeting designated response times, but did not indicate whether it would be reviewed with all Initial Assessment staff as recommended.

Status of Recommendation: Not applicable.

Findings of Additional Violations (6)

1. Additional Violation

Findings-The Ombudsman Office review found an additional violation regarding the lack of action by Bureau staff – lack of follow-up on a report of Child Abuse or Neglect on an open case. Based on the available information, the Ombudsman Office found that the actions of the Bureau were contrary to the *Child Protective Services Access and Initial Assessment Standards Chapter Seven: The Timeframe for Response* and the Bureau Policy and Procedure *IA 7.00: Initial Assessment and Safety Assessment* (formerly CM 06).

While gaining an understanding of safety concerns, the Ombudsman Office found that a referral was made regarding domestic violence and alleged alcohol issues. The referral was screened in with a five day response time. The next day and six days following the second call, additional referrals were made and screened out as multiple referrals; these included one account of the children witnessing domestic violence that resulted in injury to the mother. Three weeks after the last call that was screened out, a referral was screened in due to a restraining order preventing contact between father and the children. The children were detained due to the mental health condition of the mother and the absence of the father/protective care provider. Four days prior, ongoing staff conducted a home visit. The Ombudsman Office found no record of face-to-face contact or attempts to make face-to-face contact with the children or family between the date of the referral and the date of the home visit 3 ½ weeks later.

In an interview with ongoing staff, staff reported that the IASW was conducting the investigation. Ongoing staff could not relate information regarding the actions of the assigned Initial Assessment Social Worker to assess for the children's safety. In a telephone discussion with the assigned Initial Assessment Supervisor (IAS), the Ombudsman Office was informed that the IASW was no longer available. The IAS reported that they were not able to recall case details regarding the actions of the IASW to assess for the children's safety, including any contact or attempts at contact made by the IASW.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau review *Child Protective Services Access and Initial Assessment Standards Chapter Seven: The Timeframe for Response and* the Bureau Policy and

Procedure *IA 7.00: Initial Assessment and Safety Assessment (formerly CM 06)* with all Initial Assessment staff and explore methods of practice to support the IASWs meeting designated response times for face-to-face contact with children and families.

Bureau's Response-The Bureau is in agreement with the Ombudsman Office finding and responded that this recommendation was implemented in December of 2007 as part of the Milwaukee Child Welfare Safety Plan when all Initial Assessment (IA) staff were trained on state standards. A review of the IA program scheduled in late September 2008 will provide insight into how well the program is doing and will include a review of compliance with response times following a screened in report of child abuse/neglect. Should compliance issues be found in the review, Bureau will address them in additional staff training and monitoring.

Status of Recommendation: The Ombudsman Office was unable to receive additional information on this recommendation.

2. Additional Violation

Findings-The Ombudsman Office review found an additional violation regarding the father's mental health service provider not being invited to communicate and collaborate in the Coordinated Service Team, which is contrary to the Bureau Policy and Procedure *OCM 2.02: Standardized Protocol for Ongoing Case Management and Safety Services Coordinated Service Team (CST) Meetings*. The Ombudsman Office found that the OCM referred the father for mental heath services within the contracted agency's provider network. The father was working with the mental health service provider as recommended by Bureau staff. The mental health service provider was not invited to CST meetings, three of which were within the timeframe of the Ombudsman Office review. It was noted that the mental health service provider's involvement in other aspects of the case was subject to the mental health service provider's schedule.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau explore and implement methods to increase the involvement of service providers in the CST process with an emphasis on key professionals or individuals identified as critical related to their understanding of or involvement with changing the individual's diminished protective capacities, conditions impacting on child safety, and/or barriers of communication or cooperation that impact on case progress.

Bureau's Response-The Bureau acknowledged the finding and indicated that they would instruct supervisory staff to speak with the father's case manager regarding all service providers being invited to CST meetings consistent with the Bureau policy and procedure. The Bureau response did not address whether they would explore or implement systemic methods to increase the involvement of service providers in the CST process.

Status of Recommendation: The case manager was spoken to regarding inviting all service providers to the CST meetings. The Ombudsman Office was unable to receive any additional information on this recommendation.

3. Additional Violation

Findings-The Ombudsman Office review found an additional violation regarding documentation concerns – not updating records or entering case notes contrary to Bureau Policy and Procedure *OCM 34: Frequency and Documentation of Contact with Children, Families, & Caregivers.*

The Ombudsman Office conducted a review covering a seven month time span to determine the efforts made by ongoing staff to assist the parent with understanding the case plan and conditions for reunification. The Ombudsman Office found no case notes in the Bureau record regarding the use of a Coordinated Service Team (CST) meeting as a strategy to assist the family. In addition, the Ombudsman Office found no case notes within the Bureau record regarding court hearings that may have clarified the court conditions for reunification. In a meeting, ongoing staff acknowledged the observations of the Ombudsman Office that legal and CST case notes had not been entered at that time, but confirmed that the actions of conducting CSTs and attending court hearings were completed.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau ensure that, specific to this case, accurate legal and CST case notes are entered in the Bureau record.

