Office of the
Milwaukee
Ombudsman
for Child Welfare

April 2010

To the Milwaukee County Community:

I am pleased to submit the 2009 Annual Report of the Office of the Milwaukee Ombudsman for Child Welfare (Ombudsman Office). This report is intended to complement other quality assurance and evaluation information to assess the delivery of child welfare in Milwaukee County.

Several organizational changes occurred in 2009. Late March brought a change to Region 3 when St. Amelian-Lakeside, Inc. was chosen by the Department of Children and Families (DCF) to provide ongoing case management and safety services for Region 3. This occurred after La Causa, one of the Bureau of Milwaukee Child Welfare's (Bureau) contracted partner agencies, exercised its option to terminate their contract. Integrated Family Services, a subsidiary of St. Amelian-Lakeside, was created to provide these services. In September 2009, the DCF announced they had hired a new Bureau director, Arlene Happach. The Ombudsman Office looks forward to her efforts to improve the child welfare system in Milwaukee.

The 2009 Annual Report provides an overview of the activities of the Ombudsman Office and our recommendations for systemic improvement from the perspective of those who depend on Bureau services. Based on the past year and previous years, the data suggests a need for improved communication, better comprehension of goals, accurate and timely documentation, quality supervision, as well as a need for an independent system perspective.

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 complaints. We continue to believe an independent Ombudsman established in state statute is the best way to provide this needed service to Milwaukee County's children and families.

Sincerely,

Pamela Matthews
Ombudsman Director

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Acknowledgements

We would like to thank the following individuals for their ongoing support 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 supporting quality services for children and families;

The Planning Council for Health and Human Services, Inc. Board of Directors for their continuing commitment to keeping kids safe in Foster Care;

The Partnership Council members for their feedback on the work of the Ombudsman Office that has led to improvements in transparency; and

The staff of the Ombudsman Office and Planning Council for Health and Human Services, Inc., for creating a safe, supportive environment where children and families involved with the Bureau of Milwaukee Child Welfare can receive independent assistance in a timely, efficient, and professional manner.

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Acronym Index

ABA	American Bar Association
ASFA	Adoption and Safe Families Act
Bureau	Bureau of Milwaukee Child Welfare
CHIPS	Child in Need of Protection or Services
CPC	Child Protection Center
CPE	Case Progress Evaluation
CPS	Child Protective Services
CRP	Complaint Resolution Process
CSSW	Children's Service Society of Wisconsin
CST	Coordinated Service Team
DCF	Department of Children and Families
DPC	Diminished Protective Capacity
eWiSACWIS	Wisconsin Statewide Automated Child Welfare Information System
FP	Foster Parent
FIP	Family Interaction Plan
IA	Initial Assessment
IASW	Initial Assessment Social Worker
LGBT	Lesbian, Gay, Bisexual, and Transgender
MPD	Milwaukee Police Department
OCM	Ongoing Case Manager
Ombudsman Office	Office of the Milwaukee Ombudsman for Child Welfare
PA	Parent Assistant
Partnership Council	Milwaukee Child Welfare Partnership Council
PDF	Portable Document Format (Adobe Acrobat file)
SS	Safety Services
SV	Supervised Visitation
TPR	Termination of Parental Rights
USOA	United States Ombudsman Association
UWM	University of Wisconsin, Milwaukee

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Executive Summary

The 2009 Annual Report is the fifth 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 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 following are some highlights of the 2009 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

In 2009, the Ombudsman Office received 148 complaints and completed 26 reviews. Based on these and observations from previous years, the Ombudsman Office has identified four areas that need further attention to increase the safety of children and improve the experience of families involved with the Bureau. The Ombudsman office believes that the child welfare system in Milwaukee would benefit from improving each of the following areas and makes these seven recommendations to assist in that effort:

- **Improved Communication**
  1. Develop methods for supervisors to monitor and promote their staff's ability to effectively manage communication with parents and between Bureau departments and service providers.

- **Better Comprehension of Goals**
  2. Ensure that all staff work together to develop comprehensive plans for families that connect identified diminished protective capacities to identified safety threats, articulate what specific behaviors must change and then work with parents to help them understand their behaviors in relation to these to remove threats to their children's safety.

  3. Train case management staff to prioritize who needs to be present when scheduling CST meetings based on what specific areas need to change. The attendance of professionals and supports who have an expertise with or an acute understanding of the associated diminished protective capacities identified should be prioritized.

- **Accurate and Timely Documentation**
  4. Identify and recognize Bureau staff with demonstrated, sound documentation skills and have them develop ongoing peer-led in-service training groups to increase staff's understanding and appreciation of quality documentation requirements.

  5. Consult with relevant legal parties to determine areas of documentation that are particularly critical or do not meet requirements and secure in-service training for Bureau staff to explain how the quality of documentation impacts the legal party's ability to effectively perform their job.

6. Explore methods for holding supervisors accountable for ensuring that their staff learn and develop documentation skills that reflect best practice.

- **Quality Supervision**
  7. Implement a process in which Program Managers perform random audits of reports that require supervisory approval to determine if they are clear and accurately reflect the current condition of the family.

The Ombudsman Office makes an additional recommendation in regard to assuring an independent system perspective of child welfare in the Looking Forward to 2010 section of the report.

Contacts for Services

Throughout 2009, the Ombudsman Office responded to a total of 264 contacts for services. Contacts to the Ombudsman Office are classified as either a complaint or contact for information and referral. The number of complaints decreased slightly (10%) compared to 2008 and contacts for information and referral were up 49% from 2008.

The Ombudsman Office received 148 complaints during 2009 covering a total of 418 issues and 116 contacts for information and referral. Twenty-one complaints were resubmissions.[1] Of the remaining 127 complaints, 109 (86%) were referred to the Bureau's complaint resolution process (CRP), the internal review method the Bureau uses for resolving complaints. In four complaints all issues were found to be outside the scope of Ombudsman Office after initial review.

Reviews: Findings and Recommendations

In 2009, the Ombudsman Office carried over nine reviews from 2008 and screened in and began reviews of 28 separate complaints containing a total of 79 complaint issues. Of these, 26 reviews were completed in 2009 covering 70 complaint issues.

Complaint issues can be multi-faceted resulting in more than one finding per complaint issue. In the 26 reviews completed in 2009, the Ombudsman Office made 80 findings on the original 70 complaint issues, as well as 11 additional findings.

- Bureau actions were affirmed 81% of the time (65/80)
- For the remaining 19%, the Ombudsman Office found:
  - 5 violations
  - 9 concerns
  - 1 inconclusive finding
- The Ombudsman Office found 11 additional findings:
  - 6 violations
  - 5 concerns

Based on the 26 reviews completed in 2009, the Ombudsman Office made 29 recommendations; of these,

- 52% (15/29) were systemic
  - 75% of these (12/15) involved reviewing existing standards, policies, or practices

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

    - 13% (2/15) related to areas lacking clarity in existing policies or practices
    - the remaining (1/15) addressed training
- 48% (14/29) were case-specific

It should be noted that one of the 12 recommendations about an existing practice also included a recommendation to address associated training needs.

Looking Forward to 2010

The Ombudsman Office supports continued independent efforts to support children and families served by the Bureau of Milwaukee Child Welfare. It further recommends the following areas of additional focus for the Ombudsman Office in 2010:

- Providing complainants with a neutral approach to complaint resolution; and
- Establishing an Ombudsman Office in Wisconsin Statute.

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2009 Annual Report

Introduction

The 2009 Office of the Milwaukee Ombudsman for Child Welfare (Ombudsman Office) Annual Report is the fifth annual report on the activities of the Ombudsman Office. The Ombudsman Office responded to 264 contacts resulting in 26 reviews being completed on 70 complaint issues. One in ten contacts (26/264) resulted in a completed review. This report examines the resolution of these contacts, as well as the nine reviews that carried over from 2008. Key issues for further consideration are also identified.

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 received in 2009. This includes overall observations and recommendations pertaining to key areas of practice stemming from all complaints received or reviewed. The report also contains information on contacts for information and referral. 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 Department of Children and Families to assess the delivery of child welfare services in Milwaukee County.

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 of Milwaukee Child Welfare (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

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 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.

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 to 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 to 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 2009 Ombudsman Office 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 2009 that resulted in the Intake Coordinator/Administrative Assistant position being staffed by more than one person. See Appendix 1 for biographical details on the 2009 Ombudsman Office staff.

Outreach

The Ombudsman Office's outreach efforts in 2009 continued to focus on informing individuals and organizations who work with families involved in the Bureau. In addition, the Ombudsman Office expanded its past efforts to include: 1) providing foster parent training in partnership with the UW-Milwaukee Training Partnership and 2) meeting with Bureau staff to review the kinds of complaints received and practice implications that resulted from completed reviews. The Ombudsman Director and staff:

- Made 25 community presentations to approximately 493 attendees about the role of the Ombudsman Office, accessing the services it provides, and how it can be a resource for their clients;

- Gave a total of nine presentations to approximately 138 new Bureau staff, 72 existing Foster Care Licensing staff, and 60 existing State staff about the role of the Ombudsman Office and the services it provides;
- Held three sessions on Complaints/Outcomes with approximately 155 Bureau staff;
- Participated in three resource fairs throughout the year; and
- Presented a quarterly or annual report at six Partnership Council meetings.

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 requests for information 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 classified as complaints go through a screening process to determine whether the issues meet the criteria for the Ombudsman Office to review and whether the Bureau Complaint Resolution Process (CRP) has been utilized. The Ombudsman Office encourages individuals to follow the Bureau CRP; however, exceptions may occur.

The timeline goal for processing a review from the first date of contact until final correspondence to the complainant is approximately 104 days. The Ombudsman Office reports on the status of the review to 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; and
- 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.

For complaints that were opened and closed in 2009 (18) the average length of time to complete the review was 110 days. See Table 1 for the process timeline goals.

Process Timeline Goals

- Screening Decision, 7 days
- Start of Review to Preliminary Findings, 60 days
- Preliminary Findings to Bureau Response, 7 days if all issues affirmed or 30 days if any findings of concern or violation
- Bureau Response to Sending Final Findings to the Complainant, 7 days

- Screening Decision
  - average completion time, 3 days
  - 93% screened within 7-day timeline goal (138/148)
- Start of Review to Preliminary Findings
  - average completion time, 71 days
  - 39% completed within 60-day timeline goal (7/18)
  - 61% over the 60-day timeline goal (11/18)
    - 8 were completed within 73 days
    - 2 were due to delays in court transcript requests; and
    - the remaining review had nine complaint issues that involved multiple departments, interviews took longer than anticipated to arrange, and delayed receipt of court transcripts
- Preliminary Findings to Bureau Final Response
  - For reviews with 30 response time (9/18)
    - 56% of Bureau responses received within 30 days (5/9)
    - average response received within 45 days (1 review took 164 days)
  - For reviews with 7-day response time (9/18)
    - 22% of Bureau responses received within 7 days (2/9)
    - Average response received within 14 days
- Bureau Response to Sending Final Findings to Complainant
  - 61% completed within the 7-day timeline goal (11/18)
    - 17% (3/18) went out on day 8 due to a misunderstanding of calculating the 7-day timeline goal, and
    - 11% (2/18) went out on day 9
  - average completion time, 3 days

See Appendix 3: Process Overview and Appendix 4: Processing Guidelines for an illustration of the work flow of the Ombudsman Office and additional detail.

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Areas for Improvement and Recommendations

This section addresses key areas of concern identified by the Ombudsman Office and presents recommendations to assist with improving them. The issues were identified in specific reviews, an overview of all contacts made with the Ombudsman Office in 2009, as well as contacts and reviews from prior years.

While the Bureau has addressed some issues raised in the 2008 Annual Report that look promising, the Ombudsman Office identified four areas as particularly relevant to the public's interest and critical to ongoing improvement of Milwaukee's child welfare system. The Ombudsman Office used similar categories in 2009 to those identified in its 2008 Annual Report for comparison purposes. The four areas identified in 2008 were Communication, Goals, Documentation, and Supervision. A new area identified in 2009 was System Perspective. Each of these is an essential element within the practice of child welfare.

1. **Improved Communication**

   Communication is fundamental to assisting children and families and continues to be at the core of most complaints. Breakdown in communication is most often seen between the Bureau and its clients, but it also continues to be a problem within and between Bureau departments, service providers, and other CPS agencies.

   When communication breaks down everyone suffers. Parents are denied their right to make certain decisions regarding the care of their children, Bureau staff do not have information they need for informed decision-making, and children's safety can be threatened.

   For example, in one specific review, a foster parent took a child to the Child Protection Center (CPC) for a health assessment and was directed by CPC staff to take the child to get follow-up care with a primary care physician. Bureau policy directs staff to "seek parents consent and assistance with the medical treatment process." However, the case manager did not receive the CPC report for several weeks and was unable to consult with the parents prior to the foster parent taking the child to receive the follow-up care.

   In another review, the Bureau was informed of impending danger threats to child safety by parents located in another state to which the child would be returning. However, the information regarding current safety concerns was not coordinated nor exchanged with the CPS agency in the other state.

   Violations and concerns relating to communication issues around medical information were found in two reviews completed in 2009. The Ombudsman Office recognizes that the Bureau is making efforts to improve medical-related issues and continuity of health care for children. These initiatives are welcome, but will not replace the need for staff to improve communication with parents.

   In three reviews, the Ombudsman Office noted a failure to use Coordinated Service Team (CST) meetings as required. In one particular review, Bureau staff

undermined the efforts of a parent by rescinding an invitation a parent made to a service provider to attend a meeting to discuss a communication concern. This action further eroded the Ongoing Case Manager's (OCM) ability to work in partnership with this family.

The Bureau must improve how it communicates to better serve children and families. Therefore, the Ombudsman Office recommends that the Bureau:

Recommendation #1: Develop methods for supervisors to monitor and promote their staff's ability to manage communication with parents and between Bureau departments and service providers.

2. Better Comprehension of Goals

A majority of complainants that contact the Ombudsman Office are parents who have comprehension barriers related to limited experience and/or ability to comprehend why their children are unsafe. These parents require more assistance to understand their case plan and to make the necessary connections between their identified diminished protective capacities (DPC) and what needs to change. For these parents, it is essential to develop and implement a "comprehension plan" that identifies and acknowledges that these barriers make it difficult for parents to fully comprehend what they are being told and/or what is expected from them for reunification to occur.

For too many parents, the lack of this kind of comprehension plan compromises all other planning efforts. The Bureau has three types of plans to control for child safety: a family interaction plan to assure the least restrictive environment for children to see their parents; a change plan for parents to follow to achieve reunification; and a permanency plan if other long-term living arrangements are in the children's best interests. The best laid plans will not bear fruit if their purpose, particularly the change plan, is not adequately understood by parents with comprehension barriers.

In 2009, the Ombudsman Office found noticeable improvement in Bureau reports regarding the clearer identification of diminished protective capacities and measurable goals in the reviews it conducted. However, continued efforts for improvement are needed in moving goal development from abstract terms to concrete terms. A parent who does not know what it means to parent their child will have difficulty understanding a goal that requires them to increase their parenting skills. Making an abstract goal more concrete is critical for parents with comprehension barriers if reunification with their children is to occur.

In one review, goals lacked descriptions of intended change in the client's behavior that impacted on child safety in measurable terms. The parent was given the following abstract goal for participating in mental health services: "[the parent] will consistently meet with [their] therapist to resolve issues of anger and Depression [sic] the [the parent] suffers from." Another abstract goal was for visitation: "[the parent] will consistently show up for [their] visits and demonstrate the skills that [they] learned from [their] parent aid [sic]." The Ombudsman Office found no mention of skills, goals, or expected progress to direct the Parent Aide in providing intended service to the parent. Without concrete examples of

expected change, abstract goals can set the parent and service provider up for failure.

In a majority of complaints made to the Ombudsman Office, complainants indicated that no one had explained why their children were removed or what they needed to do for them to come home. Many said that they had not talked with their case manager about this nor did they have a written copy of their case plan that described their DPCs and the services implemented to address them. After spending some time discussing their complaint, it appeared that it was likely that the parent had a comprehension barrier that prevented them from fully grasping their situation.

The same comprehension barriers that compromise a parent's lack of understanding often contribute to negative behaviors that further erode a productive relationship with Bureau staff. In one particular review, the lack of a plan to ensure comprehension led to a series of events that may have been avoided. The poor communication over a period of time on the part of both the parent and multiple Bureau staff contributed to the parent's heightened mistrust of the Bureau that, in part, manifested itself in negative behaviors. Bureau staff's poor communication and/or lack of effort to work in partnership with this parent helped to create an adversarial relationship that was counter-productive. After Bureau staff adjusted their perception of the parent and worked to build a relationship, the situation improved and the children were able to be safely reunified with the parent.

Bureau staff need to take into consideration a parent's limited abilities and/or comprehension barriers when explaining diminished protective capacities and developing change goals. Successful planning that is understood by all parties involved is at the heart of assuring successful child welfare practice. Without a clear plan to assure parent comprehension, reunification takes longer, and permanency for children and families is put at risk. Therefore, the Ombudsman Office recommends that:

Recommendation #2: Ensure that all staff work with the relevant parties, including legal participants engaged in the decision making process, service professionals with expertise in their field, and families themselves to develop "comprehension plans." These plans should be designed to balance safety, visitation, permanency, and change planning to support a measurable connection between identified safety threats and assessed diminished protective capacities. In addition, the plans should clearly and concretely articulate what specific behaviors/conditions must change.

Recommendation #3: Train case management staff to prioritize who needs to be present when scheduling CST meetings based on what specific areas need to change. The attendance of professionals and supports who have an expertise with or an acute understanding of the associated diminished protective capacities identified should be prioritized.

3. Accurate and Timely Documentation

For the fourth year in a row, the Ombudsman Office identified the lack of accurate documentation as a problem area. This remains a frequent area of weakness within the Bureau staff's practice of child welfare, and little improvement was noticed in 2009 over previous years.

In the reviews it conducted in 2009, the Ombudsman Office found documentation that was lacking in accuracy and/or timeliness in approximately 69% (18/26) of completed reviews. Accurate and timely documentation provide a factual account of past efforts to other parties involved. When others do not have an accurate picture, it hinders informed decision-making and ultimately impacts children and families.

In one review, Bureau staff did not document a majority of alleged efforts to contact a family over approximately eight months. While staff indicated that they had made contacts with the family, they could not recall specific details and, without documentation, were unable to refer to it to refresh their memory. If this were a case moving towards a termination of parental rights, the lack of documentation could put the ability of the District Attorney's office to make a case for terminating the parent's rights in jeopardy.

In another review, the most recent Family Interaction Plan (FIP) was outdated and did not reflect multiple changes that had occurred with the visitation plan. These included changing the "least restrictive location" from in-home to a center, no longer providing door-to-door services for the mother, requiring the mother to call two hours prior to visits, and detaining another of the mother's children. A Family Interaction Report is meant to assist the OCM and to facilitate communication with parents in visitation planning efforts and is supposed to be updated whenever changes in visitation occur. In this case, the FIP had not been updated in over a year.

In a different review, Case Progress Evaluations (CPE) contained generalizations and did not reflect accurate conditions of the family over time. A new CPE is required every three months and is designed to communicate to the court and relevant parties the current condition of the family. The generalizations lacked specific examples of one parent's efforts that demonstrated their progress towards addressing their identified DPCs. Information that was contained in the CPE appeared to be copied from previous documents and had the potential to lead a reader to inaccurate conclusions of case progress.

