



Office of the  
**Milwaukee**  
**Ombudsman**  
for Child Welfare

## 2007 Annual Report



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March 2008

I am honored to present the 2007 Annual Report for the Office of the Milwaukee Ombudsman for Child Welfare (Ombudsman Office). This is the annual report produced by the 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 Ombudsman Office, however, cautions that the information in this report is not intended to make evaluative statements about the Bureau of Milwaukee Child Welfare (Bureau) services as a whole. Following are some highlights of the 2007 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 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.

### **Information Requests and Referrals and Complaints**

The Ombudsman Office responded to 136 new contacts in 2007. This is an increase of 36% from 2006. Twenty-seven of these contacts were categorized as information requests and referrals, and 109 were categorized as complaints. Additionally, there were 11 contacts carried over from 2006.

The majority of complaints were filed by parents (64%) and other relatives (15%). The top five concerns brought to the attention of the Ombudsman Office were: 1) concerns regarding lack of action by Bureau staff; 2) placement concerns; 3) concerns of not receiving fair treatment by Bureau staff; 4) visitation concerns; and 5) service delivery concerns.

Of the 109 new complaints, 13 did not meet the Ombudsman Office criteria and were screened-out, and 68 were referred to the Bureau's Complaint Resolution Process (CRP).

Of those complaints referred through the CRP, the Ombudsman Office was able to obtain information from 37 of them regarding their experiences with the CRP. Twelve of the complainants reported that the CRP was successful and their issues were resolved. Fourteen reported that the CRP was unsuccessful, and 11 reported circumstances that prevented their completion of the CRP.

### **Reviews and Findings**

The Ombudsman Office completed reviews for 42 issues involved with 15 different complaints. For those complaints received in 2007, 100% of the reviews were completed within the 60-day timeline goal with the average completion time being 39 days.

There were 23 issues (55%) where the Ombudsman Office affirmed the actions of the Bureau, two issues (5%) that were resolved during the review, three issues (7%) where violations were found, nine issues (21%) where concerns were found, and five issues (12%) where the findings were inconclusive.

Additionally, the Ombudsman Office identified four other concerns (designated as "Other Findings") that were not part of the original complaint. These findings included concerns regarding professional standards and accuracy in documentation, physical restraint of children while in Bureau custody, referring new incidents of maltreatment, and an incorrect screening decision.

### **Recommendations**

The 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.

Based on the reviews conducted in 2007, the Ombudsman Office made 48 recommendations, 38 systemic and ten case-specific. Some of the recommendations made were the same for multiple reviews. With regard to the systemic recommendations, 16 of them were regarding documentation concerns and nine recommendations were made regarding the treatment of relatives.

### **Observations, Key Issues and Recommendations**

There are seven areas of observation that the Ombudsman Office has identified as being particularly relevant to the public's interest and critical to continued improvement within Milwaukee's child welfare system. They include:

- Concerns about the Bureau's Complaint Resolution Process
- Documentation concerns

- Parents with mental health issues
- Inclusion of fathers in case planning
- The treatment of relatives
- Concerns regarding the coordinated service team process
- Concerns regarding the length of time required to revise policies

Ten recommendations are being proposed to assist in mitigating these issues.

### **Looking Forward to 2008**

The following are areas of focus for the Ombudsman Office in 2008:

- Provide ombudsman services for all children and families served by the Bureau of Milwaukee Child Welfare.
- Continue to promote the independence and impartiality of the ombudsman program.
- Continue support for improving child welfare practice in Milwaukee and Wisconsin.
- Collaborate with organizations and policymakers that are working toward making Milwaukee and Wisconsin safe and supportive for children and families involved in the child welfare system.
- Track and report progress on Ombudsman Office recommendations made to the Bureau.
- Continue outreach efforts targeting key stakeholders.
- Enhance outreach efforts to include non-traditional resources.

On behalf of the Office of the Milwaukee Ombudsman for Child Welfare staff, we greatly appreciate the opportunity to serve both the children and families involved with the Bureau of Milwaukee Child Welfare and the community.

Lisa Drouin



Ombudsman Director

# Acknowledgements

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

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

Secretary Kevin R. Hayden, State of Wisconsin Secretary of the Department of Health and Family Services, for his commitment to children and families in Wisconsin and to the ongoing success of the Ombudsman Office;

Reggie Bicha, Secretary-Designee, Department of Children and Families, for his dedication to the children and families in Wisconsin and to the ongoing success of the Ombudsman Office;

Dianne Jenkins, Office of the Secretary, Wisconsin Department of Health and Family Services, and Contract Administrator for the Ombudsman Office for her ongoing support and dedication to the success of the Ombudsman Office;

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

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

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## **2007 Annual Report**

### **Introduction**

The 2007 Office of the Milwaukee Ombudsman for Child Welfare (Ombudsman Office) Annual Report is the third annual report on the activities of the Ombudsman Office.

The Ombudsman Office was developed as part of Governor Jim Doyle's *KidsFirst* Policy Agenda, to strengthen the foster care and child welfare system in Milwaukee. Oversight of the Ombudsman Office rests with the Secretary's Office of the Wisconsin Department of Health and Family Services (DHFS). 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.

We are pleased to report that the Ombudsman Office responded to 136 new contacts in 2007 resulting in reviews being completed on 42 issues. This report examines the resolution of these contacts and those 11 carried over from 2006, and identifies key issues raised.

### **What to Expect from this Report**

This is the third annual report produced by the Ombudsman Office and it contains information about the complaints that the Ombudsman Office has received, including recommendations, alerts to possible practice issues, and observations regarding key issues. This information is intended to complement other quality assurance and evaluation information collected by the DHFS to assess the delivery of child welfare services in Milwaukee County. However, the Ombudsman Office cautions that the information in this report is not intended to make evaluative statements about the

Bureau of Milwaukee Child Welfare (Bureau) services, regardless of the number of reviews conducted. The report describes the concerns and experiences of a group of people of 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 is in any way representative of the experience of all of those who have had interactions with the Bureau or the service delivery system as a whole; at the same time, the Ombudsman Office believes that complaint-specific information can be useful in identifying areas for policy development, procedure refinement, and staff development.

## **Background**

Under contract with the DHFS' Office of the Secretary, 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 matters determined by a court of law, issues related to foster and adoptive home licensing, payment for foster care, or 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, law, and practice standards are being followed appropriately, and make recommendations for Bureau action as appropriate.
- Affirm correct actions of the Bureau when applicable.
- Make recommendations related to systemic issues that emerge as a result of reviews.

- Regularly provide information on the Ombudsman Office's activities in the community.

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

- Provide legal representation or bring legal action.
- Assign fault or blame to individuals.
- Have authority to impose its recommendations.
- Become involved in aspects of a case that is the province of the courts.
- 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.