Bureau's Response-The Bureau is in agreement with the Ombudsman Office finding and responded that the issue of timely documentation has been addressed with the case manager on this case and that the Bureau will continue to monitor compliance.

Status of Recommendation: The Ombudsman Office notes that the case record remains uncorrected.

4. Additional Violation

Finding-The Ombudsman Office found an additional violation of *OCM 34: Frequency and Documentation of Contacts with Children, Families and Caregivers*, regarding a lack of documentation in the Bureau record.

The Ombudsman Office determined that two events were not documented in the Bureau record. First, a meeting was scheduled to include security staff, the mother, the OCM and the Ongoing Supervisor but the mother did not appear. Second, a meeting was conducted with the mother, the OCM and the Ongoing Supervisor to review expectations of the mother in order to resume visitation and establish case progress goals for reunification. Neither event was documented in the Bureau record at the time of this review, approximately one month after the events occurred.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau review this specific case to ensure that documentation accurately reflects the Bureau's and the family's actions or inactions with an emphasis on the cited dates within the review; and

2. The Bureau explore possible changes to existing policy OCM 34 *Frequency and Documentation of Contacts with Children, Families and Caregivers*, to include missed contact attempts.

Bureau's Response-The Bureau indicated in their response that the Training Team supervisor of record during the timeframe cited in the review had completed a review of the case record documentation as the OCM in training who serviced the case is no longer with the agency. It was their opinion that the documentation is an accurate reflection of case occurrences during that timeframe. The Bureau stated their investment in having the case record reflect all of its efforts to engage with families including unsuccessful contact attempts, and will review OCM 34 and consider specific revisions directing procedure around documenting missed contacts.

Status of Recommendations: Bureau procedure OCM 34 was revised as of September 2008. The Ombudsman Office notes that the revised policy does not reflect the recommendation made, however the Bureau indicated that the Ombudsman Office recommendation remains under consideration. The case record remains uncorrected.

5. Additional Violation

Findings-The Ombudsman Office review found an additional violation regarding documentation practices contrary to the Bureau Policy and Procedure *IA 7.00: Initial Assessment and Safety Assessment* (formerly CM 06) in the documentation of contacts. The Ombudsman Office did not find case notes in the Bureau record at the time of the review regarding the coverage IASW's attempted contacts with the children or contact with the father.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau review the Bureau Policy and Procedure *IA 7.00: Initial Assessment and Safety Assessment* (formerly CM 06) with all Initial Assessment staff regarding contact documentation expectations related to case coverage responsibilities; and
2. The Bureau amend the case record of the case under review to reflect accurate contact information.

Bureau's Response-The Bureau disagreed with the finding of a violation, but agreed to the Ombudsman Office recommendations saying that Region Managers have reviewed Bureau's policy regarding contact documentation expectations related to case coverage responsibilities with staff and that the case record had been amended.

Status of Recommendation(s): The Ombudsman Office notes that the case record remains uncorrected.

6. Additional Violation

Findings- The Ombudsman Office found a violation of Bureau Policy and Procedure *IA 7.00: Initial Assessment and Safety Assessment (formerly CM 06)* regarding the documentation of contacts. The Ombudsman Office found in the Bureau record that

case notes from the attempted contact with the children did not accurately reflect the actions of the Bureau.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau review the Bureau Policy and Procedure *IA 7.00: Initial Assessment and Safety Assessment (formerly CM 06)* with all Initial Assessment staff regarding contact documentation expectations; and
2. The Bureau amend the case record of the case under review to reflect accurate contact information.

Bureau's Response-The Bureau did not agree with the finding, but agreed in part with the first Ombudsman Office recommendation in that the Service Manager reviewed with the IASW the Child Protective Services Access and Initial Assessment Standards and Bureau Policy and Procedure in regard to contact documentation expectations, but did not indicate whether a review with all Initial Assessment staff as recommended would occur. The Bureau also responded that the case record had been amended to reflect the accurate contact information.

Status of Recommendation(s): The Ombudsman Office notes that the case record remains uncorrected.

Findings of Concerns (6)

1. Concern

Issue: Placement—relative placement not sought-A complainant reported that the child remained in foster care for a month despite relatives being available for placement and that no explanation was made for not placing the child with relatives.

The Ombudsman Office review found no violations but did find a concern regarding three relative placement options that were not communicated at a case transfer meeting from Initial Assessment to Ongoing Services. The Ombudsman Office found that the child entered a non-relative treatment foster care placement. Six days later the IASW was provided with five relative placement considerations. One relative was ruled out due to a substantiated child protective service history, which also ruled out a second relative who lived in the same home. This decision was communicated to the first relative. The case was staffed and transferred to Ongoing Services the following day, but the other three relative placement options were not discussed in the case transfer meeting. Ongoing staff developed a plan to place the child with the father. The child was placed with the father. The Ombudsman Office acknowledges that two relatives were considered and ruled out within seven days, but the other three relatives identified were not considered during the 25 days the child was not placed with a relative.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau consider developing or expanding on an Initial Assessment to Ongoing Services case transfer form that emphasizes relative involvement and contact information.