It is not possible or desirable for staff to document every effort. However, it is important that the Bureau's records provide an accurate portrayal of each family over which it has jurisdiction. Over the past five years there has been a wide range of documenting styles observed in a variety of case notes reviewed. The majority lacked accuracy, timeliness, or both. Over the same time period, some reports stood out for being clear and relevant. Proper documentation is a skill that can be learned and is practiced by some Bureau staff. Therefore, the Ombudsman Office recommends that the Bureau:

Recommendation #4: Identify and recognize Bureau staff with demonstrated, sound documentation skills and have them develop ongoing peer-led in-service

training groups to increase staff's understanding and appreciation of quality documentation requirements.

Recommendation #5: Consult with relevant legal parties to determine areas of documentation that are particularly critical or do not meet requirements and secure in-service training for Bureau staff to explain how the quality of documentation impacts the legal party's ability to effectively perform their job.

Recommendation #6: Explore methods for holding supervisors accountable for ensuring that their staff learn and develop documentation skills that reflect best practice.

4. Quality Supervision

The analysis of complaint data continued to indicate that quality supervision of front line staff remained an area for improvement in 2009. The Ombudsman Office found that in reviews where an adverse finding was made, approximately one-half required some level of supervisory or management involvement. As mentioned in 2008, quality supervision of staff is a critical component of good child welfare practice and is necessary to keep children safe.

In one review, the disclosure of the foster parent's phone number to a grandparent occurred despite a court directive that the placement of the child be undisclosed. Placement information is not kept from parents unless the court determines that the safety of a child may be in jeopardy. While foster parents are expected to work in partnership with birth families, there appeared to be no discussion between the OCM and the foster parent or between the OCM and their supervisor regarding why disclosure of the phone number could have compromised the child's undisclosed placement and jeopardized child safety.

Within another review, there were two occurrences where the Initial Assessment-Primary reports were not completed on time. In one instance, the report was past due by one month and in the second, the report was two months overdue. In this same review, staff had not made adequate efforts to meet designated response times to address multiple Child Protective Services (CPS) reports and the alleged actions by Bureau staff were not documented.

When supervisors do not provide appropriate oversight, inaction by front line staff goes unnoticed, putting children at risk. Staff may also be put at risk by failing to learn to properly manage their work load and adhere to relevant policies, procedures, and state statutes that govern good child welfare practice.

In January 2010, the Bureau implemented a new tracking system designed to mitigate instances where staff are not meeting designated face-to-face contact requirements. This initiative shows promise, and the Ombudsman Office looks forward to seeing improvement in this area. However, this new initiative will not address situations where supervisors need to step in and provide direction to staff who are not meeting other Bureau requirements or expectations. Therefore, the Ombudsman Office recommends that the Bureau:

Recommendation #7: Implement a process in which Program Managers perform random audits of reports that require supervisory approval to determine if they are timely and accurately reflect the current condition of the family.

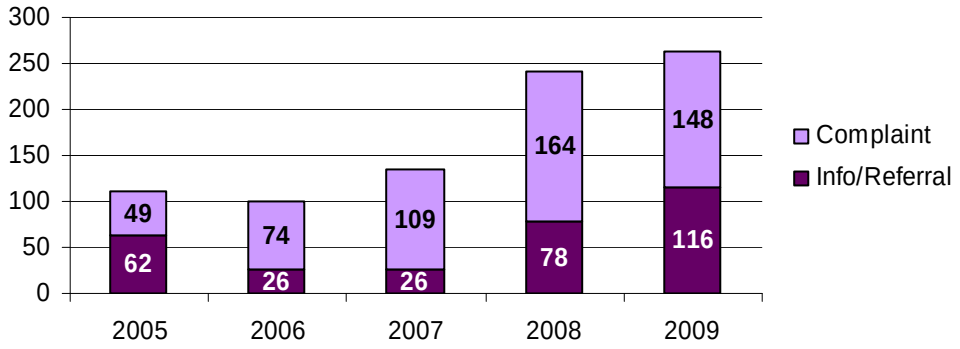
Contact Information for 2009

Contacts

Throughout 2009, the Ombudsman Office responded to a total of 264 contacts for services. Contacts for information and referrals continue to increase and were up 49% from 2008 as shown in Figure 1. Contacts by phone (243) continue to be the most frequent method of contacting the Ombudsman Office. The Ombudsman office also responded to walk-in (11), e-mail (8), and fax (2) contacts.

Figure 1

Annual Contacts to the Ombudsman Office



Of the 264 contacts for services, 148 (56%) were complaints and 116 (44%) were for information and referral. Of those requesting information and referral:

- 48% (56/116) requested and were provided general information about the Bureau
- 25% (29/116) requested legal advice and were referred to legal services in the community
- 14% (16/116) pertained to safety issues and were referred to 220-SAFE[2]

Complete information on all 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 2009 came from persons who had had previous contact with the

[2] As mandated reporters, depending on the circumstances, the Ombudsman Office may also call 20-SAFE

office (23%), followed by Bureau or Agency staff (16%), Unknown (9%), and Resubmissions (8%). See Appendix 6 for a complete list of referral sources.

Although their ranking is slightly different, the top ten referral sources were the same in 2009 as they were in 2008. Similarly, nine of these referral sources were also in the top ten in 2007 and in 2006. However, in 2007 the Department of Health and Family Services (currently, DCF) was one of the top ten referral sources, and in 2006, Public Officials made the list.

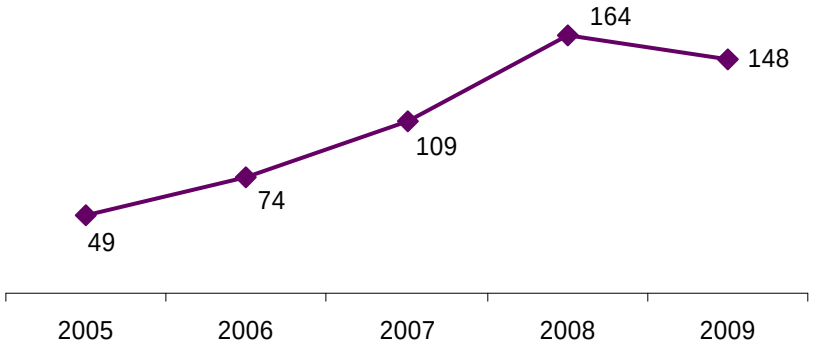
Complaint Information for 2009

Complaints

The number of complaints made to the Ombudsman Office decreased slightly from 164 in 2008 to 148 in 2009. This includes 21 complaints that were resubmitted from previous contacts. Complaints were down 11% compared to 2008, but were up 36% when compared to 2007 as shown in Figure 3.

Figure 3

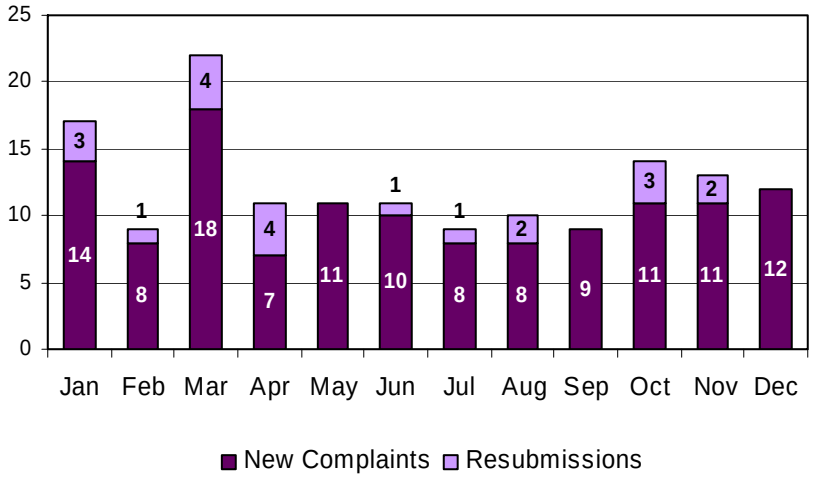
Annual Complaints to the Ombudsman Office



The number of new complaints received per month by the Ombudsman Office in 2009 varied from a high of 18 in March to a low of seven in April. The monthly average of new complaints was 10.5 complaints. Figure 4 illustrates the number of new complaints and resubmitted complaints received by the Ombudsman Office each month during 2009.

Figure 4

Complaints Received per Month in 2009

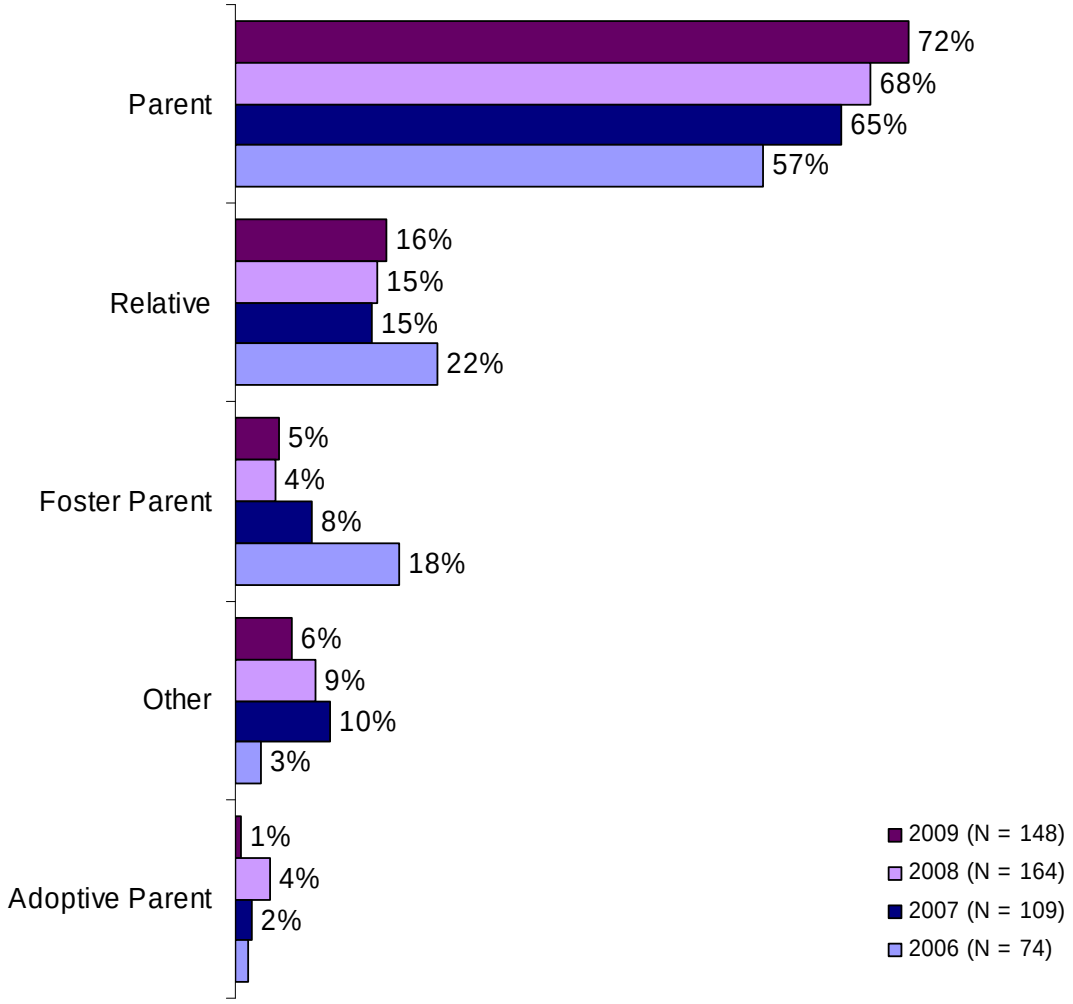


Complaint Sources

Of the 148 complaints received in 2009, 107 (72%) were made by birth parents of the child for whom the complaint was being made, 24 (16%) were made by other relatives, and seven (5%) were made by foster parents. While parents and relatives remained the top two groups making complaints against the Bureau, the percentage of foster parents making complaints was slightly higher than in 2008, but lower than in 2006 and 2007. See Figure 5 for a year-by-year comparison. In 2009, four new complaint sources were identified. Although these were not frequent sources of complaints (and therefore were included in the "Other" category), they were notable because they were new. Specifically, new complaint sources included: Bureau staff (2), a school social worker (1), and a teen (1). These may be the result of the Ombudsman Office's expanded outreach efforts.

Figure 5

Complaint Sources by Relationship to Child
2006 – 2009



Children Involved in Complaints

The Ombudsman Office tracked data on the ages of the children involved in the complaints received in 2009 and the number of children involved in each complaint. The Ombudsman Office identified 403 children in 146 of the 148 complaints[3] for which data were available.

Of the 400 children identified and for whom a date of birth was obtained, 40% were four years old or younger, 44% were between five and eleven years old, 11% were between 12 and 15 years old, and 5% were ages 16 and older. Figure 6 provides a breakdown of the ages of children involved in these 146 complaints and Figure 7 shows the number of children involved.

Figure 6

Ages of Children Involved in Complaints
(N=400)

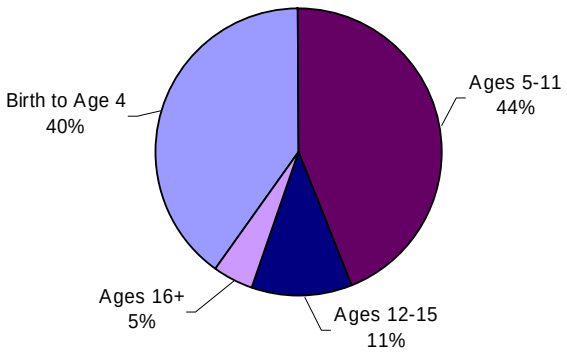
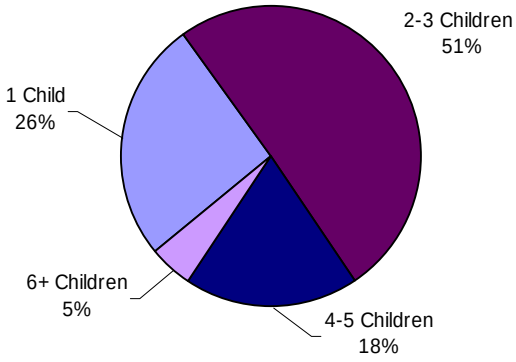


Figure 7

Number of Children Involved per Complaint
(N=146)



As shown in Figure 7, 26% of the complaints identified one child, 51% of the complaints identified two to three children, and 18% of the complaints identified four or five children. Complaints with six or more children comprised 5% of the total number of complaints.

Complaint Categories

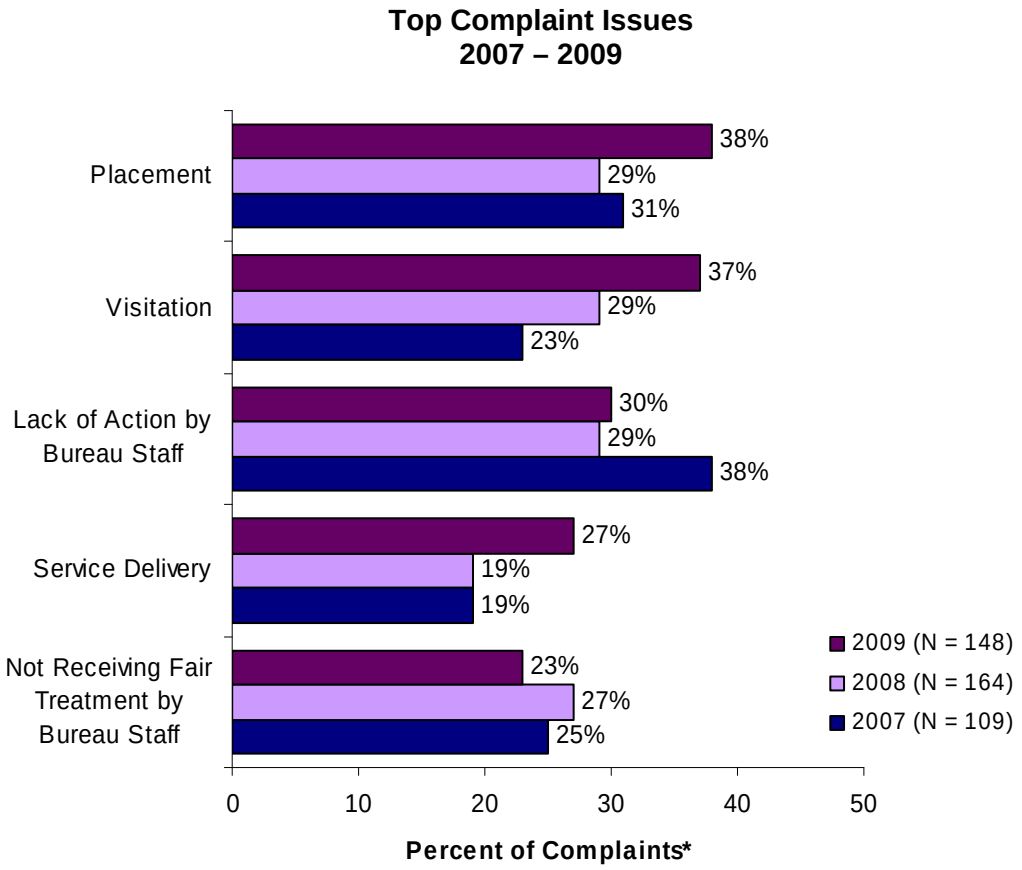
There were 418 issues involved in the 148 complaints received in 2009.[4] This is an average of 2.8 issues per complaint. Of the 418 issues identified, 33 were outside the scope of the Ombudsman Office. For complete complaint issue detail for 2009, see Appendix 7.

The most frequent complaints continue to be related to placement (38%), visitation (37%), lack of action by the Bureau (30%), service delivery (27%) concerns, and not

[3] In two complaints, the Ombudsman Office was unable to obtain information regarding both the dates of birth and the number of children involved in the complaint.
[4] 57 of these issues were in the 21 complaints that were resubmitted during the year.

receiving fair treatment by Bureau staff (23%). However, placement and visitation complaints were up slightly from 2007 and 2008, while not receiving fair treatment by Bureau staff was down slightly as illustrated in Figure 8.

Figure 8



* In past reports, complaint issue information was calculated as a percent of issues, not as a percent of complaints

Screened Out Complaints

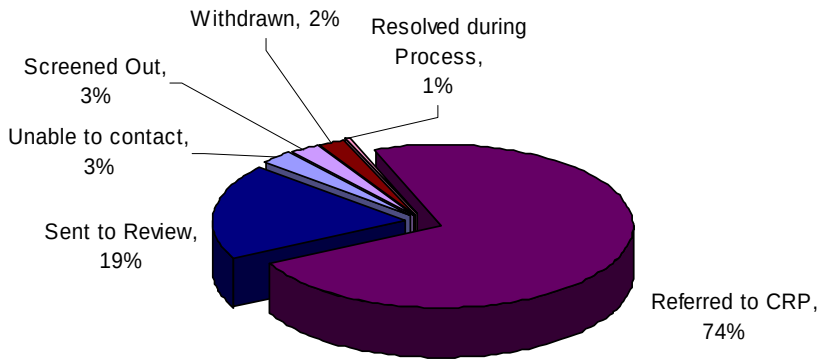
Of the 148 complaints received in 2009, 127 were classified as new complaints, and 21 were resubmitted complaints. Of the 127 contacts classified as new complaints, four (3%) did not meet the Ombudsman Office screening criteria for all issues within the complaint and were screened out. There is frequently more than one reason for each complaint, and complaints are often screened out based upon more than one screening criteria. (see Appendix 8: Screening Criteria for complete details)

Complaint Outcomes

The Ombudsman Office tracks the outcome for each complaint that is received. Of the 148 complaints received in 2009, 109 were referred to the Bureau's CRP (74%[5]), 28 were sent to review (19%), and four were screened out (3%). The outcome for all 148 complaints is shown in Figure 9.