### 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.
- May advocate for recommendations, which in turn may benefit a complainant or improve the administration of government.

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 DHFS for resolution.

Through fact-finding on case-specific issues, the Ombudsman Office monitors system performance and promotes policies, procedures, laws, and practice 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.

## **Outreach**

The Ombudsman Office's outreach efforts in 2007 focused on informing individuals and organizations who work with families involved in the Bureau about the Ombudsman Office. The Ombudsman Director and staff were involved in 15 various presentations and resource fairs throughout the year and provided information about the Ombudsman Office to hundreds of individuals. Presentations and resource fairs include the following:

- Aurora Family Services Staff
- Birth-to-Three agencies
- Brighter Futures agencies
- Children's Service Society of Wisconsin LGBT Program Staff
- COA Resource Fair
- Family Resource Centers
- Mental Health America of Wisconsin Staff
- Milwaukee Child Abuse Prevention Services Public Policy Committee
- Milwaukee County Children's Court Judges
- Milwaukee County Guardian at Litem staff
- Milwaukee Public Schools Resource Fair
- Treatment Foster Care Agencies
- Wraparound Milwaukee Provider Network Meeting (included more than 200 provider agencies)
- Wraparound Milwaukee Resource Fair
- Wraparound Milwaukee Supervisors

## **Staff**

The 2007 Ombudsman Office Staff consisted of the Ombudsman Director, an Associate Ombudsman, a part-time Consultant, a .5 FTE Administrative Assistant/Intake Coordinator, and an attorney to consult regarding legal matters. The Ombudsman Office experienced some turnover in 2007 which resulted in the Associate Ombudsman position being vacant from December 2006 until March 2007. The position was again vacant for a period of one month between October and November 2007. The Administrative Assistant/Intake Coordinator position was vacant for a period of approximately two months between September and November 2007. See Appendix 1 for biographical information on 2007 Ombudsman staff.

## **The Ombudsman Office Process: An Overview**

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

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

Timeline goals from when an individual contacts the Ombudsman Office to completing the screening process and determining if the Bureau CRP has been followed is 14 calendar days. For nearly 96% of contacts, this process was completed within the timeline established. (See Appendix 2-Process Overview and Appendix 3-Timeline Goals which illustrate the work flow of the Ombudsman Office process along with timelines throughout the process.)

The Ombudsman Office communicates with the complainant as to whether or not a review will be conducted and throughout the review process.

Upon completion of the review, the Ombudsman Office communicates the findings and any recommendations to the Bureau and requests a response. Correspondence is then sent to the complainant regarding the Ombudsman Office review, findings, recommendations if any, and the Bureau's response.

## **Ombudsman Office Contacts for 2007**

### **Contacts**

The Ombudsman Office responded to 136 new contacts in 2007. This is an increase of 36% from 2006. While nearly 93% (126) of the contacts were made by phone, the Ombudsman Office also responded to e-mail (7), mail (2), and walk-in (1) contacts. Referrals by fax are also accepted, though none occurred in 2007.

### **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. More than 27% (37) of individuals reported having learned about the Ombudsman Office through Bureau and Contracted Private Agency staff. Nearly 21% (28) had previous contact with the Ombudsman Office, 10% (14) learned of the Ombudsman Office through the Ombudsman Office's brochure, and 9% (12) learned of the Ombudsman Office through a service provider. New referral sources in 2007 include Area Coordinators, the Office of the Attorney

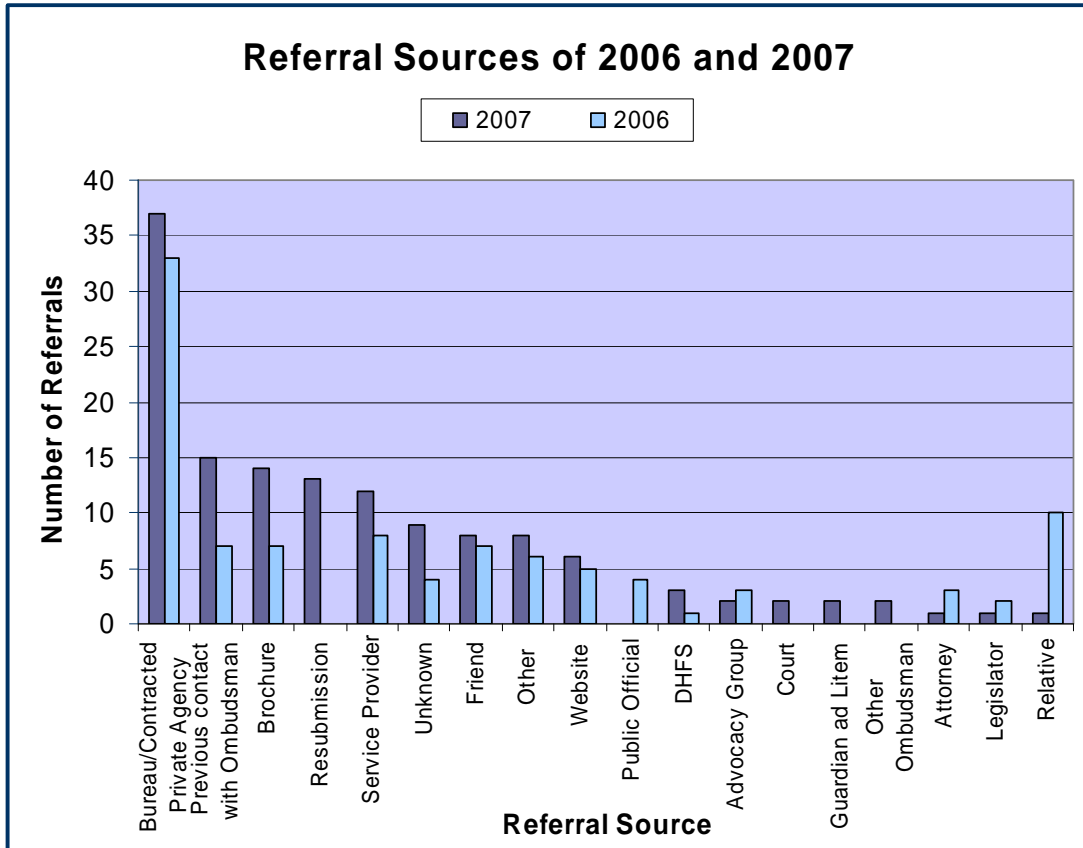
General, the NAACP, other Ombudsman Offices, and W-2 staff. Table 1 provides a breakdown of the referral sources in 2007.