Bureau's Response-The Bureau did acknowledge the finding and indicated in their response that they would interface with the Initial Assessment and Ongoing Case Management Programs to assure that the case transfer form appropriately cues staff to identify all relatives and provide all known contact information for both review in the case transfer staffing and use thereafter as they seek to place children in the homes of fit and willing relatives when continuing to reside in the home of their parent/legal guardian is not safe.

Status of Recommendation: Ombudsman Office was unable to receive additional information on this recommendation.

2. Concern

Issue: Placement—conduct of a caregiver-A complainant reported concerns that the relative caregiver ignored the expressed religious beliefs/instructions of the mother, was not cooperative with the visitation plan, and did not allow regular telephone contact between the mother and child.

Findings- The Ombudsman Office review found a concern regarding the continued placement recommendations at a court hearing. These recommendations appeared to communicate to the court an assumption that the placement had no issues impacting on the parent's preferred religious instruction of the child. The OCM had multiple discussions with the relative placement provider regarding the need to respect the parent's religious beliefs. The OCM took action to ensure that the parent's religious beliefs were followed at the child's school. In contrast to the concerns of the OCM regarding the care provider's actions, it was reported at a court hearing that the Bureau recommended placement with the relative care provider but did not extend reservations regarding the religious instruction provided to the child. At the hearing, the court noted its concern and made recommendations to resolve the issue, but the Bureau was not noted as identifying the concern.

In regards to the communication issue between the mother and the child, the mother was encouraged by Bureau staff to make telephone contact with the child at specific times, and this was again addressed in a hearing at Children's Court.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau review existing trainings and strategies used to provide information to the court and develop new strategies to support staff regarding the presentation of information to court as appropriate.

Bureau's Response-The Bureau was in agreement with the Ombudsman Office finding. The Bureau disagreed that the recommendation should be implemented Bureau-wide on the grounds that the concern is case specific and not systemic.

Status of Recommendations: Not applicable.

3. Concern

Issue: Not Receiving Fair Treatment by Bureau Staff—staff giving misinformation-A complainant reported that the Ongoing Case Manager (OCM) informed the mother that her parental rights for three of her children were terminated.

The Ombudsman Office found a concern regarding the OCM providing incorrect information and making inappropriate recommendations to the mother. The OCM indicated that she told the mother that she didn't need to attend the next court date because all her children were in Termination of Parental Rights status and just waiting for an adoptive resource, and she would not have counsel if she attended. After the mother stated her desire to attend the court date the OCM said she would discuss it with her supervisor. The OCM is no longer with the Bureau and the Ongoing Supervisor reported being unaware of the OCM's actions. The Ongoing Supervisor met with the mother a month later and provided the correct information to the mother regarding the TPR process.

The Ombudsman Office concluded that, based on the documentation in the Bureau record and the inability to interview the prior OCM, the prior OCM did provide the mother with misinformation; if acted upon by the mother, this could have negatively impacted on her right to participate in and receive legal counsel for the TPR proceedings. The information and recommendation given were not within the domain of either case management or social work expertise and exceeded their defined role. The Ongoing Supervisor unknowingly intervened one month later and provided the correct information to the mother.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau review the mother's participation with Children's Court proceedings for any possible consequences of misinformation, specifically related to the mother's court attendance. Pending any identified issues: the Bureau notify the appropriate parties at Children's Court to ensure the record reflects the mother's appropriate status and right to participate in future proceedings; and
2. The Bureau have a systemic review of related training materials to ensure that boundaries of practices are defined to not only include the expectations of worker's roles and responsibilities but also the limitations and management skills needed to cooperatively work with other professionals having a defined expertise.

Bureau's Response-The Bureau's response indicated that a review of the Children's court docket sheet on this case was performed and that there were no court dates/scheduled hearings between the dates identified in the Ombudsman Office recommendation and that, both before and after the dates in question, the mother was present with her attorney at a court proceeding. The Bureau also agreed to coordinate a review of related training materials to the issues of practice boundaries through its Training Team Supervisors to ensure that staff have a clear understanding of the roles and responsibilities and areas of practice in which deference to other professionals with defined expertise is expected.

Status of Recommendations: Ombudsman Office was unable to receive additional information on this recommendation.

4. Concern

Issue: Lack of Action by Bureau staff—inadequate assistance from staff-A complainant reported that the mother requested a copy of the supervised visitation worker's progress notes, but that the request had not been addressed.