Figure 9

Outcome of 2009 Complaints
(N = 148)



Note: Due to rounding, percentages do not add up to 100%

Complaints Referred to the Bureau Complaint Resolution Process

In 2009, the Ombudsman Office continued to focus a significant amount of time on 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 127 new complaints in 2009, 109 (86%) were referred to the Bureau Complaint Resolution Process (CRP).

This is the fifth consecutive year that the majority of complainants (53%) reported they were not aware of the process and thus had not followed it. However, while the majority of complainants had not heard of the CRP, more complainants reported having heard of the CRP when compared to previous years, including:

- 47% in 2009,
- 40% in 2008, and
- 25% in 2007.

As in the past two years, some complainants 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 continues to be a primary focus of the

[5] 86% of the 127 new complaints

Ombudsman Office's work, and we continue to partner with the Bureau and its contracted private agencies on outreach efforts.

While completing the CRP is not mandatory, the Ombudsman Office is required to encourage 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 it assists the complainant with understanding how they can successfully follow the CRP, including a discussion with them of their expectations for resolving their complaint. 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.

In October 2009, the Ombudsman Office met with the management staff of Regions 1 and 2 to discuss the coordination of efforts between offices. In explaining the Ombudsman Office's process for working with the complainant prior to referring them to the CRP, it was realized it would be helpful to include the complainant's expectations for resolution outcomes in the Ombudsman Office's written correspondence when referring a complainant to the CRP.

Providing the complainant's expectations for resolving their complaint in writing benefits both the complainant and the Bureau. It serves as a reminder for the complainant of the solutions they developed to resolve their complaint during their conversations with the Ombudsman Office. When permitted to disclose a complaint to the Bureau, it also provides clarification to Bureau staff about what the complainant's expectations are for resolving their complaint. Although there is very limited data available to report on thus far, it appears that this change may be having a positive effect on the number of complaints being resolved through the CRP.

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 contact at 90 days.

Of the 109 complainants referred to the Bureau CRP in 2009, 63 (58%) were able to be contacted and nine had not reached the 30-day follow-up point as of December 31,

2009. The outcomes for the 63 complaints for which follow-up information is available are listed in Table 1.

Table 1

Outcomes of Complaints Referred to Bureau Complaint Resolution Process in 2009

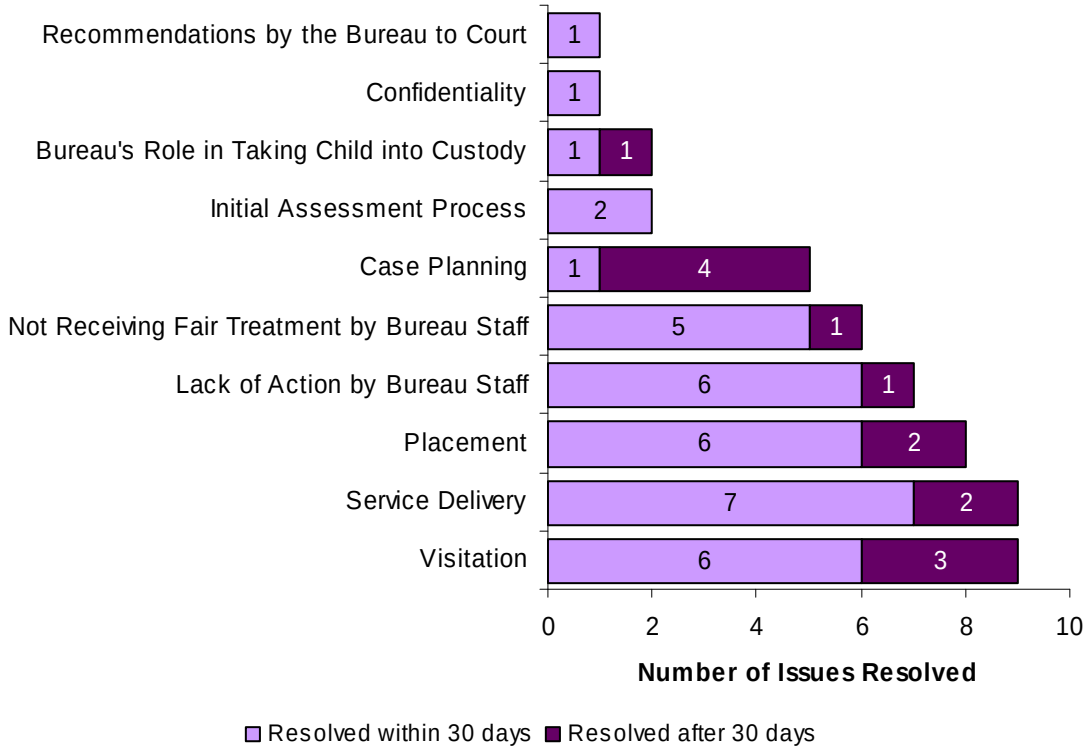
Outcome	Number
Still Attempting Completion of CRP	22
Successful Completion of CRP	21
Unsuccessful Completion of CRP-Resubmitted Complaint	14
CRP Not Followed-Did Not Resubmit	5
Unsuccessful Completion of CRP-Did Not Resubmit	1
Total	**63**

Complaints Referred to Bureau CRP – Issues Resolved

There were 21 complaints involving 50 issues where the Bureau CRP was completed and the complainants reported that their issues had been resolved. Figure 10 provides an illustration of the complaint categories along with the number of issues resolved though the Bureau CRP in each category.

Figure 10

Issues Resolved Through the Bureau CRP



At the request of the Bureau, the Ombudsman Office asks complainants who had successfully completed the Bureau's CRP at what level their complaint was resolved. Of the 63 complaints for which follow-up information was available, we were able to identify 21 complaints (33%) where the complaints had reached a successful resolution. Seven were resolved at the management level, six at the supervisory level, and two each at the case manager level and the Executive Director level. The remaining four were either resolved at a non-Bureau level (2) or the complainant did not specify (2). The Ombudsman Office will continue to collect this information when possible.

Case-Level Findings and Recommendations

Overview

The Ombudsman Office completed 26 reviews on 70 issues in 2009. 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 18 complaints received in 2009, eight (44%) reviews were completed within the 60 day timeline goal. The average completion time for all 18 reviews was 71 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 the priorities of: remedying violations and concerns whenever possible, shaping better future child welfare practice, and articulating the experiences of our complainants.

The Bureau provides the Ombudsman Office with their response to the review findings and recommendations which includes any actions taken or planned. This information is reported back to the complainant and reported to the community quarterly. The Ombudsman Office successfully implemented, with the assistance of the Bureau, a recommendation tracking report. This report tracks all recommendations made by the Ombudsman Office 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

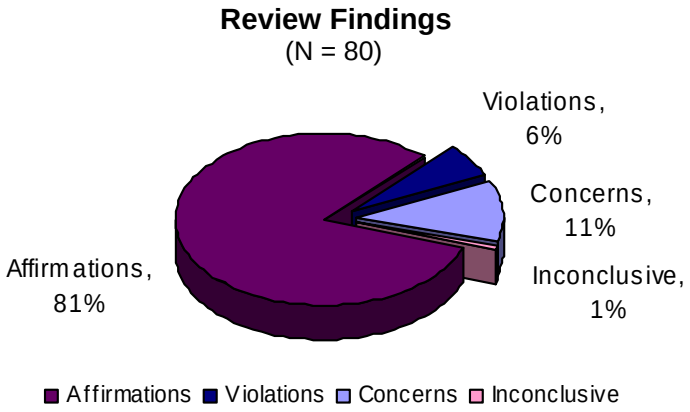
Violations or practice concerns found in the course of conducting the Ombudsman Office review that were not germane to the specific issues being complained about.

Findings

There were 70 issues[6] in 26 separate complaints for which reviews were completed or closed in 2009 resulting in 80 findings. Of these, there were 65 findings (81%) where the Ombudsman Office affirmed the actions of the Bureau; nine findings (11%) of concern; five findings (6%) of violation; one inconclusive finding (1%); and one issue (1%) that was resolved during the review. Figure 11 provides a breakdown of the findings for the issues reviewed.

[6] Issues can be multi-faceted resulting in more than one finding per issue.

Figure 11

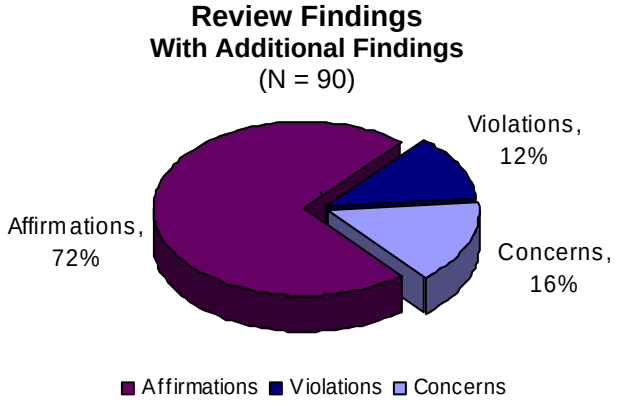


Note: Due to rounding, percentages do not add up to 100%

The Ombudsman Office identified 11 additional findings that were not part of the original complaint; including six violations and five concerns. Three of the six violations and three of the five concerns related to case planning. Other areas in which findings were found include: issues regarding timely completion of Initial Assessment activities, coordination of services, and documentation efforts.

Figure 12 illustrates the effect on the affirmation rate of the Bureau's actions when including the 11 additional findings that were made by the Ombudsman Office. See Appendix 9 for comprehensive information on Ombudsman Office findings.

Figure 12



Note: The one inconclusive finding was excluded from the above chart

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. (see Appendix 9)

Recommendations from 2009 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 26 reviews completed in 2009, the Ombudsman Office made 29 recommendations in 2009, of which 15 were systemic and 14 were case-specific. The Bureau fully agreed with all 14 of the case specific recommendations and 13 of the 15 systemic recommendations. For the remaining two systemic recommendations, the Bureau disagreed with one in its entirety and for one the Bureau felt it was only valid as case specific rather than systemic.

Of the 15 systemic recommendations made, 12 involved reviewing existing standards, policies, or practices, two were related to areas lacking clarity in existing policies or practices, and the remaining issue addressed training. It should be noted that one of the 12 recommendations in relation to an existing practice also included a recommendation to address associated training needs.

The Ombudsman Office found that in those 12 recommendations made to the Bureau, existing standards, policies, or procedures were in place, but in some cases they were not utilized at all while in others they were inadequately interpreted. As was also highlighted in 2008, this is notable because it reveals that the Bureau has appropriate child welfare policies/procedures 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 12 recommendations made, four related to procedural requirements, four focused on communication, two involved Initial Assessment (IA) expectations, and the remaining two were associated with technical supports. Practice areas or policies related to communication or safety that the Ombudsman Office recommended be reinforced with Bureau staff or supervisors include:

- Withholding placement information from parents or relatives;
- Notifying a school superintendent within 24 hours of a maltreatment report when the alleged maltreator is a public school employee;
- Communicating medical information between the Bureau and service providers;
- Enhancing Initial Assessment worker's ability to perform requirements of position; and

- Increasing the capability of after hour staff to utilize technology to obtain case information on maltreatment referrals.

Two of the Ombudsman Office recommendations made to the Bureau were related to areas in which current Bureau policy was lacking clarity or 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. The following two areas are of particular concern:

- Providing clarity in Bureau policy that the steps for communication with another CPS agency in a different county includes counties located outside Wisconsin; and
- Maintaining consistency in medical care, particularly maintaining child's primary care physician whenever possible.

The final Ombudsman Office recommendation made to the Bureau related to a training issue in regard to increasing staff's ability to apply conceptual theories of empowerment in the context of the unequal relationship between Bureau staff and the family.

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.

Milwaukee Child Welfare Partnership Council

The Milwaukee Child Welfare Partnership Council (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 presents its Annual Report to the full Partnership Council at their April meeting and presents/submits quarterly reports at their January, April, July, and October meetings.

Brochure/Poster

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. In 2009, posters were distributed to a number of organizations in conjunction with community presentations. Plans to distribute the posters more widely were scaled back as the future of the office became less certain. However, the concept of placing posters in government offices and in community settings throughout the county may be worth pursuing in the future.

Surveys

The Ombudsman Office developed four distinct survey instruments in an attempt to gather feedback from: 1) complainants regarding their satisfaction with its services and 2) Bureau staff and community members regarding the value of its presentations.

After complainants were referred to the CRP they were asked to complete a satisfaction feedback survey that was mailed to them with an accompanying postage-paid envelope. The low response rate, 15 of 109 complainants, did not allow for meaningful conclusions regarding complainant satisfaction.

Similarly, those for whom a review had been completed were also asked to complete a satisfaction feedback survey that was mailed to them with an accompanying postage-paid envelope. While the response rate was slightly higher for this group (5 of 26), the number of returned surveys was too low to draw any conclusions.

Presentation attendees were asked to fill out a feedback survey upon completion of each of 38 presentations. Bureau staff completed 222 (82% of 270 attended) and community members completed 259 (53% of 492 attended). Overall, 98% (217 of 222) of Bureau staff and 93% (241 of 259) of community members "strongly agreed" or "agreed" that the

presentation helped them to better understand the Ombudsman Office. Similarly, 93% of Bureau staff and 96% of community members “strongly agreed” or “agreed” that the presentation increased their likelihood to refer someone to the Ombudsman office. Approximately 90% (181 of 200 community attendees, 173 of 193 BMCW staff) of both groups indicated that they would recommend the presentation to someone else. When asked to rate the presentation, 67% (140 of 209) of Bureau staff and 71% (165 of 232) of community members responded that it was “very good” or “excellent.”

See Appendix 11 to view copies of survey instruments.

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 United States Ombudsman Association.

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 the 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.

Looking Forward to 2010

The Ombudsman Office was developed to strengthen the foster care and child welfare system in Milwaukee County. It provides objective, impartial, and independent reviews of complaints for children and families involved with the Bureau. Unlike other initiatives that look at the child welfare system, the Ombudsman Office views the system through the eyes of those directly affected by it. As the Ombudsman Office strives to assure quality services within the Bureau, it must also look inward to its own work to assure it is moving in the right direction. In that spirit, the following is a brief review of 2009 and a look to the future.

In 2009, the Ombudsman Office looked forward to demonstrating its value to the Milwaukee community. While a structured evaluation was to have been conducted by the Department of Children and Families, this did not occur. The uncertainty of the future of the office also affected exploration of the Ombudsman Office's involvement in child death investigations. Although data was gathered from other states, no further efforts took place surrounding participation in this process.

During 2009, the Ombudsman Office successfully implemented a system for tracking recommendations. It also expanded the quality of findings information conveyed to complainants helping to increase the transparency of the office. The Ombudsman Office also attempted to assess its performance through survey instruments with mixed results. Outreach performance was considered favorable, but satisfaction data from complainants was limited due to a low response rate that did not allow for meaningful conclusions.

Finally, the Ombudsman Office sought and received feedback on its 2008 Annual Report. Feedback was generally positive about the format and quality of the overall report. One suggestion that was incorporated into the 2009 Annual Report was to take a longer-term view of the future.

This section of the report takes a look at the year ahead and presents recommendations for impacting the future of Ombudsman services.

Providing complainants with a neutral approach to complaint resolution

The current contract for Ombudsman services expires on June 30, 2010 and the Partnership Council recommended to the DCF that the next contract should focus on an advocate approach to complaint resolution for Bureau clients.

The Ombudsman Office recognizes a desire by the community for this office to assist in resolving complaints in addition to performing reviews. There are a number of Ombudsman models in other states that provide complaint resolution to clients in addition to performing reviews of how a case was handled by Child Protective Services (CPS) workers.

With a few minor changes to the current approach, the Ombudsman Office can provide a neutral approach to complaint resolution. Having a neutral party assist or mediate complaint resolution allows both the complainant and the Bureau to have someone at

the table who can focus on the most appropriate way to resolve the complaint, which may also allow for a quicker resolution.

Working within the framework of the existing contract through June 30, 2010, when requested by a complainant, the Ombudsman Office will attend a complaint resolution meeting arranged by the "client." Guidelines were developed to ensure that both the complainant and the Bureau understand the neutral role of the Ombudsman Office during the meeting. Please see Appendix 12 for a copy of these guidelines.

Establishing an Ombudsman for Child Welfare in Wisconsin statute

With the Ombudsman Office contract expiring on June 30, 2010, the Milwaukee community will no longer have an ombudsman to provide an independent perspective of root problems in the child welfare system in Milwaukee. This consumer-driven perspective offers an opportunity to reveal practice issues that may otherwise go unnoticed by other system initiatives.

The Legislature should consider establishing an Ombudsman for Child Welfare in state statute to assure an independent system perspective. Once enumerated in statute, the office will be less likely to be directly affected by changes in the political environment. This will make the office more effective, stable, and independent.

According to the United States Ombudsman Association (USOA), the national organization of public sector Ombudsman, the American Bar Association (ABA) recognized the value of a public sector ombudsman. In 1967, the ABA recommended 12 criteria for establishing an ombudsman in statute. [7] One criterion includes assuring "independence of the ombudsman through a long term, not less than five years, with freedom from removal except for cause, determined by more than a majority of the legislative body, such as two-thirds."

The USOA incorporated the ABA's criteria into its By-laws. In 1997, the USOA Board of Directors approved a *Model Statute for Ombudsman Offices* that was developed with these criteria and 30 years of experience with the ombudsman concept in the U.S.A.[8]

It is important that the legislature clearly define the powers of the office. When the community originally advocated for an ombudsman, the provision of direct complaint resolution services for complainants involved with the Bureau were envisioned. Redress of a citizen's complaint is the foundation upon which the ombudsman model was designed. The Ombudsman Office agrees that direct service should be provided in addition to the services currently offered.

An important element in the current design that should be retained is its authority to report on system-related concerns it identifies through performing its responsibilities. The majority of recommendations made by the Ombudsman Office over its tenure have been systemic in nature. While the current Ombudsman Office has no power or authority

[7] United States Ombudsman Association. (March 22, 2010). Public sector ombudsman. Retrieved from http://www.usombudsman.org/en/references/public_sector.cfm

[8] United States Ombudsman Association. (March 22, 2010). United States Ombudsman Association Model Act for State Governments. Retrieved from http://www.usombudsman.org/en/references/model_act.cfm

to impose its recommendations, the Bureau agreed with nearly every recommendation that was made in 2009.

In 2009, the Ombudsman Office successfully developed and implemented a system to track progress on recommendations it made with which the Bureau agreed. This report informs community stakeholders of the Bureau's efforts and progress towards implementing Ombudsman Office recommendations. It also serves as a reminder for those recommendations that have not been fully implemented. The report has been well-received by these stakeholders.

Some state initiatives were implemented since the Ombudsman Office was created that have demonstrated progress towards improving the child welfare system in Milwaukee. However, they do not capture system-related issues that stem from complaints, which is a valuable perspective to the Bureau and its practice of child welfare.