**Table 1. Referral Sources**

Referral Source	Number of Referrals
Bureau/Contract Private Agency Staff	37
Previous Contact with Ombudsman Office	28
Brochure	14
Service Provider	12
Unknown	9
Friend	8
Other (one each from Public Legal Aid, Health Care Professional, NAACP, Attorney General's Office, Adoption Care Class, Phone Book, Community Resource Book, W-2 Worker)	8
Website	6
DHFS	3
Advocacy Group	2
Court	2
Guardian ad Litem	2
Other Ombudsman Office	2
Attorney	1
Legislator	1
Relative	1
<b>TOTAL</b>	<b>136</b>

Four of the five most frequent referral sources remained the same in 2007 as in 2006 – Bureau/Contract Private Agency Staff, Previous Contact with the Ombudsman Office, Brochure, and Service Providers. Figure 1 provides a comparison of referral sources from 2006 and 2007.

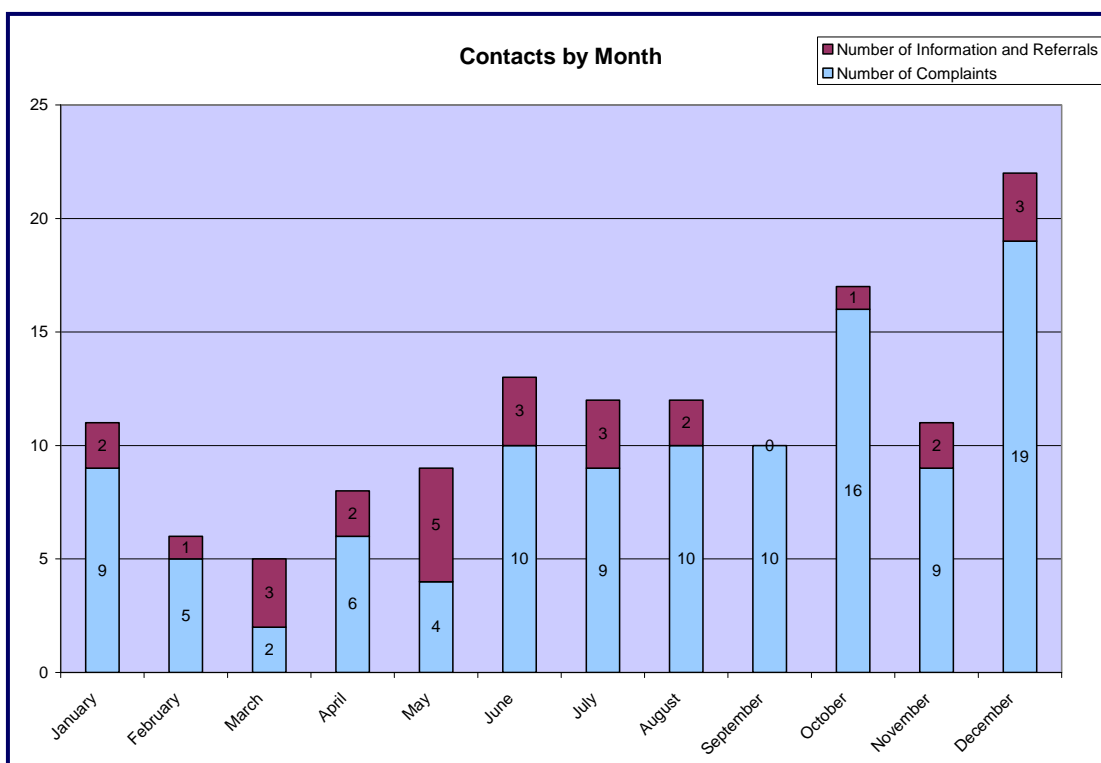
**Figure 1. Referral Sources of 2006 and 2007**



## 2007 Activity

In 2007, the Ombudsman Office provided services for 147 contacts (136 new contacts in 2007 and 11 complaints carried over from 2006). Of those 136 new contacts, 27 were categorized as information requests and referrals and 109 were categorized as complaints. Figure 2 shows a breakdown of contacts by month in 2007.

**Figure 2. Monthly Contacts in 2007**



### Information Requests/Referrals

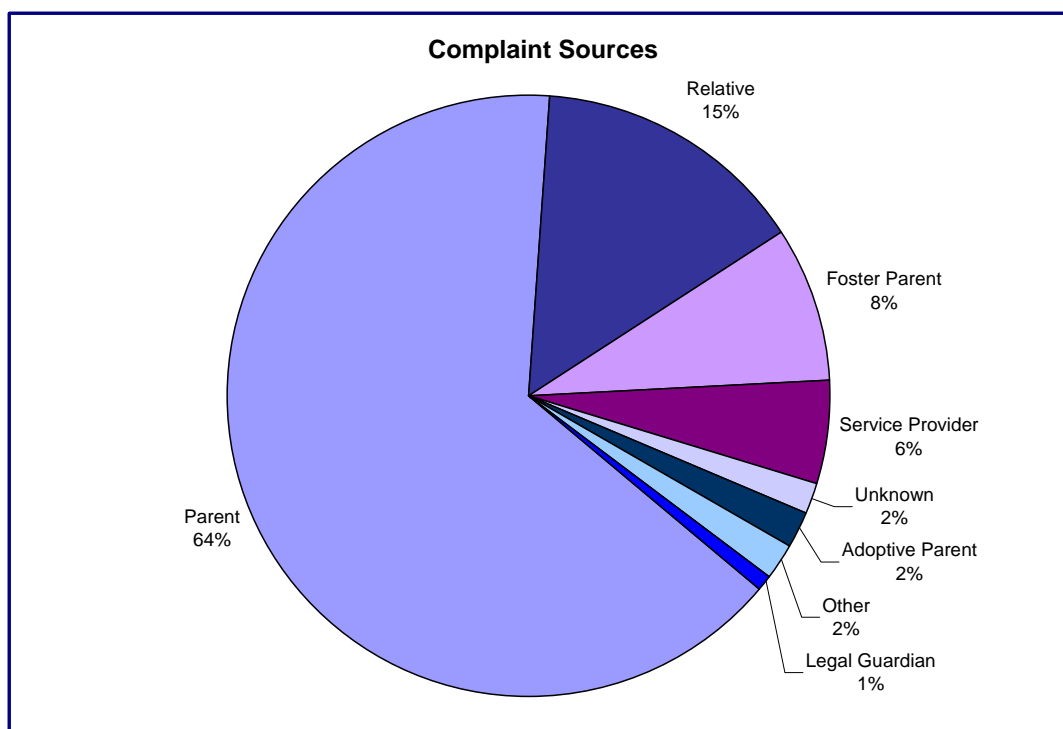
There were 27 contacts categorized as requests for information and referral in 2007. Some of these contacts include:

- Individuals wanting information on who to contact to report an unsafe child
- Requests for information regarding Bureau processes and contact information
- Questions regarding foster home licensing
- Inquiries regarding other counties
- Information regarding Lesbian, Gay, Bisexual, and Transgender/Transsexual (LGBT) children in care

### Complaint Sources

Of the 109 new contacts that were classified as complaints, 71 (64 %) were made by birth parents of the child for whom the complaint was being made; 16 (15%) were made by other relatives including eight grandmothers, two aunts and two cousins; nine (8%) were made by foster parents; and six (6%) were made by service providers. The following figure shows the complaint sources by relationship to the child. Figure 3 provides a breakdown of the complaint sources by relationship.