Findings-The Ombudsman Office found a concern regarding the Bureau Policy *OCM 35.00:Access to Client Records by Clients and Professionals* was not followed, in that the mother was denied access to her records from a service provider agency within the Bureau's contracted agency's service provider network. The Ombudsman Office noted that the case notes from the supervised visitation worker were read and used in decision-making regarding safety and as an evaluation of the mother's behavior and interaction with the children. The mother requested that the Bureau release case notes from the supervised visitation worker. The mother was directed by Bureau staff to obtain the case notes from the supervised visitation worker's agency as this was considered a third-party provider. At a later date, the mother reported to Bureau staff that the supervised visitation worker's agency denied her request for case notes, but the Bureau did not take action to assist the mother.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau review with all staff the practice implication of "empowerment" as related to a client's request to view or obtain a copy of treatment or case records;
2. The Bureau clarify in the Bureau Policy OCM 35.00 the role and responsibility of the Bureau worker in assisting and/or empowering clients to obtain third party release of information when the information is contained in the Bureau record and utilized in case planning or court reporting; and
3. The Bureau review possible actions to assist the mother identified in this complaint to gain access to requested records.

Bureau's Response-The Bureau's response acknowledged the Ombudsman finding and agreed to review Policy OCM 35.00 and add language clarifying policy regarding the Bureau's role and responsibility in assisting clients in obtaining access to third-party work products (i.e., evaluations and service provider documentation). The Bureau further agreed to assist the mother in obtaining the requested records through contact with the provider to ascertain their policy and procedure for client access to records and communicating that information to the mother. The Bureau indicated that if the mother needed further assistance they would provide her with such assistance/advocacy to gain access to the records.

Status of Recommendations: The Ombudsman Office was unable to receive additional information on this recommendation.

5. Concern

Issue: Service Delivery—not providing services-A complainant reported a concern that services to meet the child's needs were not being provided.

Findings-The Ombudsman Office review found, after multiple discussions with the Bureau, a concern regarding the strategy in case planning which includes the actions

of the Bureau to address the child's AODA, mental health, and education needs as specified in Bureau Policy *OCM 2.00: Case Management Responsibilities by Ongoing Services* and *OCM 2.02: Standardized Protocol for Ongoing Case Management and Safety Services Coordinated Service Team (CST) Meetings*. These were inconsistent among participants and lacked application.

The Bureau was able to clarify that the child's cooperation with services was severely limited, and that the priority in case planning was identified as placement stabilization. The Ombudsman Office was informed by Wraparound staff in an interview that the case plan strategy was that, through the success of addressing the child's employment and education needs, other aspects of the child's case plan would be impacted and that placement choices were made by Bureau staff independently. Wraparound staff reported that no interventions regarding the child's AODA issue were made in 2007 but that AODA issues were previously identified as a concern at the onset of Wraparound services on the case.

The Ombudsman Office review found that the strategy in case planning had decision-making and practice implementation limitations:

- In the consideration of the available professional assessments or recommendations, expressed concerns voiced by vested case participants and historical case information containing patterns of unsuccessful interventions; and
- In establishing uniformity regarding a strategy to achieve case goals within the application of Wraparound services.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau consider staffing the case to discuss possible strategies to address the youth's alleged AODA concerns and discharge planning given that the case is scheduled to close;
2. The Bureau review training opportunities for staff regarding the engagement of challenging youth and implement additional opportunities as appropriate; and
3. The Bureau review with staff and supervisors the CST process with an emphasis on goal development and service provider roles and responsibilities.

Bureau's response-The Bureau disagreed with the finding of a concern. The Bureau did agree with the first recommendation and shared a plan to "meet with the family to discuss discharge planning taking into account all unresolved issues." The Bureau also agreed with the second recommendation stressing that skill development to engage youth is an ongoing practice which also includes utilizing Wraparound services as an intensive strategy. The Bureau also agreed with the third recommendation, but no specific actions or plans were reported.

Status of Recommendations: Ombudsman Office was unable to receive additional information on this recommendation.

6. Concern

Issue: Notification—not receiving proper notification regarding a change of placement-A complainant reported that the child was removed from a group home on a Friday and Bureau staff did not provide the mother with a notice of the change of placement until the following Tuesday.

The Ombudsman Office found a concern regarding an absence of direction in Bureau Policy and Procedure *OCM 26.00 Notification of Change in a Child's Placement* as it relates to pre-dispositional cases and the timely action of the Bureau to inform the mother of a planned change of placement.

The Ombudsman Office found that the child was placed at a group home as an "assessment/over-flow" placement which was planned to end in 14 days (the day prior to the actual change of placement). Bureau staff additionally determined that there was a conflict of interest at the placement. Bureau staff further assessed a concern that the alleged maltreater may have had access to the child. Bureau staff informed the mother of the change of placement one day after the change of placement happened. Bureau staff had contact with the mother on three separate occasions prior to the change, but did not communicate the planned change of placement to the mother. Additionally, the Ombudsman Office found that at the time of the change of placement, the case had not reached disposition. The pre-dispositional status of the case would not require the Bureau to provide the mother with a formal notice of a change of placement as presented in the Bureau policy and procedure OCM 26.00 or Wis. Stat. section 48.357 of the Children's Code.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau consider expanding Bureau policy and procedure *OCM 26.00: Notification of Change in a Child's Placement* to address change of placement notification issues involving pre-dispositional cases; and
2. The Bureau consider communicating to all Bureau workers a best practice model of informing the parent of a pending change of placement.