The Ombudsman Office recognizes that CPS is a difficult job. There are numerous and complex laws, standards, and policies that govern CPS's involvement in the lives of children and families. A complaint driven viewpoint offers a unique perspective into whether CPS is carrying out their function as intended. An external review does not supplant an internal look at system performance. Both are valuable and necessary to identify system-related issues that may negatively impact those they seek to serve.

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Appendices

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Appendix 1

Staff

The 2009 Ombudsman Office Staff consisted of the Ombudsman Director, an Associate Ombudsman, a .5 FTE Administrative Assistant/Intake Coordinator, and an attorney to consult regarding legal matters.

Ombudsman Director

- Pamela Matthews has been with the Ombudsman Office since September 2008. She has comprehensive experience in local, county, and state levels of government. Ms. Matthews possesses expertise in child welfare policy analysis and development, and experience with diverse audiences and stakeholders. Ms. Matthews holds a Bachelor Degree in Community Leadership from Alverno College.

Associate Ombudsman

- David Scholl received his Advanced Social Work Certification in 2009 and 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, Coordinated Service Team Facilitator, and supervisor for Safety Services and Ongoing Case Management. Mr. Scholl holds a Master's Degree in Social Work from the University of Wisconsin-Milwaukee.

Intake Coordinator/Administrative Assistant

- Robert Meyer began in the Ombudsman Office in June 2009 as an intern and was hired in September 2009 to fill the Intake Coordinator position. Mr. Meyer holds a Bachelor's Degree in Sociology from the University of Wisconsin-Milwaukee.
- Sheena Hesson worked in the Ombudsman Office as a short-term employee during the summer of 2009 until a permanent person was hired to fill this position. Ms. Hesson holds a Bachelor's Degree in Psychology from the University of Wisconsin-Milwaukee.
- Michelle Doneis worked with the Ombudsman Office from November 2007 until May of 2009. Ms. Doneis 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. Henry 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

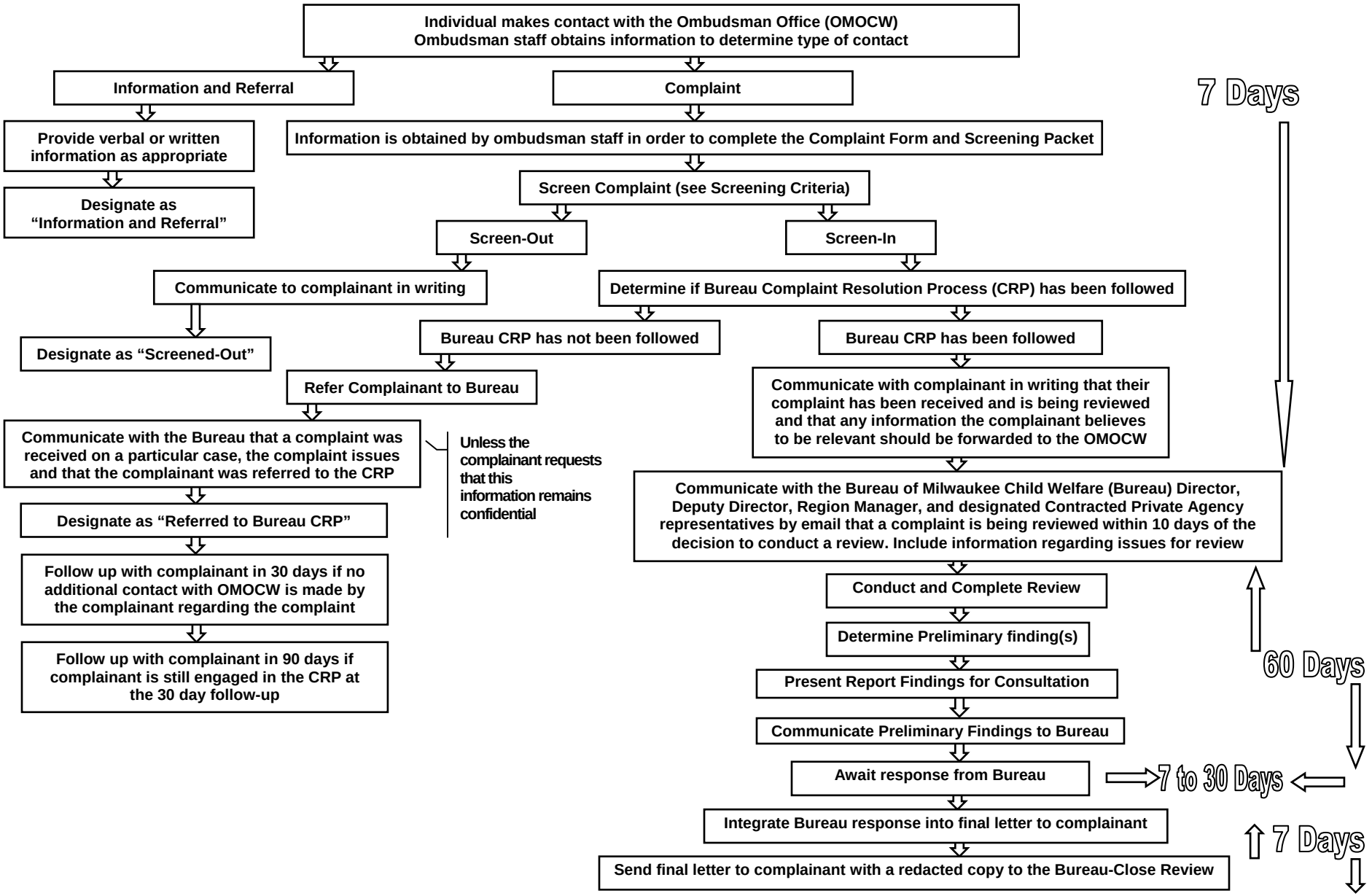
2009 Outreach

Presentations/Outreach	Date
Community – 28	
▪ Wraparound Program staff – Presentation (97 attendees)	1/8/09
▪ Jewish Family Services – Presentation (11 attendees)	1/12/09
▪ Children's Service Society of Wisconsin (CSSW), LGBT Program staff – Presentation (3 attendees)	1/20/09
▪ Penfield Children's Center staff – Presentation (18 attendees)	1/22/09
▪ St. Francis Children's Center staff – Presentation (11 attendees)	1/26/09
▪ Benedict Center – Presentation (15 attendees)	2/25/09
▪ Foster & Adoptive Parents of Greater Milwaukee – Presentation (5 attendees)	3/19/09
▪ Foster Parent Training in conjunction with University of Wisconsin-Milwaukee Training Partnership (10 attendees)	4/30/09
▪ Maximus, North – Presentation (20 attendees)	5/8/09
▪ Milwaukee Child Abuse Prevention (MCAPS) Public Policy Committee – Quarterly Report (22 attendees)	5/11/09
▪ Hmong American Friendship Association Resource Fair (number of attendees unknown)	5/30/09
▪ Bayview Community Center, Executive Director	6/3/09
▪ Family Resource Center of Sherman Park New – Presentation (4 attendees)	6/5/09
▪ Career Youth Development School of Excellence New – Presentation (15 attendees)	6/12/09
▪ Silver Spring Neighborhood Association – Presentation (9 attendees)	6/16/09
▪ Maximus, South – Presentation (15 attendees)	6/19/09
▪ Impact – Presentation (5 attendees)	6/23/09
▪ New Concept Self Development – Presentation (11 attendees)	7/7/09
▪ United Community Center – Presentation (17 attendees)	7/9/09
▪ Riverwest Neighborhood Association – Presentation (23 attendees)	8/11/09
▪ Milwaukee Public Schools Resource Fair (approx. 200 attendees)	8/26/09
▪ Milwaukee Child Abuse Prevention (MCAPS) Public Policy Committee – Quarterly Report (20 attendees)	9/14/09
▪ Children's Court Judges/Commissioners – Outreach (approx. 12 attendees)	9/21/09
▪ Fatherhood Initiative – Outreach (approx. 700 attendees)	10/9/09
▪ La Causa Family Resource Center – Presentation (7 attendees)	10/19/09
▪ Milwaukee Child Abuse Prevention (MCAPS) Public Policy Committee – Quarterly Report (13 attendees)	11/9/09
▪ Milwaukee Public Schools Social Workers – Presentation (125 attendees)	11/20/09
▪ Fresh Start Family Services, Treatment Foster Parents – Presentation (4 attendees)	12/15/09

Continued

Presentations/Outreach	Date
Bureau/Contracted Private Agency Staff – 13	
▪ CSSW Foster Care Licensing staff – Outreach Presentation (72 staff)	1/13/09
▪ Introduction to Bureau Training – Presentation (29 staff)	1/13/09
▪ All State Bureau Staff Meeting – Outreach Presentation (approximately 60 staff)	2/27/09
▪ La Causa Staff – Annual/Quarterly Report Presentation (approximately 40 staff)	3/3/09
▪ Introduction to Bureau Training – Presentation (15 staff)	5/20/09
▪ Introduction to Bureau Training – Presentation (42 staff)	7/1/09
▪ Introduction to Bureau Training – Presentation (4 staff)	8/5/09
▪ Introduction to Bureau Training – Presentation (18 staff)	9/16/09
▪ Region 3 Ongoing Staff Outreach – Presentation on Complaints/Outcomes for Jan – June 2009 (55 attendees)	10/20/09
▪ Introduction to Bureau Training – Presentation (18 staff)	10/28/09
▪ Region 1 & 2 Ongoing Staff Outreach – Presentation on Complaints/Outcomes for Jan – June 2009 (approx. 45 attendees)	11/12/09
▪ Region 1 & 2 Ongoing Staff Outreach – Presentation on Complaints/Outcomes for Jan – June 2009 (approx. 55 attendees)	11/18/09
▪ Introduction to Bureau Training – Presentation (12 staff)	12/9/09
Partnership Council – 6	
▪ Milwaukee Child Welfare Partnership Council (Partnership Council) Quarterly Meeting, Quarterly Report	1/30/09
▪ Partnership Council Quarterly Meeting, Presented 2008 Annual Report	4/24/09
▪ Partnership Council Executive Committee Meeting, Quarterly Report/Recommendation Tracking	7/17/09
▪ Partnership Council Quarterly Meeting, Quarterly Report/Recommendation Tracking	7/24/09
▪ Partnership Council Executive Committee Meeting, Quarterly Report/Recommendation Tracking	10/16/09
▪ Partnership Council Quarterly Meeting, Quarterly Report/Recommendation Tracking	10/23/09

Process Overview



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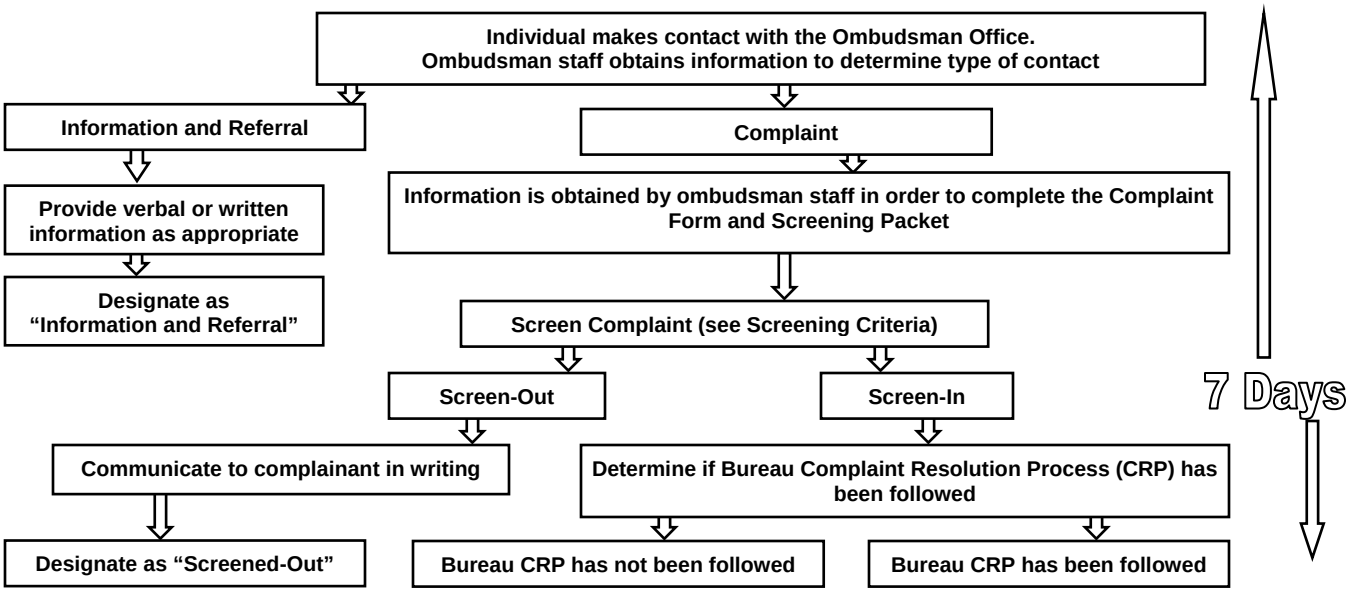
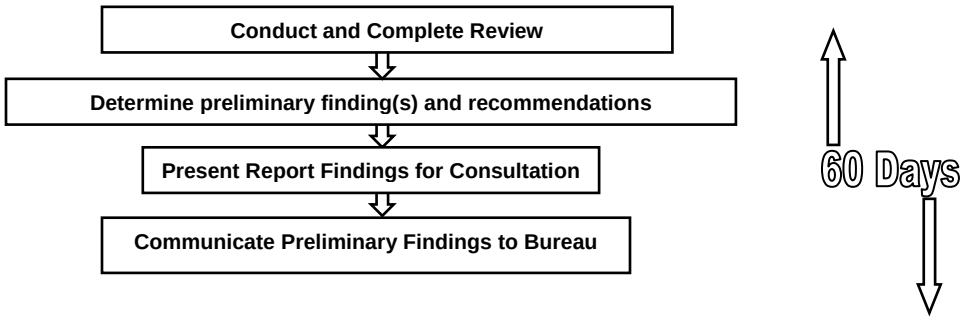
Appendix 4

Processing Guidelines



In 2009, the Office of the Milwaukee Ombudsman for Child Welfare (Ombudsman Office) changed its target for completing the screening process and determining if the Bureau Complaint Resolution Process has been followed from the date the individual contacts us from 14 calendar days to seven. For 93% of contacts, this process was completed within the timeline established. The average number of days this process took in 2009 was three. Challenges, in terms of either making contact with the complainant to obtain information necessary to complete this process or their indecision regarding filing a complaint, led to this timeline being exceeded for 10 complaints.

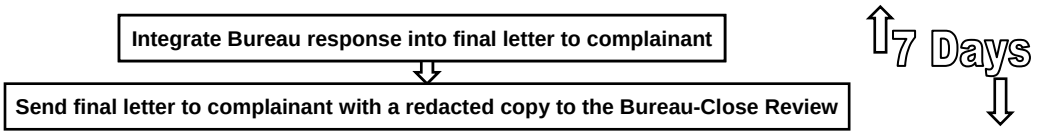


The guideline for the completion of the Ombudsman Office review is 60 calendar days from the time correspondence is sent to the complainant and the Bureau of Milwaukee Child Welfare (Bureau) that a review will take place until the time that the Ombudsman

Office sends the Bureau its preliminary findings of the review. For those complaints opened and closed in 2009 (18), seven (39%) reviews were completed within the 60 day process guidelines. The average completion time for all 18 reviews was 71 days. There were 11 reviews that went over the 60 day timeline goal; eight were completed within 73 days; in two reviews court transcript requests caused delays; and in one review there were nine complaint issues that involved multiple departments, interviews took longer than anticipated to arrange, and delayed receipt of court transcripts (due to the change in presiding Children's Court judges).

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.

In 2009, the Ombudsman Office attempted to improve upon the amount of time it took to close a review in cases where the Bureau disagreed with its preliminary findings. Rather than responding back in writing to the Bureau's response, Ombudsman Office staff met with Bureau staff to determine where and why there were disagreements and to receive and provide clarifying information. There was no clear evidence to suggest that this improved the amount of time it took to close a review.



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 2009, 61% of the final findings correspondences were completed within the seven day timeline goal with the average completion time being seven days.

Process from Contact to Final Correspondence

For complaints received in 2009 and where the review was completed in 2009, the average length of time from the date of contact to the date the final findings correspondence was sent to the complainant was 110 calendar days. This accounts for time awaiting the Bureau's response to the Ombudsman Office findings and any additional correspondence necessary to complete and close the reviews.

Appendix 5

Information and Referral Categories

Information Requested	TOTAL
Bureau - General Information	56
Legal Advice	29
Safety Threats (abuse/neglect)	16
Contact Information - Miscellaneous	15
Information about Ombudsman Office	9
Court Process/Questions	9
Advocacy	6
CPS - Other Counties	6
Foster Care-Licensing/Becoming a Foster Parent	6
Other Ombudsman Programs (non-child welfare)	5
Contact Information for Bureau Personnel	5
Child Protective Services (CPS) Process	4
Other State Departments	3
W-2	2
TOTAL REQUESTS*	**171**

* There were a total of 116 contacts for information with an average of 1.47 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	61	22	39
Bureau/Contracted Private Agency Staff	45	33	12
Unknown	23	1	22
Resubmission	21	21	N/A
Other*	14	7	7
Relative	12	5	7
Website	12	7	5
Child/Community Advocacy Group	11	7	4
Brochure	10	6	4
Friend	10	7	3
Service Provider	8	7	1
211/411 - Information	7	2	5
Other State Departments or Programs	7	4	3
Outreach	7	5	2
Media	5	4	1
Attorney	4	3	1
Previous Review Conducted	4	4	N/A
Court/Court Official	3	3	0
TOTAL		**148**	**116**
TOTAL COMBINED	**264**	**264**	

* Other includes one each of the following: Social Worker, Guardian ad Litem, Human Rights Watch New York, Specific Individual, Milwaukee Urban League, Domestic Violence Shelter, Legislator, Planning Council Board Member, Fenwick Building Worker, Walking by Office, Workplace, Voices Unlimited, prior Planning Council Employee, Counseling Agency.