**Figure 3. Complaint Sources by Relationship to Child**

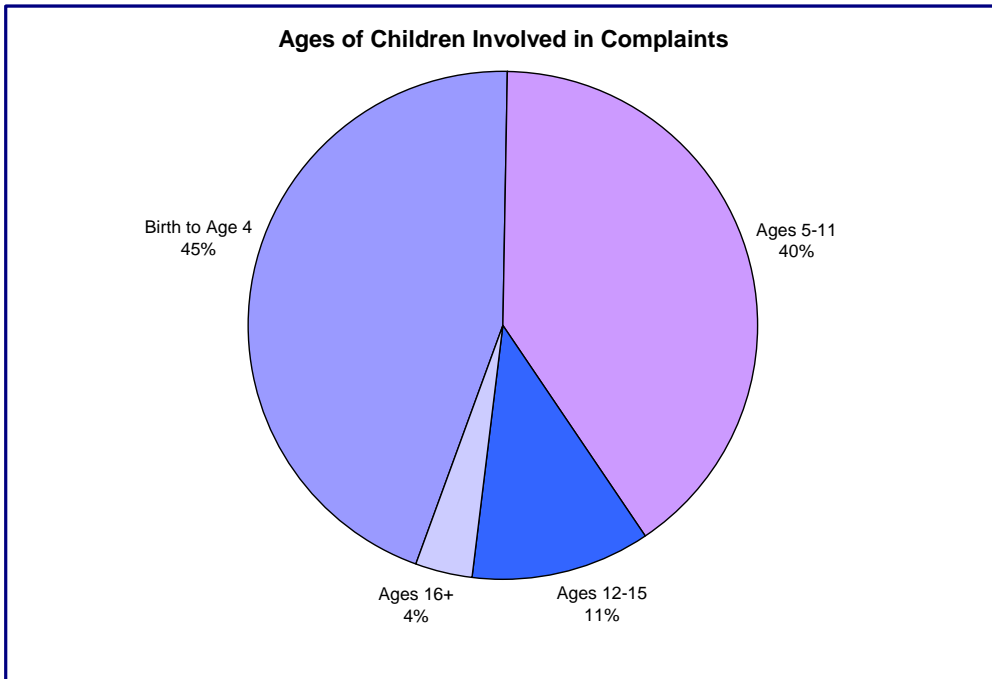


### Ages and Numbers of Children Involved in Complaints

The Ombudsman Office tracked data on the ages of the children involved in the complaints received in 2007 and the number of children per complaint. The Ombudsman Office identified 234 children in 103 of the 109 complaints; for 219 of these children, the Ombudsman Office was able to obtain their date of birth. In six complaints, the Ombudsman Office was unable to obtain information regarding both the dates of birth and the number of children involved in the complaint.

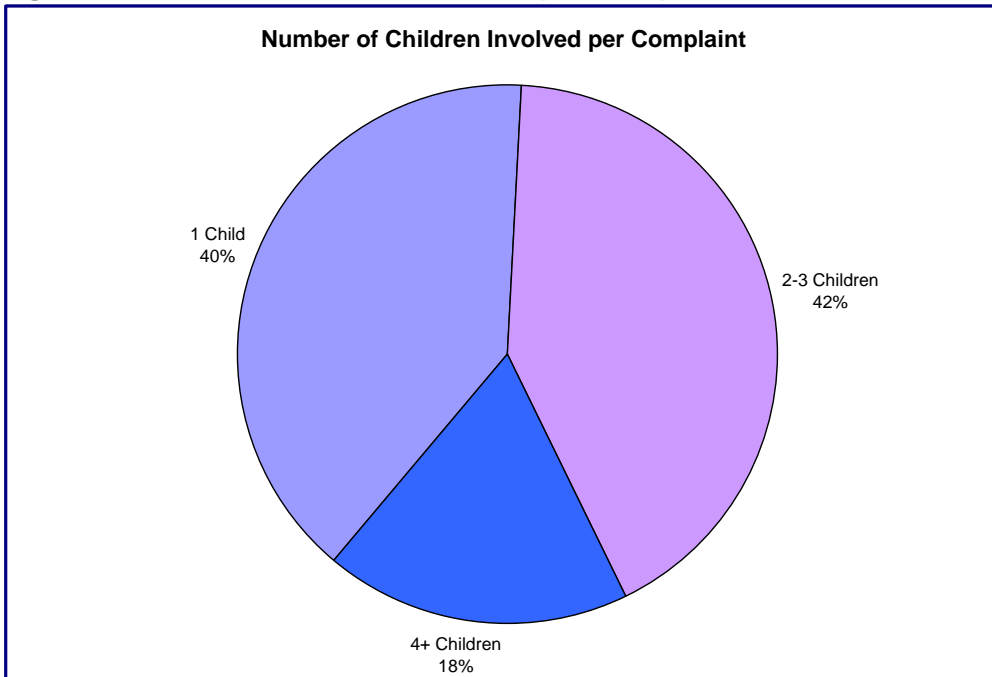
Of the 219 children, 45% were four years old or younger, 40% were between five and eleven years old, 11% were between 12 and 15 years old, and 4% were ages 16 and older. Figure 4 provides a breakdown of the ages of children involved in complaints.

**Figure 4. Ages of Children Involved in Complaints**



There was one child identified in 40% of the complaints, two to three children in 42% of the complaints and four or more children identified in 18% of the complaints. Figure 5 provides a breakdown of the number of children involved in a complaint.

**Figure 5. Number of Children Involved per Complaint**



## Complaint Categories

There were 275 issues being complained about in the 109 complaints received in 2007, for an average of 2.5 issues per complaint. The categories and number of complaints for each are shown in Table 2. Appendix 4-Complaint Categories, details the issues being complained about.

**Table 2. Complaint Categories**

Complaint Category	Number
Lack of Action by Bureau Staff	48
Placement Issues	39
Concerns of Not Receiving Fair Treatment by Bureau Staff	33
Visitation Issues	30
Service Delivery Issues	24
Issues Regarding the Bureau's Role with Taking a Child Into Custody	20
Issues with the Bureau Recommendations to the Court	15
Other-Within Scope	10
Confidentiality Concerns	9
Case Planning Concerns	7
Issues with the Bureau Record	7
Notification Issues	6
Issues Outside the Scope of the Ombudsman Office	27

### Screened Out Complaints

Of the 109 new contacts classified as complaints in 2007, 13 did not meet the Ombudsman Office screening criteria for all issues contained in the complaint and were screened out (see Appendix 5-Screening Criteria). There may be more than one reason for each complaint. Reasons for these complaints being screened out are presented in Table 3.