Bureau's Response-The Bureau's response acknowledged the Ombudsman Office finding that because the case was pre-dispositional, there was no requirement for a formal notice of change in placement, but did agree that the mother should have been notified of the placement change prior to the move. The Bureau agreed to review the Bureau procedure OCM 26 to address change of placement notification issues involving pre-dispositional cases and make revisions as needed. The Bureau also agreed to inform all Bureau workers of best practice regarding notification of parents when children are changing placements.

Status of Recommendations: The Bureau indicated that under the new Comprehensive Assessment Process model, they will be examining procedures for pre-disposition.

Findings of Additional Concerns (10)

1. Additional Concern

Findings- The Ombudsman Office review found an additional concern regarding the Bureau record – documentation lacks specific content of communications contrary to Bureau Policy and Procedure *OCM 34: Frequency and Documentation of Contact with Children, Families, & Caregivers*.

The Ombudsman Office found that the actions of the IASW were consistent with the Child Protective Services Access and Initial Assessment Standards regarding the information obtained in the assessment process, but the information was not included in the content of the documented contacts. In the Ombudsman Office interview with Bureau staff, it was reported that the IASW was informed by the mother of her intentions to obtain services to address the behaviors of the child. The mother also indicated she would obtain additional supports to address added parental stress and the added demands on her parenting roles. Additionally, in the Ombudsman Office interview with Bureau staff, it was reported that information that was obtained through collateral contacts with police and school personnel was used in understanding the frequency of the parent's use of physical discipline. The Ombudsman Office found no documentation in the Bureau record that identified the parent's plan to obtain community services or of the content of discussions with collateral contacts regarding the frequency of physical discipline used.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau ensure an addendum case note is entered into the Bureau case record to include information obtained in the assessment process regarding the frequency of physical discipline used and the parent's intentions to access community supports; and
2. The Bureau policy *IA 40.01/OCM 34.00: Frequency and Documentation of Contacts with Children, Families and Caregivers* is amended to include the requirement that staff document the specific content of communications **as previously recommended by the OMOCW in multiple prior reviews**.

Bureau's Response-The Bureau did not acknowledge the finding of a concern, but agreed with both recommendations. The first recommendation had been agreed to at the time of the interview with the IASW and the Region Manger. In response to the second recommendation, the Bureau noted that Bureau policy *OCM 34: Frequency and Documentation of Contacts with Children, Families and Caregivers* had been updated and is available in the online Bureau procedure manual.

Status of Recommendations: The Bureau Policy *OCM 34* was revised in September 2008. However the recommendation made by the Ombudsman Office is not reflected in the revised policy. The Ombudsman Office notes that this online manual is not currently available outside of the State Intranet and is therefore only readily available to state workers. The Ombudsman Office is looking forward to the implementation of the web based version to be completed in 2009. The Ombudsman Office also notes that the case record remains uncorrected.

2. Additional Concern

Findings-The Ombudsman Office review found an additional concern regarding the Bureau record – documentation lacks clarity in defining current conditions of the family as required in Bureau policy *OCM 2.00: Case Management Responsibility by Ongoing Services and OCM 30.00: Case Evaluation*. The Case Progress Evaluation (CPE) directly copies information from two prior CPE's without updating the information. The lack of a reference date suggests that the mother's whereabouts were unknown and that a mental health assessment was pending. Based on the case notes, contact with the mother was established and a psychological evaluation was completed.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau remind supervisors of their responsibility to review details of the case record, ensuring that all documentation is thorough and accurate. **This recommendation has been cited in two prior reviews conducted in 2007**; and
2. The Bureau review with all staff the Bureau Policy *OCM 2.00: Case Management Responsibilities by Ongoing Services*, stressing that all documentation in the case record and eWiSACWIS must reflect the current status of the case. **This recommendation has been cited in prior reviews conducted in 2006 and 2007.**

Bureau's Response-The Bureau is in agreement with the Ombudsman Office findings and its recommendations. The Bureau responded that in 2007 they undertook supervisory training and provided technical assistance to supervisors, they also stated that monitoring by program evaluation managers and various reviews have examined the timeliness and quality documentation. The Bureau said they will continue to work on improving this essential part of practice.

Status of Recommendations: The Bureau indicated that Bureau policy OCM 2.00 was reviewed with all staff in December 2008.