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Appendix 7

Complaint Categories

Complaint Category	Number
Placement ▪ Relative placements not sought (16) ▪ Safety of a child's placement (16) ▪ Placement not being appropriately monitored (13) ▪ Relative placement denied without just cause (7) ▪ Conduct of a caregiver (5) ▪ Disagreement with a change of placement (4) ▪ Siblings are not placed together (2) ▪ Appropriateness of the placement (2) ▪ Other: o Kinship placement changed without just cause (1) o Child's needs not being met in group home (1) o Relatives denied placement without just cause and not re-assessed (1)	**68**
Visitation ▪ Visitation is not progressing (13) ▪ Changes to the visitation plan (10) ▪ Visitation with parent is not occurring (7) ▪ Visitation with extended family is not occurring (6) ▪ Bureau of Milwaukee Child Welfare (Bureau) is canceling/suspending visits (5) ▪ Child is missing visits (5) ▪ Visits should be unsupervised (4) ▪ Visits should be supervised (2) ▪ No visitation plan is in place (2) ▪ Parent is missing visits (1) ▪ Other: o Lacking flexibility as court ordered (1) o Management of the visitation plan (1) o Lack of clarity in the Family Interaction Plan (1) o Disagreement regarding restrictions on person's allowed to attend mother's supervised visitation (1)	**59**

Continued

Complaint Category	Number
Lack of Action by Bureau Staff ▪ Inadequate assistance from staff (32) ▪ Lack of return contact (7) ▪ Information withheld by staff (7) ▪ Lack of follow-up on a report of child abuse or neglect on an open case (3) ▪ Lack of follow through by staff regarding concerns (1) ▪ Lack of contact with parent for consent for medical treatment (1) ▪ Other: o Lack of home visit with parent (1) o Lack of contact with guardian regarding health needs of a child (1) o Lack of monthly contact (1)	**54**
Service Delivery ▪ Conflict between recommendations of service provider and Bureau (8) ▪ Lack of timeliness of service delivery (7) ▪ Lack of communication between Bureau and service provider (6) ▪ Service providers (6) ▪ Not addressing medical needs of a child (5) ▪ Not addressing mental health needs of a child (3) ▪ Not addressing mental health needs of a parent/caregiver (3) ▪ Not addressing needs as court ordered (3) ▪ Not addressing basic needs of a child (2) ▪ Not addressing educational needs of a child (2) ▪ Not addressing needs as requested (2) ▪ Not providing services (1)	**48**
Not Receiving Fair Treatment by Bureau Staff ▪ Bias against mother (13) ▪ Staff giving misinformation (10) ▪ Disrespectful treatment/lack of professionalism from staff (5) ▪ Bias against father (3) ▪ Retaliatory/threatening behavior by staff (3) ▪ Bias against other-family members (2) ▪ Other: o Reunification decision did not include consultation with other professionals (1)	**37**

Continued

Complaint Category	Number
Case Planning ▪ Conditions for return of the children (17) ▪ Case plan does not address a particular need (6) ▪ Not involving relatives with case planning (1) ▪ Other: o Inconsistency of case management (2) o Inconsistent Coordinated Service Team (CST) meetings (1) o Change in worker assignment hindered case plan & permanency plan (1) o Case plan set up barriers to progress (1) o Protective plan is not safe or appropriate (1) o Does not address disruptive behaviors of mother (1) o Children exposed to discussions involving adult topics & case planning (1)	**32**
Bureau's Role with Taking a Child into Custody ▪ Concern that a child was taken into custody and should not have been (15) ▪ Concern that a child should have been taken into custody and was not (5) ▪ Lack of follow-up on a report of child abuse or neglect (3) ▪ Incorrect assessment that resulted in the removal of a child (3) ▪ Disagreement with a Screen-Out decision (2) ▪ Disagreement with a Screen-In decision (1) ▪ Other: o Time elapsed for emergency detention (1)	**30**
Bureau Recommendations to the Court ▪ Inaccurate information provided to court (16) ▪ Concern/disagreement with recommendations made (4) ▪ Lack of verification of information sent to the court by Bureau staff (1) ▪ Other: o Lack of action taken to comply with Adoption and Safe Families Act (ASFA) (1)	**22**

Continued

Complaint Category	Number
Initial Assessment Process ▪ Lack of interviewing parents (4) ▪ Lack of timeliness in beginning initial assessment (1) ▪ Lack of timeliness in completing initial assessment (1) ▪ Other: o Lack of interviewing the alleged maltreater (2) o Lack of thorough Initial Investigation of the primary caregiver (2) o Inadequate investigation of child safety in an allegation of maltreatment (2) o Relatives not utilized in an Out-of-Home safety plan (2) o Disagreement with maltreatment finding (1)	**15**
Notification Issues ▪ Not receiving proper notification regarding a change of placement (5) ▪ Not receiving proper notification regarding taking a child into custody (1) ▪ Other: o Not receiving notification regarding a maltreatment appeal hearing (1) o Not receiving results of a maltreatment appeal hearing (1)	**8**
Confidentiality Concerns ▪ Inappropriately releasing confidential information (2) ▪ Name of the reporter of maltreatment was released (1) ▪ Other: o Inappropriate request for signed consent (1) o Inappropriate information shared with foster parents (1)	**5**
Other – Within Scope ▪ Inconsistency of case management services (1) ▪ Frequent changes of ongoing case management (1) ▪ Unclear documentation of the results of a maltreatment appeal hearing (1) ▪ Substantiated maltreatment – appeal process (1)	**4**
Bureau Record ▪ Information missing (2) ▪ Missing information and/or information withheld from a records request (1)	**3**

Continued

Complaint Category	Number
Issues Outside the Scope of the Ombudsman Office Attorney Related Concerns (12) ▪ Attorney not providing adequate services (10) ▪ Other: o Relative unable to afford attorney (1) o Guardian ad Litem (GAL) at Family Court not performing their duties in child's best interests (1) Court Related Concerns (9) ▪ Disagreement with court decisions (2) ▪ Other: o Relative not allowed in emergency detention hearing (1) o Having a closed session without representation (1) o Interstate jurisdiction issue (1) o No notice of hearing or representation at hearing (1) o Bias of legal participants (1) o Disagreement with Family Court decision (1) o Assistant District Attorney not following ASFA in filling a Termination of Parental Rights (TPR) petition (1) Payment Related Issues (2) ▪ Other: o Child support (1) o Foster care payment (1) Provider Network Issues (1) ▪ Other: o Child's therapist not communicating appropriately with mother and Bureau (1) Other (9) ▪ Inactions of Milwaukee Police Department (3) ▪ One instance each of the following: Juvenile in need of Protective Services (JIPS) case, Previously reviewed by the Ombudsman office, Accuracy of Bureau maltreatment data, Other parent's inaction, Denial of Social Security Income (SSI) Disability, and Therapist not following mandated reporter law	**33**

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Appendix 8

Screening Criteria

The Office of the Milwaukee Ombudsman for Child Welfare (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 of Milwaukee Child Welfare (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.

The frequency by which the above screening criterion was applicable to the four complaints where all issues were screened out was:

- 75% (3/4) did not involve a specific child and/or family involved with the Bureau (either currently or in the past 90 calendar days).
- 75% (3/4) all issue(s) being complained about did not occur within the past year, or it was not clear when the issue(s) occurred.
- 50% (2/4) were not within the scope of issues the Ombudsman Office reviews.
- 50% (2/4) were not within the jurisdiction and/or responsibility of the Bureau.
- 50% (2/4) did 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.

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Appendix 9

Complaint Issues Reviewed
Findings and Related Information

In 2009, the Office of the Milwaukee Ombudsman for Child Welfare (Ombudsman Office) completed 26 reviews on 70 complaint issues that produced 80 findings, 11 additional findings, and 29 recommendations. The Ombudsman Office traditionally makes a recommendation(s) when a complaint issue is not affirmed. In some cases, prior to the Ombudsman Office's final finding affirming a complaint issue a recommendation may be made and embraced by the Bureau of Milwaukee Child Welfare (Bureau).

A system was implemented in 2009 for tracking and receiving status updates regarding recommendations made by the Ombudsman Office that the Bureau agreed to embrace. A Recommendation Tracking Report is generated quarterly and provides greater transparency of the Bureau's efforts towards implementing Ombudsman Office recommendations. The Bureau agreed with 28 of the 29 recommendations made by this office in 2009. The following case detail includes the status of recommendations reported by the Bureau as of December 31, 2009.

Findings Affirming the Actions of the Bureau (65)

Placement (14)

- **Placement not being appropriately monitored-**A complainant reported that two children ran away from their placement and that Bureau staff did not address this issue.
- **Placement not being appropriately monitored-**A complainant reported that the children's welfare, safety, and medical needs were not being monitored adequately.
- **Placement not being appropriately monitored-**A complainant reported that the Ongoing Case Manager (OCM) was not monitoring the living arrangements of the child and/or providing appropriate notice of changes in placement.
- **Placement not being appropriately monitored-**A complainant reported that relative placement providers had inappropriate discussions with the children and did not account for the children's safety.
- **Disagreement with a change of placement-**A complainant reported that the Bureau was placing the child with non-relatives contrary to the child's best interest and safety.
- **Disagreement with a change of placement-** A complainant reported that children were taken out of a maternal relative placement and placed with a paternal relative without just cause or considerations of working with the maternal relative.
- **Disagreement with a change of placement-**A complainant reported that the Initial Assessment Social Worker (IASW) did not allow adequate time for the relative to make arrangements for the placement needs of the child.

- **Relative placement not sought-**A complainant reported that a relative was not utilized as a placement.
- **Relative placement not sought-**A complainant reported that relatives were made available as placement options, but no action or considerations of placement with these relatives were made.
- **Safety of a child's placement-**A complainant reported that a child was placed with their father while the father continued to violate his parole, allowed the child to be driven by an unlicensed driver, and allowed the child to stay with a relative for multiple weeks without appropriate sleeping arrangements.
- **Child's needs are not being met in a group home-**A complainant reported that a placement was not consistent in addressing the teen's needs regarding the allowance of home passes, support of religious instruction, and development of appearance and conduct expectations.
- **Conduct of a caregiver-**A complainant reported that group home staff did not follow the instructions of the Bureau and the mother with regard to allowing her child to participate in a field trip.
- **Relative placement denied without just cause-**A complainant reported that the Bureau denied placement with a paternal grandparent and did not reconsider that grandparent for placement when their circumstances changed.
- **Children removed from kinship placement without just cause and not returned-**A complainant reported that the children had been placed with relatives for over one year but were removed after a routine medical exam identified a scar that had previously been reported to the OCM.

Bureau Recommendations to the Court (11)

- **Inaccurate information provided to court-**A complainant reported that false information is contained in the court report regarding:
  (1) the mother's untreated mental health concerns,
  (2) the step-father's indication that he wanted to proceed with a Termination of Parental Rights (TPR), and
  (3) the mother's involvement in the child's injury and her abuse of the child.

  The complainant also reported that the following information was not included in the court report:

  (4) the child's aggressive behavior toward the mother, and
  (5) the child's mental health condition.
- **Inaccurate information provided to the court-**A complainant reported that Bureau staff reported to Children's Court that two of the children were seen and were described as doing fine, but they were actually in another state after running away from their placement. Furthermore, Bureau staff did not report the mother's compliance with services accurately to court.

- **Inaccurate information provided to the court-**A complainant reported that Bureau staff, in making placement recommendations to the court, were biased against the grandparent and that their recommendations included false concerns regarding the relative's co-inhabitants, financial situation, and the mother's activities while living in an upstairs unit.
- **Inaccurate information provided to the court-**A complainant reported that information regarding the father's lack of cooperation with the Bureau, diminished protective capacities, and conditions impacting on child safety were suppressed.
- **Inaccurate information provided to the court-**A complainant reported that the IASW did not communicate child safety issues accurately to Children's Court at a guardianship hearing.
- **Inaccurate information provided to the court-**A complainant reported that Bureau staff provided inaccurate information to court regarding the mother's cooperation and mental health condition.
- **Lack of action taken to comply with the Adoption and Safe Families Act (ASFA)-**A complainant reported that the Bureau did not take action to address the child's permanency needs within the timeframes of ASFA.

Visitation (10)

- **Visitation with parent is not occurring-**A complainant reported that the mother did not have visitation with one of her children for a period of time.
- **Visitation with parent is not occurring-**A complainant reported that visitation with the mother had not been occurring and that the Bureau had not taken action to change the situation.
- **Visitation with extended family is not occurring-**A complainant reported that in the absence of parental involvement, visits with the grandparent ended.
- **Visitation with extended family is not occurring-**A complainant reported that the Bureau was not allowing visitation between the child and grandparent.
- **Child is missing visits-**A complainant reported that the mother was not having visitation with a child who was placed with the father.
- **Inappropriate person allowed visitation-**A complainant reported that the Bureau allows visitation with the child's biological parent who had previously had their parental rights terminated and had a Child Protective Services (CPS) history.
- **Visitation should be supervised-**A complainant reported that safety concerns in the home were not considered in the decision to implement unsupervised visitation with the father.
- **Visitation should be unsupervised-**A complainant reported that the mother continued to have supervised visitation in the absence of child safety concerns despite completing court ordered conditions.

- **The Bureau is canceling/suspending visits-**A complainant reported that the mother's visitation was suspended and progress reversed unjustly.
- **Visitation regressed without justification-**A complainant reported that in two instances, progress to a less intrusive visitation plan was changed without justification and without the Bureau making efforts to assess the conditions impacting on child safety.

Not Receiving Fair Treatment by Bureau Staff (8)

- **Bureau staff being rude and/or disrespectful, displaying unprofessional behavior-**A complainant reported that the OCM was unprofessional and that individuals in higher positions of authority, when informed of the concern, refused to address the complaint.
- **Bureau staff being rude and/or disrespectful, displaying unprofessional behavior-**A complainant reported that the Ongoing Case manager (OCM) became visibly aggressive with a member of the mother's household.
- **Bureau staff giving misinformation-**Complainants reported that relatives followed the Bureau's Complaint Resolution Process (CRP) and were provided misinformation regarding the decision to return the children to the relative placement.
- **Bureau staff giving misinformation-**A complainant reported that the OCM misinformed a relative placement provider about their right to attend Children's Court proceedings and that an order could be changed once it was written.
- **Bias against the mother-**A complainant reported that Bureau staff referred to the mother in a demeaning manner to a third party, refused to accept or respond to calls, and reported to the court that the mother has mental health issues based on the number of attempts the mother made to contact the Bureau.
- **Bias against mother-**A complainant reported that the OCM made biased statements to the child regarding their mother.
- **Bias against the father-**A complainant reported that the cancellation of family therapy services, lack of visitation progress, domestic violence counseling requirement, and the lack of identified safety concerns were evidence of assumptions about the father resulting in a lack of progress towards reunification.
- **Bureau staff implemented inappropriate techniques in handling a child-**A complainant reported that an OCM forcibly laid hands on a child at the conclusion of a supervised visit.

Lack of Action by Bureau Staff (7)

- **Inadequate assistance from staff-**A complaint reported that Safety Services (SS) closed a case without adequately addressing the family's unmet needs for therapy and sustainable housing.

- **Inadequate assistance from staff-**A complainant reported that the IASW did not offer services or implement actions to ensure the safety of a child.
- **Information withheld by staff-**A complainant reported that the mother made a formal written request for Bureau records regarding her child and the alleged maltreatment involving the father, but no records were provided.
- **Information withheld by staff-**A complainant reported that **(1)** the children's medication and **(2)** placement information were not provided to the mother.

  Ombudsman Office Recommendations-While in the process of completing the review and prior to making a formal finding, the Ombudsman Office made the following two recommendations with which the Bureau agreed:

  A. The Bureau should review this specific case to evaluate the children's safety, permanency and welfare needs, and procedural actions regarding the disclosure of placement information.
  B. The Bureau should review with all Ongoing staff the procedure requirements of withholding placement information from parents.

  Status of Recommendation: The Bureau reported in a letter to the Ombudsman Office that actions had been taken to implement the recommendations prior to the completion of the review. The Ombudsman Office considers these recommendations completed.
- **Lack of follow-up on a report of child abuse or neglect on an open case-**A complainant reported that the mother reported maltreatment concerns regarding her child, but that appropriate action was not taken to investigate the allegation.
- **Lack of return contact-**A complainant reported that the IASW did not provide feedback to the reporter regarding the outcome of an investigation of child maltreatment.

Bureau's Role With Taking A Child Into Protective Custody (6)

- **Disagreement with a screen-out decision-**A complainant reported that the mother provided alleged maltreatment information to the Bureau and that the information was screened-out.
- **Disagreement with a screen-out decision-**A complainant reported that Bureau staff did not appropriately interpret threatened or reported abuse in a report of child maltreatment.
- **A child was taken into custody and should not have been-**A complainant reported that the Bureau took a teenage child into custody without legal grounds or justified reasoning.
- **A child was taken into custody and should not have been-**A complainant reported that the mother's child was taken into protective custody without just cause.
- **A child should have been taken into custody and was not-**A complainant reported that Bureau staff did not thoroughly investigate allegations of abuse and

neglect and relied on inaccurate information provided by the Milwaukee Police Department (MPD).

- **Lack of follow-up on a report of child abuse or neglect-**A complainant reported that the Bureau did not adequately investigate a child's safety or take actions to ensure for the child's welfare in response to an allegation of child maltreatment.

Service Delivery (4)

- **Service providers-**A complainant reported that a supervised visitation worker discouraged the grandparent from becoming involved with and voicing concerns regarding the children's welfare.
- **Service providers-**A complainant reported that Bureau staff implemented a psychological evaluation with an unqualified and biased service provider; the service provider was a former therapist of the father.
- **Not addressing educational needs of a child-**A complainant reported that children missed excessive school when taken into custody and that Bureau staff did not attempt to maintain the children's school of enrollment.
- **Not addressing needs as court ordered-**A complainant reported that the Bureau was not providing the mother with services ordered by the court.

Initial Assessment (3)

- **Inadequate investigation of child safety in response to an allegation of maltreatment-**A complainant reported that Initial Assessment (IA) staff conducted their first interview with a child in the presence of the alleged maltreator, which compromised an accurate account of events and they did not implement a forensic interview or involve law enforcement.
- **Lack of thorough initial assessment of primary caregiver-**A complainant reported that the IASW did not make adequate assessments, including family dynamics and surrounding circumstances, in the conclusion of child safety.
- **Lack of development and management of an out-of-home safety plan using relatives-**A complainant reported that available relatives are not being utilized as resources in the safety plan.

Case Planning (1)

- **Conditions for return of children-**A complainant reported that the mother had completed services for reunification, was repeating those services, and that neither she nor her support systems had been involved in Coordinated Service Team (CST) meetings.

Notification (1)

- **Not receiving proper notification regarding a change of placement-**A complainant reported that the mother was not provided information related to multiple changes of placement for her children.

Inconclusive Finding (1)

1. Inconclusive

Issue: Notification—not receiving proper notification regarding a change of placement-A complainant reported that a child was removed from a placement, but that the mother was not notified of the change of placement.

Finding-The Ombudsman Office review found that the Bureau made multiple efforts to engage the mother in a planned change of placement that included the cooperative efforts of Wraparound, Children's Court in the form of a guardianship petition, a relative, and Bureau staff. However, the Ombudsman Office was not able to locate a "Notice of a Change of Placement" in the Bureau record. The current Ongoing Supervisor (OS) reviewed the actions of the previous OCM at the point of case transfer and concluded that the previous OCM followed Bureau policy *OCM 26.00: Notification of Change in a Child's Placement* regarding a similar event the following month. The previous OCM was not available for an interview to gain clarity.

The Ombudsman Office concluded that while the application and efforts of the Bureau to inform and engage the mother in planning regarding the change of placement were clear, the actual documentation that should be contained in the case file per Bureau policy *OCM 26.00* could not be located during the Ombudsman Office review.

Ombudsman Office Recommendations-The Ombudsman Office made a recommendation that the Bureau evaluate a greater use of the eWiSACWIS electronic data storage capability to include correspondence in a PDF format or document scanning within case notes.

Bureau's Response-The Bureau agreed with the finding and the recommendation made by the Ombudsman Office. The Bureau noted that eWiSACWIS is a statewide database system for Wisconsin beyond the scope of modification for the Bureau, but the expanded use of imaging for most correspondence was under consideration, although there was not a specific timeframe to implement expanded use.

Status of Recommendation: The Bureau indicated that they currently scan court documents into eWiSACWIS. As equipment is replaced they will look to have more scanning capabilities. The Ombudsman Office considers this recommendation completed.