**Table 3: Screened Out Complaints**

Screening Criteria	Number
The complaint is not within the scope of issues the Ombudsman Office reviews.	9
The complaint does not involve a specific child and/or family involved with the Bureau (either currently or in the past 90 calendar days).	3
The issue(s) being complained about occurred within the past year, or it is not clear at this time when the issue(s) occurred.	2
The complaint does not appear to be within the jurisdiction and/or responsibility of the Bureau	3
The complaint does not appear to be within the power and authority of the state agencies and/or private agencies serving children and families through the Bureau to control or resolve	4
The complainant does not appear to have direct substantive or procedural interest that is directly affected by the matter complained about.	3

## **Complaints Referred to the Bureau Complaint Resolution Process**

In 2007, the Ombudsman Office focused a significant amount of time in seeking to empower individuals to clarify and articulate their concerns, so that they might take them forward to the Bureau in order to resolve their own issues. Of the 109 new complaints in 2007, 68 were referred to the Bureau Complaint Resolution Process (CRP).

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

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

The Ombudsman Office staff takes the time to listen to the complainant's concerns and helps them articulate their issues. The Ombudsman Office staff reviews the complainant's issues with them to ensure accuracy and thoroughness in the staff's understanding of the issues and problem-solves with the complainant's regarding how to successfully follow the CRP. This 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 through 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 communicates with the Bureau that a complaint was received regarding a particular case and about the specific issues of the complaint.

### **Follow-up: Complaints Referred to Bureau Complaint Resolution Process**

The Ombudsman Office contacts complainants 30 days after their referral to the Bureau CRP to ascertain the outcome of the process if the complainant has not contacted the Ombudsman Office again to provide information and/or resubmit their complaint. Follow-up contact is attempted by telephone and letter if the Ombudsman Office is unable to reach a complainant by telephone. Of the 68 complainants referred to the Bureau CRP in 2007, 37 were able to be contacted and nine awaited

the 30-day follow-up contact timeline. The outcomes for the 37 contacts are listed in Table 4.

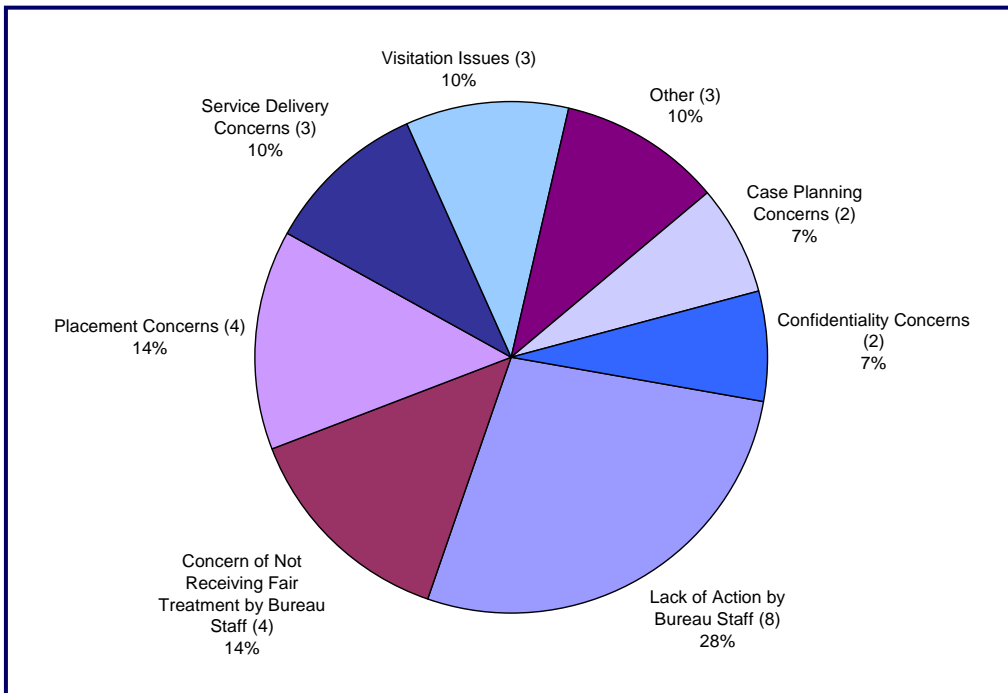
**Table 4. Outcome of Complaints Referred to Bureau Complaint Resolution Process**

Outcome	Number
Successful Completion of CRP	12
Unsuccessful Completion of CRP-Resubmitted Complaint	14
Unsuccessful Completion of CRP-Did Not Resubmit	3
Circumstances that Prevented Completion of CRP	8

**Complaints Referred to Bureau CRP – Issues Resolved**

There were 29 issues contained in the 12 complaints where the Bureau CRP was completed (10 with the complainant going through the process on their own and two with the Ombudsman Office aiding the complainant going through the CRP) and the complainants reported that their issues had been resolved. Figure 6 provides an illustration of the categories along with the percentages of each complaint category for issues resolved through the Bureau CRP.

**Figure 6. Issues Resolved Through the Bureau CRP**



## Findings and Recommendations Overview

The Ombudsman Office completed reviews for 42 issues in 2007. The goal for the completion of an Ombudsman Office review is 60 calendar days from the time correspondence is sent to the complainant and the Bureau that a review will take place until the time that the Ombudsman Office sends the Bureau its findings of the review (see Appendix-Timeline Goals). For those complaints received in 2007, 100% of the reviews were completed within the 60 day timeline goal with the average completion time being 39 days.

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

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

<p style="text-align: center;"><b>Violations</b></p> <p>Describes only those practices that are observably out of compliance with existing policy, standard, or law.</p>	<p style="text-align: center;"><b>Concerns</b></p> <p>Describes 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.</p>
<p style="text-align: center;"><b>Resolved</b></p> <p>Describes those issues that reached resolution during the Ombudsman Office conducting the review.</p>	<p style="text-align: center;"><b>Inconclusive</b></p> <p>Describes those 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.</p>

The term “other findings” is used to describe 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. The Ombudsman Office also makes recommendations regarding “other findings”.