3. Additional Concern

Findings-The Ombudsman Office review found an additional concern regarding the Bureau record – documentation lacks clarity in defining current conditions of the family in that documentation of identified safety threats does not meet *Child Protective Services Safety Intervention Standards, Chapter Five: Safety Information and Safety Assessment, Analysis and Plan* where the "safety plan must describe in detail the specific impending danger threats." The Ombudsman Office review also found that narratives within documents contained in the Bureau record lacked current information reflecting the condition of the family.

In a letter to the Ombudsman Office from the Bureau, the Bureau stated that the Case Progress Evaluation (CPE) had "updated information regarding child's progress in each document." While the presence of updated information can be agreed upon, the lack of a qualifying date of the progress creates misinformation within the document. As noted previously, the CPE reported that AODA services were provided "last year." Without a qualifying date of the statement the report leads

an unclear interpretation of the time when AODA services were provided. The time of services provided would depend on the interpreted time of the statement, the date of the first CPE containing the reference (Date 1), the date of the current CPE (Date 2: 1 year and 2 months later), or a date referenced in the same paragraph when a placement with the mother started (Date 3: 6 months after Date 1).

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau review with all staff and supervisors the *Child Protective Services Safety Intervention Standards, Chapter Five: Safety Information and Safety Assessment, Analysis and Plan*, specifically key definitions of impending dangers, safety threats, threshold criteria and their impact on safety planning; and
2. The Bureau review with staff and supervisors the Bureau policy and procedure [*OCM 2.00: Case Management Responsibility by Ongoing Services*] regarding their respective roles and responsibilities for maintaining current information in the Bureau record to accurately reflect the conditions of the family.

Bureau's Response-The Bureau disagreed with the finding of a concern, but agreed to the Ombudsman Office recommendations.

Status of Recommendations: Ombudsman Office was unable to receive additional information on this recommendation.

4. Additional Concern

Findings-The Ombudsman Office review found an additional concern regarding the actions of the Bureau to address a violation found by the Ombudsman Office. The Ombudsman Office reported a violation finding to the Bureau regarding the lack of attempted contact with a child within the designated response time. The Bureau responded with alternative information on two separate occasions that indicated that contacts were attempted for both children at their respective schools on two separate dates. In an interview with Bureau staff, it was clarified by the IASW that the attempted contact was made on one date and involved only one child at their school. Bureau staff reported in the interview that in efforts to correct the documentation error an inaccurate Access case note was entered prior to clarifying with the IASW of the events in question due to the IASW being on a medical leave.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau set a standard to address how correction or clarifying case notes are entered in the Bureau record to include considerations of supervisory directives and for identifying the responsibility of who enters the case note based on their participation in or connection to the event in question.

Bureau's Response-The Bureau did not acknowledge the finding, but agreed in part to the recommendation in that they indicated that the Region Manager will remind the Service Manager and IASW of current practice standards.

Status of Recommendation: Not applicable.

5. Additional Concern

Findings-The Ombudsman Office review found an additional concern regarding the Bureau providing accurate information to the Court. The Ombudsman Office acknowledges the challenges of providing information at court hearings and the increased difficulties under direct examination, cross-examinations and redirect examinations.

The Ombudsman Office found that the Bureau recommended the continued placement with the father to the court. The Bureau reported the improved efforts of the father related to the child's education needs and increased ability to care for the child. The Bureau did not include concerns related to the father's limited income support, the child's living arrangements, or the lack of a bed for the child. The Ombudsman Office viewed the recommendation to the court as communicating an assumption of the placement being free of concerns and not offering a clear understanding of the family's condition that may impact on court decisions or directives.

Similarly, the Ombudsman Office found that the Bureau reported concerns to the court regarding the father's behavior when participating in unsupervised visitations. However, the Bureau modified the father's visitation plan three months prior to supervised, but did not report this change to the court prior to the court ordered continuance of unsupervised visitation. Other parties reported on the seriousness of the father's behaviors but no direction was taken to link the behaviors of the father, the lack of cooperation with AODA services, the visitation plan, and the unclear knowledge of his living arrangements with the accessibility to the child in the paternal relative care provider's home.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau specify, in the change of placement petition and/or pending hearing, not only the identified reasons to place the children with the mother, but that it also clarify to the court the concerns regarding the respective placements of the children as identified by Bureau staff and based on the Bureau record.

Bureau's Response-The Bureau is in agreement with the Ombudsman Office finding and agreed with the recommendation, but only as it applies to this case and not as a system-wide recommendation.

Status of Recommendations: Ombudsman Office was unable to receive additional information on this recommendation.

6. Additional Concern

Findings-The Ombudsman Office review found an additional concern that placement planning developed at a CST with mental health professionals, the family, and prior Bureau staff was not transferred to the current OCM or their Supervisor.

Ombudsman Office Recommendations - The Ombudsman Office recommended that the Bureau explore and develop as needed a system to monitor that, at the time of a case transfer, information in the Bureau record is updated by the appropriate

staff and reviewed in full by the staff receiving the case prior to or in conjunction with a case transfer meeting.