Findings of Violations (5)

1. Violation

Issue: Initial Assessment process—Lack of interviewing parents-A complainant reported that IA staff did not meet with the mother or adequately investigate the condition of the family within a timely manner prior to taking the children into custody.

Finding-The Ombudsman Office review found and concluded that the designated timeframe requirements for face-to-face contact with the mother did not occur as outlined in the *Wisconsin CPS Access and Initial Assessment Standards, Chapter 7: The Timeframe for Response.* The Ombudsman Office made its finding based on the following: a reasonable belief that within a nine month time period and six CPS reports/referrals, contact efforts should have produced greater or clearer results; the period of time from when the first referral of alleged maltreatment was made to the conclusion of the Initial Assessment, the Initial Assessment process greatly exceeded a period of time for required actions to be taken as outlined in the *Wisconsin CPS Access and Initial Assessment Standards, Chapter 12.L: Supervisory Approval and Documentation*; and Bureau staff did not consistently document efforts to contact the parent as outlined in Bureau policy *IA 40.03: IA Case note Documentation.*

Ombudsman Office Recommendations-The Ombudsman Office made the systemic recommendation that the Bureau implement a strategy to support Initial Assessment staff's ability to:

A. contact families within designated response times;
B. maintain a documented record of their efforts;
C. complete all casework activities within the designated 60 days; and
D. ensure supervisory accountability and oversight.

Bureau's Response-The Bureau accepted the finding and agreed to the recommendation made by the Ombudsman Office. The Bureau indicated that attempts were not made in a timely manner throughout the assessment process and over several referrals of alleged maltreatment. Efforts made did not produce results consistent with best practice standards for information collection. In addition, the Bureau acknowledged that the Initial Assessment process took an excessive amount of time and resulted in inadequate action on the part of the Bureau. Efforts to contact the parent were insufficient and were not adequately and appropriately documented per Bureau policy. The Bureau further indicated that the recommendation was currently being addressed through an Action for Child Protection initiative.

Status of Recommendation:
This recommendation was made in the fourth quarter of 2009, therefore no status information was available as of 12/31/09.

2. Violation

Issue: Lack of action by Bureau staff—lack of follow through by staff regarding concerns-A complainant reported that children were left with relatives in Milwaukee by their parents living in another state because the parents were unable to care for them. The complainant reported that relatives contacted the Bureau of Milwaukee Child Welfare for assistance, but the assessment of the children's safety was limited and action to protect the children was not taken.

Finding-The Ombudsman Office found that parents in another state sent their children to live with relatives in Milwaukee early in the summer. The condition of the family in the other state was observed and reported by the relatives to the Bureau in mid and late summer. The Milwaukee relatives contacted the Bureau repeatedly over a two month period regarding maltreatment issues involving the parents' condition in the state. These CPS referrals were addressed by multiple Access staff and all were screened out with no present danger threats identified. The referrals were received during regular business hours and by after-hours staff. One maltreatment referral was received by after-hours staff and computer laptop accessibility was reported as a barrier to accessing case history information. The after-hours staff reported that after-hours referrals have a focus on present dangers.

The Ombudsman Office concluded that the collective information reported over a two month period provided a foundation for reasonable concern that the children had been or would be subject to neglect under *Wis. Stat. section 48.981(1)(d)* and met the threshold criteria for impending danger threats to the children's safety in three areas of the *CPS Safety Intervention Standards, Appendix Six: The Safety Threshold And Impending Danger Threats To Child Safety*. In addition, the escalation of the family conditions reported was directly cited in the *CPS Access and Initial Assessment Standards, Chapter 3: Information Standards* regarding making decisions based on a single report or an "incident-based approach" and that "escalating family conditions, even where no specific type of abuse or neglect has been reported, may be indicative of threats to child safety."

Ombudsman Office Recommendations-The Ombudsman Office made two systemic recommendations that:

1. The Bureau evaluate the Access and Initial Assessment staff's ability to use current technical supports to obtain case information with an emphasis on after-hours staff receipt of maltreatment referrals; and

2. The Bureau review with all Access and Initial Assessment staff that although present danger and immediate safety are a primary concern, impending danger threats and substantial risk as identified in statutory definitions are equally important in evaluating child safety and the prevention of maltreatment.

Bureau's Response-.The Bureau concurred with the finding made by the Ombudsman Office that there was an incorrect interpretation of neglect as defined by *Wis. Stat. section 48.981(1)(d)*. The Bureau agreed with the first recommendation to continue to make efforts to develop technical support for staff. The Bureau disagreed with the second recommendation for a formal evaluation of all staff in their practice regarding *CPS Access and Initial Assessment Standards, Chapter 3: Information Standards* and *Chapter Five: Decisions at CPS Access*.

Status of Recommendation: Regarding Recommendation 1, the Bureau indicated that they have Access staff entering information from after-hour reports, which allows them to access eWiSACWIS for more information on a particular family or case. The Ombudsman Office considers this recommendation completed. As for Recommendation 2 the Ombudsman Office only tracks those recommendations with which the Bureau agrees.

3. Violation

Issue: Initial Assessment process—Lack of follow-up on a report of child abuse or neglect-A complainant reported maltreatment concerns to the Bureau regarding the actions of school staff, but no action was taken.

Finding-The Ombudsman Office found that the required notice to the school district superintendent was not performed, as prescribed by the State in the *Wisconsin CPS Access and Initial Assessment Standards for a Secondary Assessment: Chapter 18.B.* During an interview, there was obvious confusion when it was brought to the attention of Bureau staff that this notification was required. Bureau staff indicated that they were unaware of this statute/standard and were unsure if the principal had been notified as required. The Ombudsman Office confirmed with Bureau staff that the role of the caseworker was verbally discussed with the parent, required interviews took place, and appropriate contact with the police was made. The Bureau informed the parent of the results of the investigation of alleged maltreatment. The Ombudsman Office found that all other requirements called for in the CPS Access and Initial Assessment Standards for a Secondary Assessment were followed.

The Ombudsman Office concluded that, although all other requirements were met as prescribed by the State in the CPS Access and Initial Assessment Standards for a Secondary Assessment, staff did not follow the requirement under *Chapter XVIII.B [Ref. s. 48.981(7)(a)17., Stats.]* which states, "*When an alleged maltreator of a student is a public school employee and the report was made by someone outside of the school system, the CPS caseworker must notify the school superintendent or her/his designee of the report within 24 hours*."

Ombudsman Office Recommendation-The Ombudsman Office made the recommendation that the Bureau review with all Access and Initial Assessment staff the procedural requirement in the *Wisconsin CPS Access and Initial Assessment Standard, Chapter XVIII.B,* regarding Secondary Assessments that they must notify the school superintendent or her/his designee of the report within 24 hours when an alleged maltreator of a student is a public school employee and the report was made by someone outside of the school system.

Bureau's Response-The Bureau agreed with the finding and the recommendation made by the Ombudsman Office. The Bureau acknowledged that both the Initial Assessment staff and the supervisor were unaware of this standard and did not forward a copy of the complaint to the school superintendent within the 24 hour period. The Bureau indicated that they will remind all Initial Assessment staff of this requirement at an all staff meeting on March 26, 2009.

Status of Recommendation: The Bureau indicated that the interim director discussed this requirement with staff at a meeting on March 26, 2009. The Ombudsman Office considers this recommendation completed.

4. & 5. Violation

Issue: Lack of action by Bureau staff—lack of contact with parent regarding consent for medical treatment-A complainant reported that the children were

vaccinated without parental consent or consultation with the children's primary doctor.

Findings-

(1) The Ombudsman Office review found that Initial Assessment staff made initial contact with the family and that the parents were described as non-cooperative, evasive, and made no specific disclosures of medical information or concerns. Initial Assessment staff took physical custody of the children, conducted a medical screening, and transferred the case to Ongoing Services. Ongoing staff's first attempted contact with the parents was eight days after the screening that recommended immunizations and four days after the children were immunized.

The Ombudsman Office concluded that between the time of a medical recommendation and the application of the medical treatment, Bureau staff made no efforts to contact the parents to "seek their consent and assistance with the medical treatment process" in accordance with Bureau policy *OCM 4.00: Obtaining Medical Treatment for a Child*.

(2) The Ombudsman Office concluded that there was a lack of timely communication between Bureau staff and the foster parent in relation to the actions taken to implement routine medical care for the children. The Ombudsman Office acknowledged that the Interagency Agreement between the Children's Hospital of Wisconsin and the State of Wisconsin Department of Health and Family Services, Bureau of Milwaukee Child Welfare allowed the Child Protection Center (CPC) to make referrals for "treatment services," but it did not appear to include the authority to consent for treatment. The Ombudsman Office acknowledged that the *Milwaukee County Circuit Court Children's Division-Directive Children's 04-07* granted the Bureau the authority to consent to routine medical care; however, the court directive did not appear to grant that same authority to a foster parent.

Recommendations-

(1) The Ombudsman Office made the case specific recommendation that Bureau staff continue to work with the parents regarding the medical care of their children and to provide a written case plan that contained future medical care objectives that allow for parental involvement prior to implementing medical treatment, followed by regular case progress evaluations that document the specifics of achieved objectives or barriers to reaching those objectives.

(2) The Ombudsman Office made the systemic recommendation that the Bureau review requirements with Ongoing staff regarding the provision of medical care to children, specifically in the nature of the Bureau's instructions and their granted authority.

Response-Through multiple letters from the Bureau occurring over the course of two months, the Bureau agreed with the findings and both recommendations. However, they believed that recommendation (2) was case specific rather than systemic. For this reason the Ombudsman Office tracked the recommendation from that perspective.

Status of Recommendation-

(1) The Bureau indicated that the current case plan and case progress evaluation was updated to reflect the medical care objectives to allow for parental involvement and that the parents would need to ensure that all of their children's needs were being adequately met at all times, no matter the circumstance. The Bureau also indicated that the OCM has allowed for parental involvement prior to implementing medical treatment, and that the Bureau would follow up to ensure that the OCM was ensuring parental involvement and that it was documented in the case plan.

(2) The Bureau indicated that they would be meeting with the judiciary, internal legal council, and community health care providers to clarify existing guidelines for informing biological parents and obtaining any necessary consents for the sharing of health information and the provision of health care. Completion is anticipated by next quarterly report.

Findings of Additional Violations (6)

1. Additional Violation

Finding-The Ombudsman Office review found that this case involved a transfer of guardianship, which remained open under a Child in Need of Protection or Services (CHIPS) order. Within the timeframe reviewed, the OCM had three documented contact attempts to meet with the mother, and documentation related to these contacts lacked content or were incomplete. In addition, the OCM made monthly visits to the children's school/child care center, but not the child's home.

The Ombudsman Office concluded that the Bureau's actions were lacking with regard to their efforts to contact the mother and the children in an appropriate setting were in contrast to Bureau policy *OCM 34.00: Frequency and Documentation of Contact with Children, Families, and Caregivers;* including documenting contacts that occurred.

Ombudsman Office Recommendations- The Ombudsman Office made the systemic recommendation that the Bureau remind all ongoing staff of case management responsibilities related to open cases that involve a transfer of guardianship.

Bureau's Response-The Bureau concurred with the finding and recommendation made by the Ombudsman Office and indicated that they had reviewed the related policy and procedures with the ongoing case manager, supervisor, and program manager to ensure documentation standards are upheld.

Status of Recommendation: The Bureau identified this as a case specific issue and indicated that they had clarified with the ongoing case manager the expectations of responsibility around transfer of guardianship. Because the Ombudsman's office identified this as a systemic issue, the Bureau indicated that they would communicate the expectations around case management responsibilities on cases involving transfer of guardianship by March 30, 2010, when the policies and procedures were due to be revised.

2. Additional Violation

Finding-The Ombudsman Office review found that a CPS Report of alleged child maltreatment was screened in and that three months later an additional CPS Report was screened in. Nearly three months after the latest CPS Report, no Initial Assessment–Primary report had been approved for either CPS report.

The Ombudsman Office concluded that the Initial Assessment-Primary report was not completed within 60 days with supervisory approval as required by the *Wisconsin CPS Access and Initial Assessment Standards, Chapter 12.L: Supervisory Approval and Documentation.*

Ombudsman Office Recommendations-The Ombudsman Office made the case specific recommendation that the Bureau ensure a timely completion of all requirements related to the Primary Assessment including the supervisory approval of the Initial Assessment–Primary report.

Bureau's Response-The Bureau agreed with the finding and the recommendation made by the Ombudsman Office. The initial assessment for this case was subsequently completed, reviewed, and approved by the supervisor. The Bureau further indicated they recognize the importance of the statutory mandated completion of the Initial Assessments within 60 days and continue to take measures to ensure compliance with this mandate.

Status of Recommendation: The Ombudsman Office considers this recommendation completed.

3. Additional Violation

Finding-The Ombudsman Office review found that efforts to contact the family were repeatedly not entered in the Bureau record.

The Ombudsman Office concluded that Bureau staff did not consistently document efforts to contact the parent as outlined in Bureau policy *IA 40.03, IA Case Note Documentation.*

Ombudsman Office Recommendations- The Ombudsman Office made a multi-part systemic recommendation in a separate issue that included having the Bureau implement a strategy to support Initial Assessment staff's ability to maintain a documented record of their efforts.

Bureau's Response- The Bureau agreed with the finding and recommendation made by the Ombudsman Office. The Bureau reported that this recommendation was currently being addressed through an Action for Child Protection initiative.

Status of Recommendation:
The Ombudsman Office made this recommendation in the fourth quarter of 2009, therefore no status information was available as of 12/31/09.

4. Additional Violation

Finding-The Ombudsman Office review found a lack of Case Progress Evaluation (CPE) that was in contrast to *DCF Memo Series 2006-09: Wisconsin Child Protective*

Services Safety Intervention Standards. Case plans and subsequent Case Progress Evaluations (CPEs) are to be completed every three months.

The Ombudsman Office found that impending danger threats to child safety, along with recommended goals and services to change conditions contributing to impending dangers, were known for three years. The last CPE was not completed for the last year of that time period.

The Ombudsman Office concluded that a guardianship transfer under *Wis. Stat. section 48.977* relieves the Bureau from the responsibility of maintaining permanency plans and court reports. However, this did not include all of the other responsibilities associated with case management as outlined in Bureau policy and the *Wisconsin CPS Safety Intervention Standards*.

Ombudsman Office Recommendations-The Ombudsman Office made the following recommendations:

1. In a systemic recommendation, that the Bureau remind all ongoing staff of case management responsibilities related to open cases that involve a transfer of guardianship

2. In a case specific recommendation, that the Bureau reinitiate the Coordinated Service Team process based on an updated Case Progress Evaluation that includes an outline of the parent's diminished protective capacities and/or conditions impacting on child safety, goals and services aimed to change those capacities and/or conditions, and a specific outline of the different participant's rolls and responsibilities.

Bureau's Response- The Bureau agreed with the finding and the case specific recommendation made by the Ombudsman Office. The Bureau agreed to further explore the systemic recommendation through quarterly meetings with Bureau administration.

Status of Recommendation:

Recommendation 1: The Bureau identified this as a case specific issue and indicated that they have clarified with the ongoing case manager the expectations of responsibility around transfer of guardianship. Because the Ombudsman's office identified this as a systemic issue, the Bureau indicated that it would communicate the expectations around case management responsibilities on cases involving transfer of guardianship by March 30, 2010 when the policies and procedures are due to be revised.

Recommendation 2: The Bureau indicated that the CST process had been reinitiated. Thereafter, CST meetings would occur every three months in conjunction with case progress evaluations (CPE). The Bureau further indicated that most recent CPE reflected the most recent case progress, including diminished caregiver protective capacities and the goals and services necessary to bring about change in hopes of enhancing what is diminished. The most recent CPE indicated that supervised family interaction and family therapy services were in place. Additionally, roles and responsibilities were listed for all parties as

part of the CPE. The Ombudsman Office considers this recommendation completed.

5. Additional Violation

Finding-The Ombudsman Office review found that the most recent Family Interaction Plan was outdated. Since that time, the scheduled dates and times of visits frequently changed. The "least restrictive location" changed from in-home to a center, transportation methods changed and no longer provided door to door services for the mother, restrictions were put in place that required the mother to call two hours prior to visits, and the mother gave birth to another child who was detained. A current Family Interaction Plan may have addressed barriers presented by the dynamics of the case including: the mother confusing the dates and times of visits, the mother being argumentative and/or manipulative with staff regarding the visitation plan, and the complexity of case management due to the number of providers involved.

The Ombudsman Office concluded that the Bureau's actions were not consistent with Bureau policy *OCM 5.00: Establishing and Carrying Out a Family Interaction Plan,* which indicates that a written copy be provided to the family and all relevant parties when changes are made to the Family Interaction Plan. In this case, almost a year and a half passed with considerable changes to the family/case conditions and challenges related to visitation services, yet no updated written plan was communicated to the participants when changes occurred.

Ombudsman Office Recommendations-The Ombudsman Office made the case specific recommendation that a revised Family Interaction Plan be distributed to the relevant parties involved that outlined the detailed schedule of visitation dates, times and locations, and included specific responsibilities of the parent, placement providers, and service providers.

Bureau's Response-The Bureau agreed with the finding made by the Ombudsman Office. The Bureau further indicated that the case specific recommendation was appropriate at the time of the review, however implementing the recommendation would not be pursued as visits had been suspended. When the suspension was lifted the Bureau would develop and share the Family Interaction Plan with all parties.

Status of Recommendation: The Ombudsman Office considers this recommendation completed.

6. Additional Violation

Finding-The Ombudsman Office review found that CST meetings were only attempted four times in a three year period. Although this case involved a transfer of guardianship that remained open under a CHIPS order it required quarterly CST meetings, which were not attempted.

The Ombudsman Office concluded that the lack of actions taken to conduct CST meetings were in contrast with Bureau policy *OCM 2.02: Standardized Protocol for Ongoing Case Management and Safety Services Coordinated Service Team (CST) Meetings*.

Ombudsman Office Recommendations-The Ombudsman Office made the following two recommendations:

1. In a systemic recommendation, that the Bureau remind all ongoing staff of case management responsibilities related to open cases that involve a transfer of guardianship. (recommendation also applied to another issue within the complaint)

2. In a case specific recommendation, that the Bureau reinitiate the CST process based on an updated CPE that includes an outline of the parent's diminished protective capacities and/or conditions impacting on child safety, goals and services aimed to change those capacities and/or conditions, and a specific outline of the different participant's roles and responsibilities. (recommendation also applied to another issue within the complaint)

Bureau's Response-The Bureau concurred with the finding made by the Ombudsman Office and with Recommendation 1, as a case specific recommendation, but not as a systemic recommendation. The Bureau agreed to further explore Recommendation 2 through quarterly meetings with the Bureau administration.

Status of Recommendation:

Recommendation 1: Bureau identified this as a case specific issue and indicated that they had clarified with the ongoing case manager the expectations of responsibility around transfer of guardianship. Because the Ombudsman Office identified this as a systemic issue, the Bureau indicated that they would communicate the expectations around case management responsibilities on cases involving transfer of guardianship by March 30, 2010 when the policies and procedures were due to be revised.

Recommendation 2: The Bureau indicated that the CST process had been reinitiated. Thereafter, CST meetings were to occur every three months in conjunction with case progress evaluations (CPE). The most recent CPE reflected the most recent case progress, including diminished caregiver protective capacities and the goals and services necessary to bring about change in hopes of enhancing what is diminished. The most recent CPE indicated that supervised family interaction and family therapy services were in place. Additionally, roles and responsibilities were listed for all parties as part of the CPE. The Ombudsman Office considers this recommendation completed.