### **Other Findings**

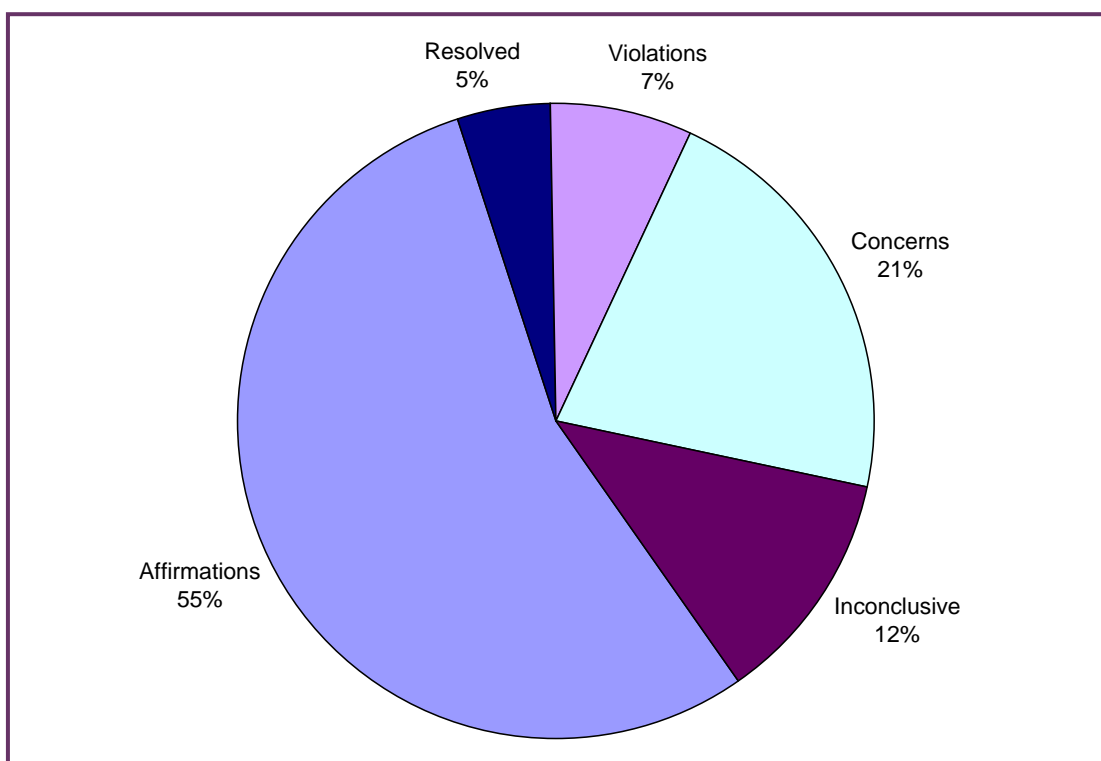
Describe violations or practice concerns found in the course of conducting the Ombudsman Office review that were not germane to the specific issues being complained about.

The Bureau provides the Ombudsman Office with their response to the review findings and recommendations that includes any actions taken or planned to be taken in the future.

## Review Findings

There were 42 issues reviewed in 15 separate complaints in 2007. There were 23 issues (55%) where the Ombudsman Office affirmed the actions of the Bureau; two issues (5%) that were resolved during the review, three issues (7%) where violations were found; nine issues (21%) where concerns were found; and five issues (12%) where the findings were inconclusive. Figure 7 provides a breakdown of the findings for the issues reviewed.

**Figure 7. Findings for Issues Reviewed (42)**



## Other Findings

The Ombudsman Office identified four additional concerns (designated as “Other Findings”) that were not part of the original complaint. These findings include concerns regarding professional standards and accuracy in documentation, physical restraint of children while in Bureau custody, referring new incidents of maltreatment, and an incorrect screening decision.

## Recommendations

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

### Recommendations from Reviews Conducted

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 the issue involves an event or situation that has already occurred. In these instances, the Ombudsman Office focuses its recommendations on how to ensure that the event or situation does not occur again.

Based on the reviews conducted in 2007, the Ombudsman Office made 48 recommendations, 38 systemic and ten case-specific. Some of the recommendations made were the same for multiple reviews. The following summarizes the recommendations made as a result of conducting reviews:

#### Systemic Recommendations

Sixteen recommendations were made regarding issues with documentation.

1. In seven reviews, the Ombudsman Office recommended that the Bureau **review** with all staff and supervisors **the policy titled Frequency and Documentation of Contacts with Children and Families**.
2. In five reviews, the Ombudsman Office recommended that the policy titled **Frequency and Documentation of Contacts with Children and Families be amended to include the requirement that staff document the specific content of communications** as previously recommended by the Ombudsman Office.
3. In two reviews, the Ombudsman Office recommended that the Bureau **remind supervisors of their responsibility to review details of the case record, ensuring that all documentation is thorough and accurate**.
4. The Ombudsman Office recommended that the Bureau **review** with all staff and supervisors the policy: **Case Management Responsibilities by Ongoing Services stressing that all documentation** in the case record and eWiSACWIS **must reflect the current status of the case**. *This recommendation has been submitted to the Bureau with regards to other reviews conducted in 2006, and the Bureau has initiated action to implement this recommendation.*
5. The Ombudsman Office recommended that the Bureau **review** with all staff and supervisors the policy: **Case Management Responsibilities by Ongoing Services stressing that all documentation** in the case record and eWiSACWIS

**must always reflect professional standards.** *This recommendation has been submitted to the Bureau with regards to other reviews conducted in 2006, and the Bureau has initiated action to implement this recommendation.*

Nine recommendations were made regarding the treatment of relatives.

6. In three reviews, the Ombudsman Office recommended that the Bureau **review and evaluate training materials which address the engagement and assessment of relatives.** *This recommendation has been submitted to the Bureau with regards to other reviews conducted in 2006, and the Bureau has initiated action to implement this recommendation.*
7. In three reviews, the Ombudsman Office recommended that the Bureau **ensure that supervisory consultation reinforces the role of relatives for children in care.** *This recommendation has been submitted to the Bureau with regards to other reviews conducted in 2006, and the Bureau has initiated action to implement the recommendation. The Ombudsman Office has been informed that a new policy has been in place since January 2007 which responds to this concern, requiring case managers to begin assessing for relative placement earlier in the process.*
8. In three reviews, the Ombudsman Office recommended that the Bureau **provide prospective relative caregivers a reasonable estimate of the length of time and procedures necessary to assess their home for possible placement of children whether or not the children have been or will be placed in their care.** *This recommendation has been submitted to the Bureau with regards to other reviews conducted in 2006, and the Bureau has initiated action to implement the recommendation.*

The remaining 13 recommendations covered a variety of areas.