Bureau's Response-The Bureau indicated that the case transfer procedure was reviewed with the staff at the ongoing service contracted agency to ensure that all information is conveyed when a case is transferred from one case manager to another and that a case transfer checklist has been developed for use by staff.

Status of Recommendation: Not applicable.

7. Additional Concern

Findings-The Ombudsman Office review found an additional concern with regard to the *Child Protective Services Access and Initial Assessment Standards, Chapter 7: Timeframe for Response*, specifically as it related to the lack of action regarding continuing efforts to achieve an initial face-to-face contact with the child/victim and parent after receiving a referral of alleged maltreatment to assess for the safety of the children in question.

The Ombudsman Office found documentation in the Bureau case record that in response to the Child Protective Service Report the IASW attempted an initial face-to-face contact within the designated response time but that this contact was not successful. The Ombudsman Office found no documentation of any other attempts made by the Bureau to have face-to-face contact until 39 calendar days later. The Ombudsman Office found documentation that the IASW made this second attempt followed by an attempted telephone contact an additional 18 days later.

Two weeks after the attempted telephone contact a second referral was received and the IASW made another attempt to make face-to-face contact the same day, which was within the designated response time, but this contact was unsuccessful. Eight days later the IASW made an attempt to have face-to-face contact, and two days after that a referral was received and identified as a multiple referral on the same incident. Sixteen days after the last attempted contact, the IASW sent a certified letter. Face-to-face contact was not made until 109 calendar days after the initial referral. During that time, an additional two referrals were received, the IASW attempted four face-to-face contacts in total with notes left at the home, one telephone call, and one certified letter.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau review with staff existing policies and procedures regarding Initial Assessment and determine if further clarification is needed regarding expectations for establishing face-to-face contact and attempts to establish face-to-face contact; and
2. The Bureau review with staff and supervisors the expectations of re-attempting face-to-face contacts with critical case participants to evaluate child safety after receiving a referral of alleged child maltreatment in a timely fashion, implementing modifications to establish consistency as needed.

Bureau's Response-The Bureau acknowledged this finding and has taken actions to implement the two recommendations. In regard to the first recommendation, the Bureau has implemented comprehensive training for IA staff as part of the Milwaukee Child Welfare Safety Plan. The training reinforces that timely, face-to-face contact is necessary to ensure that child safety has been addressed.

In response to the second recommendation, the Bureau noted that the policy on *Procedures to Locate Families during the Initial Assessment* was updated in August of 2007. This policy identifies the process an IASW should initiate to contact a family when they are unable to determine that a child is safe and reinforces with the Region Managers a review of the existing policy and the use of the policy in day-to-day practice.

Status of Recommendations: The Bureau held an Initial Assessment Comprehensive Review in Fall 2008. The Ombudsman Office received no further information on the outcome of the review

8. Additional Concern

Findings-The Ombudsman Office review found an additional concern regarding a lack of policy on communication efforts between program areas.

On a Friday, Safety Services referred a failed safety plan to 220-SAFE, reporting the parent's refusal to cooperate. Safety Services identified two safety threats prior to and after the failed safety plan referral.

The following Wednesday, Initial Assessment concluded their initial assessment citing no safety threats. Some concerns were acknowledged, and other issues were dismissed based on the parent's denial of a concern. Initial Assessment noted that an agreement was reached between Initial Assessment and Safety Services to have the case return to Safety Services with a change in case managers.

The Ombudsman Office found no documentation of discussions between Safety Services and Initial Assessment to address the discrepancies between each program's findings with regard to safety threats. The Ombudsman Office found no sharing of information regarding the numerous observations made by Safety Services and the parent's condition and its impact on child safety, which appears to meet the threshold criteria as a safety threat.

Additionally, the Ombudsman Office found no discussion between Safety Services and Initial Assessment regarding discrepancies both in the parent's reported willingness to cooperate with services and in the parent's report of drug use. In efforts to understand the parent's willingness to cooperate with services, the Ombudsman Office found no discussion regarding a clear set of expectations of the parent or desired outcomes.

Ombudsman Office Recommendations-The Ombudsman Office recommended that:

1. The Bureau review its policies and procedures to determine if they are adequate with regard to how key topics are to be communicated and

documented clearly between program areas when re-referrals of maltreatment are made; and

2. The Bureau review with program staff expectations of communication standards between program areas on cases with joint involvement.

Bureau's Response-The Bureau agreed with the Ombudsman Office that documentation of the discussion between the two programs was inadequate and agreed with both recommendations. The Bureau stated that this issue was being addressed in the training of the IA and Safety Services staff under the implementation of the Milwaukee Child Welfare Safety Plan, as are the implementation of the two recommendations. The Bureau will forward copies of the revised procedures when they are completed.

Status of Recommendations: Ombudsman Office was unable to receive additional information on this recommendation.