Findings of Concerns (9)

1. Concern

Issue-Lack of Action by Bureau staff—lack of follow through by staff regarding concerns-A complainant reported that children were left with relatives in Milwaukee by their parents living in another state because the parents were unable to care for them. The complainant reported that relatives contacted the Bureau for assistance, but the assessment of the children's safety was limited and action to protect the children was not taken.

Finding-The Ombudsman Office review found an absence of policy or a clear set of expectations for collaborating with a reporter and a CPS agency in a county outside of Wisconsin in efforts to promote the safety and welfare of children. The Ombudsman Office noted sufficient information regarding alleged prior neglect and possible conditions that would subject the children to further neglect was available. Relatives, the children's school, and local law enforcement all contacted the Bureau with maltreatment issues, which accumulated in CPS reports over two months. The reports involved the children's prior condition associated with neglect while living with their parents in another state and the threat that the parents were taking the children back to that state. Relatives indicated that when maltreatment concerns regarding the parents residing in another state were reported to the Bureau, they were not provided with contact information for CPS in the parents' county of origin. While Bureau staff contacted the parents' county of origin in the other state to obtain CPS history information, they did not report or provide information to that state (to which the children could return) regarding current neglect reports in Milwaukee.

Ombudsman Office Recommendations-The Ombudsman Office made the recommendation that the Bureau explore and implement a set of standards similar to the *Wisconsin CPS Access and Initial Assessment Standards, Chapter 2: Multi-County Reports* to address child safety and welfare issues in circumstances involving CPS agencies and counties outside of Wisconsin.

Bureau's Response-The Bureau concurred with the finding made by the Ombudsman Office. The Bureau indicated that the CPS Standards included direction on out of county situations and pointed out that this language should be interpreted to mean any location outside of the county receiving a referral. However, they agreed that there did not appear to be any clear indication on record that any Bureau staff made any such contact with the CPS authorities in the other state or directed any reporter to take such action and that it should have been done. The Bureau agreed with the recommendation made by the Ombudsman Office and completed a review with Bureau management staff to clarify the application of the *CPS Access and Initial Assessment Standards, Chapter 2: Multi-County Reports*.

Status of Recommendation:

The Bureau indicated that they completed a review with management to clarify the application of the CPS Access and Initial Assessment Standards, Multi-County Reports, which includes contacting other states when information indicates a family is from or going to another state. The Bureau was due to work on revising Access and Initial Assessment procedures (which would include contacting other states) by March 30, 2010.

2. Concern

Issue-Lack of action by Bureau staff—lack of contact with parent for consent for medical treatment-A complainant reported that the children were vaccinated without parental consent or consultation with the children's primary doctor.

Finding- The Ombudsman Office review found that there was a lack of timely communication between CPC and the OCM prior to actions taken to implement routine medical care for the children. In the absence of the parents' initial

cooperation, limited information was obtained but was not clearly transmitted to medical staff. Reports from medical staff were not received by Ongoing Services until three weeks after the medical screening was completed. Immunizations were provided to the children prior to the case manager receiving information from CPC that they were recommended. The Ombudsman Office was unable to find or be directed to a single data system containing current medical examination findings and treatment recommendations, past and future appointments, and historically significant information of past treatment, diagnosis, and medical providers that was accessible by all Bureau program departments. This appeared to undermine the ability of the OCM to provide informed instructions to care providers and to engage with parents.

The Ombudsman Office concluded that the Bureau's process for obtaining and disseminating medical information was not performed in a timely manner, which involved coordinating information between different program departments of Initial Assessment, Ongoing Services, the foster care provider under the guidance of Children's Service Society of Wisconsin, and the CPC. The Ombudsman Office acknowledged that the starting point for obtaining a child's medical information was the report provided by the parents of the children and that the parents' lack of cooperation significantly hindered the Bureau's ability to maintain the safety and well-being of the children and/or the ability to follow the parents' preferences related to medical care.

Recommendation- The Ombudsman Office made the systemic recommendation that the Bureau enhance the communication process between the CPC and the Bureau, specifically in the CPC's timely transfer of medical assessment results and recommendations directly to Bureau staff responsible for decision-making and management of the case.

Response-Through multiple letters from the Bureau occurring over the course of two months, the Bureau agreed with the finding and recommendation made by the Ombudsman Office.

Status of Recommendation-The Bureau indicated that their staff receive a copy of the medical report, findings, and recommendations before they leave the CPC office. If someone other than Bureau staff brings the child into the CPC then the report gets faxed to Bureau staff.

3. Concern

Issue-Lack of action by Bureau staff—Information withheld by staff-A complainant reported that the mother was not kept informed of medical assessments, recommendations, or actions to provide for the children's medical needs.

Finding- The Ombudsman Office review found that the children initially informed their mother of medical appointments that had taken place. The medical conditions of the children were discussed a week later during a family conference, but the mother became frustrated and left the meeting early. During a Service Implementation Hearing, dental and medical recommendations based on the foster care health

screenings were discussed. Twice during the following month the mother called the OCM requesting information. In both instances the mother was depicted as unable to focus and was not provided with the information requested.

The Ombudsman Office concluded that Bureau staff initially made formal efforts to provide the mother with information regarding the medical care of her children, although the mother's participation and comprehension of the discussions appeared limited. At a later date the mother then informally requested information regarding her children, at which time neither the OCM nor mother appeared to be communicating effectively. Communication barriers hindered the process to provide the information to the mother and appeared rooted in an ineffective worker-parent relationship or lack of partnership to achieve the goals of the family and the Bureau. Both Bureau staff and the parent contributed to the communication barriers. While both could have made efforts to alleviate the condition, Bureau staff ultimately had the responsibility for making these efforts.

Ombudsman Office Recommendations-The Ombudsman Office made the case specific recommendation that the Bureau provide the mother with a written outline describing the medical/dental care provided to her children while placed in out-of-home care. The outline should include: the contact information of the physicians, medical treatments reported to have been performed, and any follow-up care recommendations made.

Bureau's Response-The Bureau acknowledged the finding and agreed to the recommendation made by the Ombudsman Office. The Bureau indicated that attempts were made to provide the mother with the information requested, but that there were communication barriers. The Bureau further indicated that they would provide the mother with a written outline describing the medical/dental care provided to her children while they were placed in out-of-home care.

Status of Recommendation:
This recommendation was made in the fourth quarter of 2009 therefore no status information was available as of 12/31/09.

4. Concern

Issue-Lack of action by Bureau staff—Information withheld by staff-A complainant reported that the children's doctors' information was not provided to the mother.

Finding-The Ombudsman Office review found that there had not been a formal notice providing the doctors' information to the mother and that information was provided upon request. Bureau staff noted that keeping the mother informed of the children's doctors had been a challenge as doctors were selected by the placement providers, and there had been many changes in the children's placements. The Ombudsman Office review found 16 placements for five children in one year. The Ombudsman Office also noted that legal custody was court ordered to remain with the mother, but restricted her ability to contact the foster home.

The Ombudsman Office concluded that the Bureau made reasonable efforts to keep the mother informed of the children's doctors, but frequent physician changes contributed to underlying issues, which hindered the Bureau's effectiveness.

Ombudsman Office Recommendations-The Ombudsman Office made the recommendation that the Bureau consider making the consistency of medical care a priority for children in or entering out-of-home care through efforts to maintain the same primary care physicians for the child

Bureau's Response-The Bureau agreed with the finding and the recommendation made by the Ombudsman Office and indicated that the Region instructed its supervisors to meet with their staff to reinforce that a child's primary physician be maintained whenever possible. Children's Service Society of Wisconsin (CSSW) agreed to also reinforce this with their staff.

Status of Recommendation: The Bureau indicated that they were working on a nursing initiative that would address this problem and that it would consider efforts to maintain the same primary care physician. The Bureau anticipated this to be fully implemented by June 1, 2010.

5. Concern

Issue-Not receiving fair treatment by Bureau staff—bias against the mother-A complainant reported that the OCM was biased in their understanding and reporting of the mother's actions to address visitation, placement, and signed consent issues.

Finding-The Ombudsman Office review found that there appeared to be a bias generated from a misunderstanding of the mother, the Bureau's inadequate communication efforts, and a perceived lack of actions taken to work in partnership with the family and de-escalate conflicts.

Initial Assessment staff did not appear to complete and/or take action within a timely fashion and did not appear to make appropriate efforts to meet with the mother during the assessment of the family. Poor efforts by Initial Assessment staff created a situation where the focus was on the relationship issues between the mother and the Bureau rather than investigating the CPS referral. This de-emphasized the conditions within the family and impacted on the child's welfare and safety.

When the children were in out-of-home care, Ongoing staff appeared not to take adequate actions to communicate or build a working "partnership" relationship with the mother in response to her requests for information. These requests were responded to with indifference and although Ongoing staff investigated concerns for safety raised by the mother, the results were not communicated to her.

The Bureau made efforts but encountered barriers when they tried to enroll the children in school. However, it appeared that these were not communicated with the mother leading to her perception that an unequal level of accountability existed regarding the requirement for the children to be in school. Bureau staff maintained assumptions of the mother that were not based on observations nor accurate historical accounts, which lead to greater scrutiny and restrictive services.

Furthermore, the mother's efforts to resolve communication barriers were undermined by the actions of Bureau staff.

The Ombudsman Office concluded that Bureau staff did not apply their philosophies or principles that "recognize and support the families' strengths" and "work in partnership with the families to promote independence." The lack of understanding by the mother combined with heightened concerns of aggression that were not based on direct observation nor evidence created a climate of bias. In addition, poor communication and/or a lack of partnership in the working relationships contributed to an adversarial relationship between the Bureau and the mother. The continuation of this relationship without adequate efforts to adjust was in itself a continuation of bias when considering the role and responsibilities of Bureau staff.

Ombudsman Office Recommendations-The Ombudsman Office made the case specific recommendation that the Bureau review the case with regard to the mother's perceptions of bias and discuss how to promote effective communication efforts and work in partnership with this family.

Bureau's Response-The Bureau acknowledged the finding and agreed with the recommendation made by the Ombudsman Office. The Bureau reported that Ongoing case management staff worked closely with the mother in an attempt to improve communication and build a partnership. It took some time to build a relationship, but eventually the communication did improve and ultimately the children were able to be safely reunified with the mother.

Status of Recommendation:
The Ombudsman Office considers this recommendation completed.

6. Concern

Issue-Bureau recommendations to the court—Inaccurate information provided to court-A complainant reported that false information was contained in the court report that stated the mother had a Child Protective Services (CPS) history of abuse and criminal charges of battery.

Finding-The Ombudsman Office review found that information in the court report and the Request for Emergency Detention, or Pick-up Order, was not consistent with the criminal record. The criminal record reflected that the mother was not found guilty of child abuse. This information was repeated in the Order for Temporary Physical Custody and the Original Disposition Report to the Court created by Ongoing Services. In addition, all other parties cited with criminal records in Initial Assessment's court report did not include a finding or a sentence.

The Ombudsman Office concluded that an unequal emphasis was put on the history of the mother in comparison to other parties cited with a criminal record, that the criminal record of the mother was not clearly communicated in a report to court, and that incorrect information was placed in two other court related documents

Ombudsman Office Recommendation-The Ombudsman Office made the case specific recommendation that the Bureau make corrections to the Bureau record to accurately reflect the mother's criminal record and provide written notice to the mother regarding a correction of information contained in the Request for Emergency Detention, or Pick-up Order, and subsequent Original Disposition Report to Court.

Bureau's Response-The Bureau agreed with the finding and the recommendation made by the Ombudsman Office and indicated that they had worked with the Assistant District Attorney's Office to file a correction document to the legal file to ensure there was no appearance of bias against the mother. A copy of the correction was sent to the child's parents and all representative legal counsel. In addition, this identified error and all efforts to correct would be documented in the eWiSACWIS case file.

Status of Recommendation: The Bureau indicated that they corrected the record and provided written notice to the mother regarding the correction. The Bureau record and follow-up contact with the complainant confirmed the completion of this recommendation. The Ombudsman Office considers this recommendation completed.

7. Concern

Issue-Visitation—issue regarding the management of the visitation plan-A complainant reported that escalating misunderstandings between the visitation worker, OCM, and the mother led to a less restrictive visitation plan that was not appropriate.

Finding- The Ombudsman Office review found that a supervised visitation (SV) worker and the mother maintained an effective working relationship until a communication issue developed regarding the progress within the visitation plan.

The mother requested that the SV worker be present at a meeting, but the OCM informed the SV worker that they did not need to attend. After the meeting, the mother called the SV worker upset about the SV worker not attending. In the days that followed, the mother made multiple calls to the SV worker regarding the communication issue. The agency providing visitation services brought their concerns regarding the mother's behavior to the OCM and visitation was moved to a facility that was not appropriate for visits and included the SV worker, their supervisor, and two security guards.

The Ombudsman Office concluded that Bureau staff's actions were not consistent with Bureau principles to work in "partnership" with families to promote independence, but undermined efforts of the family to address their concerns with the visitation plan and contributed to the escalating conflict between the family and the Bureau. Bureau staff did not follow the intent of Bureau policy *OCM 2.02: Standardized Protocol for Ongoing Case Management and Safety Services Coordinated Service Team (CST) Meetings*, which indicates that a meeting may be called at any time if circumstances warrant and/or develop a plan to address conflicts through mediation.

Ombudsman Office Recommendations-The Ombudsman Office made the case specific recommendation that the Bureau review the case with regard to the mother's perceptions of bias and discuss how to promote effective communication efforts and work in partnership with this family. (recommendation also applied to another issue within the complaint)

In making this recommendation, the Ombudsman Office considered that the children had been returned home, but a continued relationship must be maintained with the mother until case closure.

Bureau's Response-The Bureau acknowledged the finding and agreed with the recommendation made by the Ombudsman Office. The Bureau indicated that the visitation plan was revised due to concerns reported by the visitation staff and that Bureau staff did attempt to meet with the family at a CST to resolve the concerns, but this meeting was not successful. The Bureau reported that the recommendation was implemented by Ongoing Case Management staff prior to the final review of the case by the Ombudsman Office. The Bureau further reported that in order to remove the perception of bias and promote effective communication with this family, the supervisor took a primary role in this case and assigned a new case manager as the secondary case manager and that this was beneficial to the family and ultimately resulted in the children being reunified with the mother.

Status of Recommendation:
The Ombudsman Office made this recommendation in the fourth quarter of 2009 therefore no status information was available as of 12/31/09.

8. Concern

Issue-Notification—not receiving proper notice of a change of placement-A complainant reported that the Bureau did not provide the mother with a notice of a change of placement.

Finding-The Ombudsman Office review found that a teen was placed in an assessment center for two months and that the teen's placement was then changed to a non-relative/unlicensed placement. There were no emergency circumstances and the case had not reached disposition. No attempts were made to notice the mother of this change of placement, and there were concerns related to her disagreement and possible response.

The Ombudsman Office concluded that Bureau staff did not take adequate actions to apply intervention philosophies that focused on the family system or respected the individual by considering the impact of not informing the mother of a change in her teen's placement. For further clarification, the Ombudsman Office did not find a violation since there was no dispositional order; the Bureau was not required to formally notice a change of placement as outlined in *Wis. Stat. section 48.357.* The Ombudsman Office also noted that the type of placement was approved in the court order.

Ombudsman Office Recommendations-The Ombudsman Office made the case specific recommendation that the Bureau provide the mother with a notice of the change of placement that occurred. The notice would include the name and address

of the placement, the reason for the change in placement, and a statement describing why the placement was preferred in relation to other placement options in meeting the objectives of a case plan and/or conditions of the court.

Bureau's Response-The Bureau agreed with the finding and the recommendation made by the Ombudsman Office and indicated that the mother had been fully informed of the name and address of the placement, the reason for the change in placement, and why the placement was preferred in relation to other placement options in meeting the objectives of the case plan.

Status of Recommendation: The Ombudsman Office considers this recommendation completed.

9. Concern

Issue-Confidentiality—inappropriate request for signed consent-A complainant reported that the mother was requested to sign blank or incomplete authorizations/releases for confidential information.

Finding-The Ombudsman Office review found that during a Family Conference meeting the OCM presented blank consent forms to the mother. Staff made efforts to fill the forms out as they were being explained to the mother. The mother was not cooperative in this process and did not want to sign them prior to reviewing them with her attorney who was present by phone. It was agreed upon that the OCM would fax them to the attorney for review. This was interpreted and reported that the mother "refused" to sign consent to obtain information on the children (i.e., school, medical, etc.).

The Ombudsman Office concluded that there was not a specific statute, standard, or policy regarding the steps to request a parent to sign consent forms. The Bureau took actions to complete the consent forms with the parent, but legal consultation was desired. A reasonable person would believe that the consent forms would need to be filled out prior to their review by legal counsel in order for an attorney to adequately advise their client. In addition, the act of requesting legal counsel did not have the same implied meaning as "refusing" to provide consent.

Ombudsman Office Recommendations-The Ombudsman Office made the case specific recommendation that the Bureau review with staff the difference between a client "refusing" to provide consent in comparison to a client wanting legal consultation prior to providing consent and how to accurately report this to the court.

Bureau's Response-The Bureau acknowledged the finding and agreed to the recommendation made by the Ombudsman Office. The Bureau agreed that the term "refusal" to sign the consent was not accurate, but would consider this to be a communication issue rather than a confidentiality issue. The Bureau indicated that they would follow the recommendation to review with staff the difference between a client's "refusing" to provide consent in comparison to a client wanting legal consultation prior to providing consent.

Status of Recommendation:
The Ombudsman Office made this recommendation in the fourth quarter of 2009 therefore no status information was available as of 12/31/09.

Findings of Additional Concerns (5)

1. Additional Concern

Finding-The Ombudsman Office review found that the IASW first contacted the child and the mother nearly two weeks after an alleged maltreatment call was screened in. Efforts and/or attempts to establish face-to-face contact with the family within the designated response time were hindered due to a reported crisis on another case involving a missing child. A coverage practice of re-assigning the case was not applied nor was a supervisor involved in that decision.

The Ombudsman Office concluded that the timely initiation of the investigation did not appear to be consistent with the intent of the *Wisconsin CPS Access and Initial Assessment Standards, Chapter 7: The Time Frame for Response*.

Ombudsman Office Recommendations-The Ombudsman Office made the systemic recommendation that the Bureau explore practice methods to increase supervisory awareness and enhance a supportive environment to prioritize the need to make face-to-face contact with families within designated response times to allegations of child maltreatment.

Bureau's Response-The Bureau agreed with the finding and the recommendation made by the Ombudsman Office. The Bureau indicated that they were aware of the concern and were in the process of revising the case assignment procedure in order to increase supervisory awareness of referrals assigned to IASWs in their respective units It was expected that the revision would increase the percentage of face-to-face contacts with families within the designated response times assigned to the access report.

Status of Recommendation: Effective January 4, 2010, the Bureau indicated they will implement a tracking system for supervisors to utilize to ensure face-to-face compliance. This information is reviewed weekly within each region. The Ombudsman Office considers this recommendation completed.