9. In two reviews, the Ombudsman Office recommended that the Bureau review and, if necessary, revise relevant policies and procedures to **ensure that the workforce is provided with sufficient direction regarding the need for supervisory and other forms of consultation at times of significant decision-making.**
10. The Ombudsman Office recommended that the Bureau **review** with all relevant staff and supervisors **the requirement that primary caregivers who are the subject of investigation for maltreatment be interviewed directly when they are available.**
11. The Ombudsman Office recommended that the Bureau **reconcile the requirements for notification of change of placement as described in Chapter 48 with an adapted policy that provides for notification of intended change of placement.** This new policy would allow for notification of the change ten days prior to the change, but would not require the name and/or address of

- the placement resource; the policy should include instructions that parties are subsequently notified of a newly identified placement resource immediately.
12. The Ombudsman Office recommended that the Bureau **take measures to ensure that State and private agency staff at all levels of authority are given adequate reinforcement about the responsibility for tasks involving the assessment of new referrals in open Ongoing Case Management cases.** The Ombudsman Office noted that Bureau policies already include clear and detailed procedures for this scenario.
  13. The Ombudsman Office recommended that **continued efforts be made to reinforce the importance of case planning and decision making, and the documentation of those activities.**
  14. The Ombudsman Office recommended that the Bureau **incorporate into existing policy and procedural guidelines the requirement that staff verify custodial orders.** Such procedures should speak to the need to verify custodial orders even prior to a CHIPS finding.
  15. The Ombudsman Office recommended that Bureau **policy regarding custody matters involving children on a CHIPS order should also comply with the requirements of the Interstate Compact for the Placement of Children agreement and the Uniform Child Custody Enforcement Jurisdiction Enforcement Act.**
  16. The Ombudsman Office recommended that the Bureau draft and distribute a formal memorandum to all State and contracted private agency employees **clarifying that written recommendations and evaluations are not to be altered in any way, and that any revisions to such documents must be made by the author of the document.**
  17. The Ombudsman Office recommended that the Bureau **review** with staff and supervisors the **policy titled Family Assessment and Treatment Plan, the policy titled Case Evaluation, and the Ongoing Child Protective Services Standards and Practice Guidelines, stressing the importance of providing specific and detailed information regarding all family members related to how they function, their strengths, treatment needs, etc.**
  18. The Ombudsman Office recommended that Bureau and contracted private agency **staff are trained in, or provided information regarding, physical restraints of a child.**
  19. The Ombudsman Office recommended that the Bureau **require incident reports whenever a child is restrained from all service providers that are providing services to children involved with the Bureau.** These reports should include but not be limited to details about what behavior led to the need for the restraint, how the child was restrained and strategies to address the child's behavior. It is the Ombudsman Office's contention, in keeping with the standards of practice in

the field, that whenever hands are put on a child, regardless of the terminology used (hold, restraint, etc.) that the situation is treated as a critical incident that warrants close investigation by the assigned staff and consultation with the supervisory staff.

20. The Ombudsman Office recommended that the Bureau **review the Child Protective Service Investigation Standards with Intake and Initial Assessment staff and supervisors.**

### **Case-Specific Recommendations**

1. The Ombudsman Office recommended that the Bureau consider the complainants' request that the Bureau provide an explanation to them of why it was determined that the child would not be placed again in the relative's home and why the relative was not considered to be a potential adoptive resource. Additionally, the complainants requested that the Bureau's concerns about the relative's behavior which may have precluded placement with them be explained to them.
2. The Ombudsman Office recommended that the Bureau consider the complainants' request that the Bureau review and evaluate the desire for a Visitation Plan between the child and paternal grandparent and/or to allow the grandparent other forms of contact with the child from the present time forward.
3. The Ombudsman Office recommended that the Bureau consider providing appropriate assistance to the father regarding family court processes in preparation for case closure with the Bureau.
4. The Ombudsman Office recommended that the Bureau consider continuing to allow the father to communicate with the Bureau via e-mail as is appropriate and effective.
5. The Ombudsman Office recommended that the Bureau consider ensuring that the father is notified of any significant incidents involving his child in writing and in accordance with relevant Bureau policy (e.g. behavioral or emotional problems at the mother's home, school information, medical and dental information, progress in therapy, etc.).
6. The Ombudsman Office recommended that the Bureau consider ensuring that all services provided to the father are conducted by professionals qualified to treat and address the range of issues with which the father presents.
7. The Ombudsman Office recommended that the Bureau consider obtaining an updated evaluation of the father's psychological functioning and parental capacity and then provide services as recommended and deemed appropriate by the evaluating psychologist.

8. The Ombudsman Office recommended that the Bureau consider collaborating with the father to identify barriers to progressive visitation and develop strategies to reduce these obstacles.
9. The Ombudsman Office recommended that the Bureau consider the advisability of initiating family therapy including both parents, as had been previously requested by family members and ordered by the court, in order to resolve continued co-parenting issues.
10. The Ombudsman Office recommended that the Bureau consider ensuring regular supervisory review of the father's service delivery, visitation plan, and progress on goals. Supervisory review should include regular assessment of the need for additional or revised services.

## Observations, Key Issues, and Recommendations

This section focuses on observations, key issues, and recommendations resulting from all Ombudsman Office activities. Some of these include significant issues identified within specific reviews, others from the overview of all contacts made with the Ombudsman Office in 2007. Additionally, the Ombudsman Office notes areas where these issues have been presented to the Ombudsman Office over multiple years. The following areas are those that the Ombudsman Office has identified as being particularly relevant to the public's interest and critical to continued improvement within Milwaukee's child welfare system:

### 1. Concerns About the Bureau's Complaint Resolution Process (CRP)

**Recommendation #1:** The Ombudsman Office recommends that the Bureau implement a centralized way to acknowledge, record, and refer complaints for timely resolution.

**Recommendation #2:** The Ombudsman Office recommends that the Bureau implement a tracking system for all complaints, including those that come through the Ombudsman Office, to record and compile outcomes.

**Recommendation #3:** The Ombudsman Office recommends that the Bureau develop and implement a plan that significantly increases the avenues through which to educate staff and clients about the CRP.

**Rationale:** For the third year in a row, the Ombudsman Office has identified concerns related to the Bureau's CRP. Some examples that are noteworthy include:

- The majority of complainants contacting the Ombudsman Office have reported being unaware of the Bureau's CRP.
- The Ombudsman Office has received feedback from many clients that, upon reaching the management level in the CRP, they are referred back to supervisors or primary assigned workers for resolution. The CRP is intended to provide complainants with the opportunity to discuss concerns directly with supervisors and managers.
- The Ombudsman Office found a lack of clarity on the Bureau's part regarding what communication from clients is for the purpose of formally pursuing resolution as opposed to more general communication from clients. For example, Bureau supervisors may interpret client complaints as "venting" as opposed to communication of a grievance.
- The Ombudsman Office notes several instances in which the Bureau at various levels of authority has referred clients to the Ombudsman Office rather than advancing them through the CRP.