9. Additional Concern

Findings-The Ombudsman Office review found an absence of policy in regard to addressing the misconduct or suspected misconduct of other mandated reporters working with children as it relates to Wis. Stat. section 48.981(2).

The Ombudsman Office found that a principal of a school was present prior to and during the incident of the mother's alleged physical abuse of the child. The principal's involvement appears questionable in two respects. First, the principal's conduct prior to and during the alleged physical abuse appears to demonstrate that the principal failed to take action to address the situation. Second, the principal's conduct after the alleged physical abuse reflects a failure to report the alleged physical abuse in accordance with the Children's Code, Wis. Stat. section 48.981(2), as a person having a reasonable cause to suspect child abuse. The IASW's Supervisor (the supervisor at the time of the incident was not available to participate in the review) reported that no known actions to address the principal's conduct were taken.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau consider developing a formal internal process to review and initiate actions to address misconduct or suspected misconduct of other professionals working with children.

Bureau's Response-The Bureau indicated in their response that while they recognized the concern of this issue, there was an uncertainty regarding the necessity of an internal process to resolve the issue of mandated reporters' failure to report. The Bureau indicated that it would seek advice from legal counsel on how best to handle this type of issue.

Status of Recommendations: Ombudsman Office was unable to receive additional information on this recommendation.

10. Additional Concern

Findings-The Ombudsman Office review found an additional concern regarding the IASW's contact at a Milwaukee Public High School. The IASW reported that contact

was attempted on either of two dates at the high school but was informed that the child was on a field trip. The high school reported that there is no record of an IASW visit in the school's visitor's log. While security at schools and access to confidential information of a student falls under the responsibility of the school, Bureau staff should be aware of their actions when entering a public school and the need to follow the school's procedure to allow the Bureau access to students, information and records. Bureau staff should be proactive in efforts to follow the procedure even if the school fails to take appropriate actions.

Ombudsman Office Recommendations-The Ombudsman Office recommended that the Bureau review with all staff the general protocols set by MPS for Bureau visitors when entering a school and how Bureau staff should address inconsistencies of MPS staff in following the protocol.

Bureau's Response-The Bureau did not acknowledge the finding, but agreed that having Bureau staff sign a visitor's log when visiting a school would provide another level of accountability and prevent any disagreement as to when contact was attempted and/or made. The Bureau indicated that the Region Manager will remind the Service Manager and the IASW involved in the case of this protocol and the importance for Bureau to notify schools to ask visitors to sign in.

Status of Recommendation: Not applicable.

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Appendix 10

2008 Communication Activities

Meetings Attended	Date
Community – 15	
▪ Brighter Futures Meeting – Attended	1/15/08
▪ Brighter Futures Meeting – Attended	3/18/08
▪ Milwaukee Child Abuse Prevention Services (MCAPS) Coalition, Public Policy Committee	6/9/08
▪ Brighter Futures Meeting – Attended	6/17/08
▪ MCAPS Network, Public Policy Committee	7/14/08
▪ Brighter Futures Meeting – Attended	7/15/08
▪ MCAPS Network, Public Policy Committee	9/8/08
▪ Brighter Futures Meeting – Attended	9/16/08
▪ BMCW Community Education Opportunity : Keeping Children Safe – Attended	9/18/08
▪ MCAPS Network – Public Policy Committee	10/13/08
▪ Brighter Futures Meeting – Attended	10/21/08
▪ Community Meeting: Sponsored by Senator Lena Taylor on the new structure of the Wisconsin Department of Children and Families (DCF) – Attended	10/22/08
▪ MCAPS Network, Public Policy Committee	11/10/08
▪ Brighter Futures Meeting – Attended	11/18/08
▪ MCAPS Network, Public Policy Committee	12/8/09
Policy – 6	
▪ Wisconsin Citizen Review Panel Feasibility	3/16/08
▪ Wisconsin Child Welfare Committee, Subcommittee Meeting	5/5/08
▪ Child Welfare Committee Leadership Team Meeting	10/21/08
▪ Child Welfare Committee Leadership Team Meeting	11/6/08
▪ Child Death Review Training	11/13/08
▪ Wisconsin Child Welfare Committee Meeting	11/17/08
State/BMCW/Contracted Private Agency – 11	
▪ Milwaukee Partnership Council Executive Committee Meeting	4/18/08
▪ Contract Administrator	6/4/08
▪ Semi-Annual Community Meeting on Child Welfare – Attended	9/10/08
▪ Milwaukee Partnership Council Executive Committee Meeting	9/19/08
▪ La Causa, CEO	9/22/08
▪ BMCW Leadership-Director, Deputy Director	9/22/08
▪ Children's Family Community Partnership (CFCP), CEO	10/1/08
▪ Contract Administrator	10/3/08
▪ Children's Service Society of Wisconsin (CSSW), CEO	10/10/08
▪ Milwaukee Partnership Council Executive Committee Meeting	10/17/08
▪ DCF Sec. Reggie Bicha and senior staff	10/20/08