2. Additional Concern

Finding-The Ombudsman Office found that the OCM facilitated the release of the foster parent's (FP) telephone number to the grandparent with the approval of the FP. The Ombudsman Office noted that the Bureau encourages foster parents to work in partnership with the agency and birth families to facilitate regular contact and include the family in as much of the child's life as possible, especially when the permanency plan is reunification. Bureau policy *OCM 2.00: Case Management Responsibility by Ongoing Services* directs the OCM to arrange, coordinate and evaluate a family interaction plan, but it also directs the OCM to continually assess for the safety of the child and to seek supervisory approval and consultation. The OCM did not seek supervisory approval or consultation before allowing for the exchange of phone numbers between the grandparent and the FP. The Ombudsman

Office also found no evidence to suggest that the OCM considered how the disclosure of the FP's phone number was not consistent with the court directive for the placement to remain undisclosed.

The exchange of phone numbers was not accompanied by any discussion or instructions on the part of the OCM to set parameters or limits regarding unsupervised communication. The FP indicated that they were not given a copy of the Family Interaction Plan (FIP) nor did the FP have a clear understanding of what role the grandparent was supposed to have in regard to allowable interaction with the child.

The Ombudsman Office concluded that the disclosure of the Foster Parent's phone number to the grandparent was in contrast to the court directive that the placement of the child be undisclosed. The Ombudsman Office noted that the FIP is formatted in a way that prompts Bureau staff to address considerations of safety regarding interaction with both parents and siblings, but not interactions with extended family members or other considerations such as a court order for a nondisclosure of placement information. Considerations of these factors were overlooked in the supervisory approval process. Key participants did not have a clear understanding of the information outlined in the FIP with an emphasis on the "participants" roles and expectations.

Ombudsman Office Recommendations-The Ombudsman Office made the following systemic recommendations that:

1. The Bureau explore additions to *OCM 5.00: Establishing and Carrying Out a Family Interaction Plan* to provide direction to the OCM regarding relative contact allowances and restrictions, court directives or considerations that include but are not limited to nondisclosure of placement information, and emphasize the supervisory role in the approval process to ensure for quality and accuracy of the Family Interaction Plan.

2. The Bureau review with responsible agencies the expectation of care provider's having a copy of the Family Interaction Plan as outlined in *OCM 5.00: Establishing and Carrying Out a Family Interaction Plan.*

Bureau's Response-The Bureau disagreed with the finding as presented by the Ombudsman Office and indicated that the ongoing case manager did not facilitate the release of the foster parent's telephone number, but was made aware of the exchange after it had occurred. However, the Bureau acknowledged that the OCM was responsible for assisting the parties in understanding the court directives and should have obtained supervisory consultation once disclosure of the phone number was known. The Bureau reviewed best practice expectations with related staff to ensure clarity. Regarding the recommendations, the Bureau did not believe that this issue extended beyond this specific case, but indicated that they would explore the recommendations if they determined them to be systemic.

Status of Recommendation:

Recommendation 1: The Bureau indicated that they will incorporate this information as policies and procedures are reviewed and updated. The Bureau will report on this recommendation by next cycle on status.

Recommendation 2: The Bureau indicated that they will report by next cycle on status.

3. Additional Concern

Finding-The Ombudsman Office review found a practice inconsistency regarding the Bureau's philosophy and principle: "Successful and comprehensive responses to child abuse and neglect require coordinated service systems and supports, formal and informal, in order to assist families in preventing, ameliorating, and changing those conditions that negatively affect child and family well-being."

The Ombudsman Office concluded that in the interest to promote the engagement of appropriate family/relatives in case planning, and as possible placement providers, the Bureau should promote the coordination of service systems to assist families gaining access to community services. Although a relative placement provider did not specifically request assistance to obtain child care supports or other formal resources, child care was an identified concern and left to the family to manage, which proved unsuccessful. In a separate relative placement, formal child care services were implemented as a support and as part of a safety plan. Bureau staff reported that there was not a process within the Bureau or a structured arrangement with an agency to assist relatives in obtaining child care under the urgent circumstances of accepting a placement of a relative's child in their home. In some cases foster parents were assisted with a letter regarding a placement in order for foster parents to gain access to child care, making arrangements with a child care provider to implement services while payments were approved in the Wisconsin Shares Child Care Subsidy Program.

Ombudsman Office Recommendations-The Ombudsman Office made the systemic recommendation that the Bureau (a) coordinate with the Wisconsin Shares Child Care Subsidy Program and (b) explore internal methods to support pending placement options of a child with a fit and willing relative by reducing system barriers in the obtainment of urgent community resources for child care.

Bureau's Response-The Bureau agreed with the finding and the recommendation. The Bureau further indicated that the State Department of Health Services (DHS) would take over from Milwaukee County child care eligibility determinations in January 2010 and that DHS and the Department of Children and Families were aware of the need to develop a new process for authorizations for both foster parents and relative caregivers. The Bureau identified efforts of staff that support caregivers in securing day care through letter writing and addressing barriers.

Status of Recommendation: The Bureau indicated that the Wisconsin Shares Child Care Subsidy Program provided multiple on site trainings on the changes for child care. In addition, support to relatives was enhanced through the new graduated licensing process. The Ombudsman Office considers this recommendation completed.

4. Additional Concern

Finding-The Ombudsman Office review found that a male was repeatedly observed in the mother's home. The mother changed the explanation of his role and functions

within the family several times, refused to provide his name or any identifying information, and blocked attempts of the Parent Assistant (PA) to monitor the children. The PA was eventually able to identify the male and obtained his address. The mother indicated that he was going to assist with meal preparation and identified him as a support. The mother also explained that she wanted him to observe the actions of the Bureau. The Bureau's assessment of the mother identified that a lack of natural supports was a barrier to the mother's ability to maintain the children's safety, and increased supports were recommended by both a therapist and the Bureau. The PA identified this man as a distraction and requested that he be excluded from supervised visitation with the children. The Bureau agreed. The Bureau did not ask the mother if this man should be included in CST planning nor did they attempt to include him as a support.

The Ombudsman Office concluded that the Bureau had established a case plan goal of developing the mother's supports. The Bureau gained information on one of the mother's identified supports through the efforts of the PA, but Bureau staff took no action to engage the support or encourage the mother to include him in the Bureau's intervention. The Bureau's actions appeared inconsistent with the intent of Bureau policy *OCM 2.02, Standardized Protocol for Ongoing Case Management and Safety Services Coordinated Service Team (CST) Meetings*.

Ombudsman Office Recommendations-The Ombudsman Office made the case specific recommendation for Bureau staff to explore how to work with the mother and her identified support to develop a mutual understanding, within the Coordinated Service Team, of expectations and responsibilities for child safety and measurable steps to reunification.

Bureau's Response-The Bureau understood the concern and agreed with the recommendation made by the Ombudsman Office. Their response indicated that Region management would discuss the concern with their leadership team to ensure the full engagement of all related parties in CST meetings.

Status of Recommendation: The Bureau indicated that the case manager conducted a home visit to help the mother understand the CST process and the support person was included in the CST process. The Ombudsman Office considers this recommendation completed.

5. Additional Concern

Finding-The Ombudsman Office review found that CPEs had generalizations of case progress, but lacked specific details. The generalizations lacked specific examples of actions the parent took that demonstrated their enhanced protective capacities and that should have been included in the three month summary. Similarly, Permanency Plans lacked detailed information in its summary of the previous six months, and the majority of information appeared to be copied from the previous document, leading the reader to false conclusions of case progress. The Ombudsman Office identified credible sources that indicated the OCM verbally communicated and responded to questions adequately regarding the family's condition. Finally, the Ombudsman Office found that only two CST meetings had been conducted over the previous two years. Bureau staff identified significant barriers to using the CST model and the efforts that were made to maintain a level of

communication as an alternative. The Ombudsman Office acknowledged that each case was different and that policy was not designed nor intended to be inclusive of every possible situation, thus occasional exceptions to policy are inevitable. However, when an exception is identified as being necessary, the decision making process utilizing supervisory roles and sound professional judgment should be entered in the case record.

The Ombudsman Office concluded that documentation in the CPE and Permanency Plans appeared to be copied from the previous documents, leading the reader to false conclusions of case progress and did not reflect accurate conditions of the family over time. There was also a lack of documentation in the record that explained why CST meetings were not used or how other methods were applied in the absence of the CST approach.

Ombudsman Office Recommendations-The Ombudsman Office made the recommendation that the Bureau create a summary dating back to the time noted that would capture the details of the parent's enhanced diminished protective capacities and conditions of the home that supported child safety, noting any barriers and plans to address these barriers. Furthermore, the Ombudsman Office recommended that the summary should be included in the next CST, recorded in the next CPE, and shared with the court at the next opportune time.

Bureau's Response-The Bureau agreed with the finding and the recommendation made by the Ombudsman Office.

Status of Recommendation: The Bureau indicated that the barriers to reunification were addressed, the Court approved reunification, and the child was reunified with the parent. The court summary was completed at the extension hearing. The Ombudsman Office considers this recommendation completed.

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Appendix 10

2009 Communication Activities

Meetings	Date
Community – 29	
▪ Milwaukee Child Abuse Prevention Services (MCAPS) Coalition, Public Policy Committee	1/12/09
▪ Brighter Futures Meeting	1/27/09
▪ MCAPS Network, Public Policy Sub-Committee	1/29/09
▪ MCAPS Network, Public Policy Committee	2/9/09
▪ Brighter Futures Meeting	2/17/09
▪ Youth Aging Out of Foster Care, Panel Discussion and Resource Fair	2/28/09
▪ MCAPS Network, Public Policy Committee	3/9/09
▪ Children's Rights, Eric Thompson	3/24/09
▪ MCAPS Network, Public Policy Committee	4/13/09
▪ Brighter Futures Meeting	4/21/09
▪ The Medically Fragile Foster Child: Improving Health Status through Education and Community Linkages, Project overview and preliminary findings	5/11/09
▪ MCAPS Network, Public Policy Committee	5/11/09
▪ Brighter Futures Meeting	5/19/09
▪ A Community Conversation About the Safety of Children in Foster Care, Planning Council Report Discussion	5/27/09
▪ Career Youth Development, Executive Director and PR/Community Outreach Special Events	6/3/09
▪ MCAPS Network, Public Policy Committee	6/8/09
▪ Brighter Futures Meeting	6/18/09
▪ The Medically Fragile Foster Child, Advisory Board Meeting	6/22/09
▪ MCAPS Network, Public Policy Committee	7/13/09
▪ Brighter Futures Meeting	7/21/09
▪ MCAPS Network, Public Policy Committee	9/14/09
▪ Brighter Futures Meeting	9/15/09
▪ African Americans United for Inclusive Child Welfare Reform, Community meeting	10/7/09
▪ MCAPS Network, Public Policy Committee	10/12/09
▪ African Americans United for Inclusive Child Welfare Reform, Community meeting	10/28/09
▪ MCAPS Network, Public Policy Committee	11/9/09
▪ Brighter Futures Meeting	11/17/09
▪ MCAPS Network, Public Policy Committee	12/14/09
▪ Brighter Futures Meeting	12/15/09

Continued

Meetings	Date
Policy – 5	
▪ Senate/Assembly Child Welfare Listening Session, Milwaukee	2/12/09
▪ Special Committee on Strengthening Wisconsin Families, Public Hearing on Foster Care related legislation, Milwaukee	4/2/09
▪ Ombudsman Workgroup Meeting	9/11/09
▪ Joint Legislative Public Hearing on Indian Child Welfare Bills – SB288/AB421, Madison	9/16/09
▪ Ombudsman Workgroup Meeting	10/20/09
Partnership Council – 21	
▪ Milwaukee Child Welfare Partnership Council (Partnership Council), Executive Committee Meeting	1/16/09 1/26/09
▪ Partnership Council Chair, Pastor Ivy	1/29/09
▪ Partnership Council Associate Member, Colleen Ellingson	1/30/09
▪ Partnership Council Meeting	2/3/09
▪ Partnership Council, Health Care Committee Meeting	2/13/09
▪ Partnership Council, Executive Committee Meeting	3/13/09
▪ Partnership Council, Executive Committee Meeting	4/24/09
▪ Partnership Council Meeting	5/6/09
▪ Partnership Council, Health Care Committee Meeting	5/15/09
▪ Partnership Council, Executive Committee Meeting	6/12/09
▪ Partnership Council Executive Committee Meeting	6/17/09
▪ Partnership Council Chair, Pastor Ivy and Janel Hines, Quarterly Report discussion	7/24/09
▪ Partnership Council Meeting	9/11/09
▪ Partnership Council, Ombudsman Workgroup	9/18/09
▪ Partnership Council Executive Committee Meeting	10/20/09
▪ Partnership Council, Ombudsman Workgroup	10/23/09
▪ Partnership Council Meeting	11/18/09
▪ Partnership Council, Community and Cross Systems Committee Meeting	
▪ Partnership Council, Health Care Committee Meeting	11/23/09
▪ Partnership Council, Executive Committee Meeting	12/11/09
▪ Partnership Council, Community and Cross Systems Committee Meeting	12/18/09

Continued

Meetings	Date
State/Bureau/Partners – 14	
▪ Bureau of Milwaukee Child Welfare (Bureau) Interim Director, Mary Pat Bohn	1/16/09
▪ Department of Children and Families, Division of Safety and Permanence, Administrator, Cyrus Behroozi	1/16/09
▪ Bureau, La Causa Transition Meeting	2/10/09
▪ Children's Protection Center (CPC), Dr. Lynn Sheets and Mark Lyday	2/16/09
▪ Joint Child Welfare (Bureau)/W-2 CEO Meeting	2/18/09
▪ Bureau CEO Meeting, review 2008 Annual Report	4/15/09
▪ Integrated Family Services (IFS), Teri Zwicki and Michael Boeder	6/3/09
▪ Bureau Interim Director, Mary Pat Bohn, process discussion	6/24/09
▪ Bureau CEO Meeting, review 2nd Quarterly Report & Recommendation Tracking Report	7/15/09
▪ Presiding Children's Court Judge Mary Triggiano, Transition discussion (process issues)	7/15/09
▪ IFS Management Team Meeting, Discuss OMOCW quarterly training for staff	8/17/09
▪ Semi-Annual Community Meeting on Child Welfare – Attended	9/14/09
▪ Children's Family Community Partnership (CFCP) Management, Review process discussion	10/29/09
▪ Bureau Director, Arlene Happach	11/4/09

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Appendix 11

Survey Instruments

COMPLAINANT FEEDBACK FORM Date _____

Your feedback is important to the success of the Office of the Milwaukee Ombudsman for Child Welfare (OMOCW).

1.) Do you feel	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
a. The staff of the OMOCW was courteous.	☐	☐	☐	☐
b. The Associate Ombudsman clearly explained the role and objectives of the OMOCW.	☐	☐	☐	☐
c. The Associate Ombudsman assisted you in clarifying your complaint issues regarding the Bureau of Milwaukee Child Welfare (BMCW).	☐	☐	☐	☐
d. The Associate Ombudsman assisted you in developing your plan to follow the Complaint Resolution Process (CRP).	☐	☐	☐	☐
e. The Associate Ombudsman helped clarify your desired outcomes regarding your complaint with the BMCW.	☐	☐	☐	☐
f. The summary you received from the OMOCW accurately reflected your complaint issues.	☐	☐	☐	☐

2.) Would you recommend this process to someone else? ☐ Yes ☐ No

3.) Is there anything else you would like to tell us?

_____

_____

_____

_____

_____

_____

Post CRP Referral Feedback Form, revised 12/2008

COMPLAINANT FEEDBACK FORM Date _____

Your feedback is important to the success of the Office of the Milwaukee Ombudsman for Child Welfare (OMOCW).

1.) Do you feel	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
a. The OMOCW clearly explained how the findings were determined.	☐	☐	☐	☐
b. The OMOCW clearly explained why the findings were determined.	☐	☐	☐	☐
c. The recommendations would have made a positive impact on your situation if they had been implemented sooner.	☐	☐	☐	☐
d. Other children and families involved in the BMCW will benefit from these recommendations if the BMCW implements them.	☐	☐	☐	☐

2.) Would you recommend this process to someone else? ☐ Yes ☐ No

3.) Is there anything else you would like to tell us?

_____

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_____

_____

Post Review Feedback Form, revised 12/2008

PRESENTATION FEEDBACK FORM Date _____
Feedback is important to the success of our office.

1. I am a: *(Please check one)* **Region**

- ☐ Initial Assessment Worker _____
- ☐ Ongoing Services Worker _____
- ☐ Safety Services Worker _____
- ☐ Foster Care/Adoptions
- ☐ Other _____

***2.* Would you say the information presented today:** *(please check only one response)*

	Strongly Agree	Agree	Disagree	Strongly Disagree
a. Helped me to better understand the OMOCW.	☐	☐	☐	☐
b. Was an appropriate topic for our organization to learn more about.	☐	☐	☐	☐
c. Will increase the likelihood that I may refer someone to the OMOCW.	☐	☐	☐	☐

3. The handout provides useful information and will be a helpful reminder. ☐ Yes ☐ No

4. Would you recommend this presentation to someone else? ☐ Yes ☐ No
If yes, please let us know who: _____

5. What is your overall evaluation of this presentation?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

6. What did you find most helpful about this presentation? Please be specific.

_____

_____

_____

_____

7. What did you find least helpful about this presentation? Please be specific.

_____

_____

_____

_____

COMMUNITY PRESENTATION FEEDBACK FORM Date _____

Feedback is important to the success of our office.

1. **Please check one that best describes your profession:**

☐ Social Worker	☐ Foster Parent
☐ Program Manager	☐ Youth Support Worker
☐ Day Care Provider	☐ Parent Support Worker
☐ Case Manager	☐ Public Education Provider
☐ Health Care Provider	☐ Other _____

   a. **Are you a mandated reporter?** ☐ Yes ☐ No

2. **Would you say the information presented today:** *(please check only one response)*

	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**
a. Was new to me.	☐	☐	☐	☐
b. Helped me to better understand the OMOCW.	☐	☐	☐	☐
c. Was an appropriate topic for our organization to learn more about.	☐	☐	☐	☐
d. Will increase the likelihood that I may refer someone to the OMOCW.	☐	☐	☐	☐

3. **The handout provides useful information and will be a helpful reminder.** ☐ Yes ☐ No

4. **Would you recommend this presentation to someone else?** ☐ Yes ☐ No **If yes, please let us know who:** _____

5. **What is your overall evaluation of this presentation?**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

6. **What did you find most helpful about this presentation? Please be specific.**

_____

_____

_____

7. **What did you find least helpful about this presentation? Please be specific.**

_____

_____

_____

Appendix 12

Guidelines for Ombudsman Office Participation in the Complaint Resolution Process

Guidelines for the Office of the Milwaukee Ombudsman for Child Welfare's (Ombudsman Office) requested participation in the Bureau of Milwaukee Child Welfare's (Bureau) Complaint Resolution Process (CRP).

Assertions of the Ombudsman Office's participation:

The Ombudsman Office will reinforce communication that;

- Respects the substantive and procedural interests of the complainant.
- Respects the point of view of the complainant.
- Respects the jurisdiction, responsibility, and limitations of the Bureau.
- Respects the power, authority, and limitations of the Bureau.

The Ombudsman Office's participation is limited to the complaint issues and resolution expectations identified by the complainant as drafted in the Ombudsman Office's official notification.

The Ombudsman Office will record any agreements for resolution made as a participant in the CRP.

Possible misperceptions of the Ombudsman Office's participation:

The Ombudsman Office is not an advocate and will not side with the complainant or the Bureau.

The Ombudsman Office has no authority to enforce any recommendations discussed or agreed upon in the CRP.

The Ombudsman Office will not make a finding or judgment about the actions or inactions of the Bureau or the complainant while participating in the CRP.