- The Ombudsman Office is concerned that the CRP itself is cumbersome for many clients, especially those with acute mental health concerns. The Ombudsman Office has received a large volume of complaints from individuals with acute, at times untreated, mental illness and has concerns about the cognitive and behavioral stability necessary to pursue and complete the CRP. (It should be noted that positive outcomes occurred with several of those clients as a result of close communication between the Ombudsman Office and the Bureau).
- While some issues brought to the attention of the Ombudsman Office were resolved through the CRP, the majority of them were not. Of 200 issues referred through the CRP, 29 issues were reported resolved and the remainder required some other means of resolution.

The Ombudsman Office has had the opportunity to share these concerns with the Bureau, and has, in addition, worked together closely with the Bureau to respond to imminent concerns on the behalf of clients. The Bureau has been responsive to communication about the CRP and has expressed interest in enhancing the CRP so that documentation is clearer and more formal.

## 2. Concerns About Documentation

**Recommendation #4:** The Ombudsman Office recommends that the Bureau develop and implement a plan to improve documentation that addresses the areas of concern identified by the Ombudsman Office.

**Rationale:** Accurate and timely documentation of all case activity is essential to good child welfare practice. For the second year in a row, the Ombudsman Office has identified concerns with regard to weakness in documentation in the Bureau record. Some specific areas of concern include:

- The Ombudsman Office found that documentation does not clearly include what is known about client needs and history, which results in a “starting over” process each time the case changes hands and prevents the communication of crucial information.
- The Ombudsman Office found a lack of content within case notes. Specific descriptive information is often not included in case notes, which also prevents communication of crucial information and interferes with informed decision-making.
- The Ombudsman Office found a lack of information about the process through which critical decisions are made and the content that contributes to the decision.

This observation is particularly relevant in that the preponderance of violations concerns, and inconclusive findings noted refer to the pivotal role that documentation plays in the effective and safe management of cases.

### **3. Parents with Mental Health Issues**

**Recommendation #5:** The Ombudsman Office recommends that the Bureau seek consultation outside the Bureau to determine successful models used when working with this population in other child welfare arenas.

**Recommendation #6:** The Ombudsman Office further recommends the consideration of piloting an enhanced program to better meet the needs of this population.

**Rationale:** The Ombudsman Office received many complaints from individuals with chronic and persistent mental health issues. Many of these individuals are clearly challenged, in some instances prohibitively so, by trying to understand the child welfare system. These individuals require a significant amount of staff time and resources to achieve successful communication and outcomes. Given time constraints, lack of training and understanding of mental illness, and lack of resources for this population, Bureau staff have appeared to struggle to provide adequate services to these individuals. A particular challenge has been the ability to assist in the development of an ongoing natural support system once the Bureau is no longer involved.

### **4. Concerns About Inclusion of Fathers in Case Planning**

**Recommendation #7:** The Ombudsman Office recommends that the Bureau develop and implement a plan to ensure that the Bureau is engaging fathers and taking the necessary steps to encourage involvement in the case planning process.

**Rationale:** The Ombudsman Office received multiple complaints regarding the inclusion of fathers in case planning. Some examples include:

- Concerns regarding a lack of uniformity regarding visitation with both non-adjudicated and adjudicated fathers. A specific example of this lack of uniformity is the question of at what point in time a “presumptive” father is permitted visitation.
- Concerns regarding a lack of uniformity in communication of key decisions and activities to fathers.
- Concerns regarding a lack of sensitivity to the emotional connection of fathers to their children.

## 5. Concerns About the Treatment of Relatives

**Recommendation #8:** The Ombudsman Office recommends that the Bureau develop and implement a plan to improve engagement with relatives who may be either formal or natural support resources for the family.

**Rationale:** The Ombudsman Office continues to receive complaints from relatives who believe they are being mistreated by the Bureau. Some examples include:

- For the third year in a row, the Ombudsman Office received multiple complaints regarding relatives' perceptions that they are not valued as resources for children in care.
- For the second year in a row, the Ombudsman Office received multiple complaints that relatives' emotional connections to children, and children's reciprocal connection to relatives, are not supported or preserved.
- Timeliness of relative assessment remains a critical issue. The Ombudsman Office received multiple complaints in which relatives were denied placement of infant children because the children had established attachments to non-relative caregivers during periods of time in which relatives were available for placement and had gone on record seeking placement.

## 6. Concerns Regarding the Coordinated Service Team (CST) Process

**Recommendation #9:** The Ombudsman Office recommends that the Bureau evaluate whether it would be beneficial to the safety, permanence, and well-being of the children and families served to take the responsibility of facilitating the CST process from the case managers and dedicate resources to having CST facilitators conduct all CST meetings.

**Rationale:** The CST process is central to the activities of case management. Trainers in the CST process report that proficiency at facilitating the CST process takes upwards of two years, with regular practice. The Ombudsman Office received multiple complaints regarding the Bureau's CST Process. The Ombudsman Office found a significant number of cases which the CST process was not being conducted appropriately. Some examples include:

- CST meetings not occurring at the regularly scheduled intervals if a change in the case manager occurred.
- CST meetings appearing more like a case staffing than following the process intended.
- CST meetings not being documented according to Bureau policies.

- Case Managers reporting feeling a significant amount of stress in facilitating CST meetings.
- Family members reporting they are not being included in the CST process.
- Service providers reporting they are not being included in the CST process.
- Natural supports that can assist the family after the Bureau is no longer involved with the family are not being identified and included in the process consistently.

## **7. Concern Regarding the Length of Time Required to Revise Policies**

**Recommendation #10:** The Ombudsman Office recommends that the Bureau develop a process for how, when, and by whom policies will be revised as needed to ensure timely implementation of new and revised policies.

**Rationale:** The Ombudsman Office made numerous recommendations for policy revisions both 2006 and 2007. The Bureau committed to revising policies in some cases and considering many of these recommendations in others. The Bureau referred the recommendations to the committee that was working on revising all Bureau policies. The Ombudsman Office is concerned about the amount of time that lapsed between when recommendations were made and accepted (either for change or consideration) and the time it took for a policy to be revised, in many cases taking several months or longer.

## Issues Reviewed

In this section, findings that affirm the Bureau's actions are presented, as are violations, findings of concern, and resolved, inconclusive and other findings. For all findings, a response is requested. In the event the Bureau has additional information, questions, or a disagreement regarding the findings and recommendations as submitted by the Ombudsman Office, there is subsequent correspondence in an effort to resolve issues.

Bureau responses listed in this report are either direct citations or paraphrases taken from their correspondence to the Ombudsman Office.

### Findings Affirming the Actions of the Bureau

Of the 42 issues reviewed, there were 23 issues where the Ombudsman Office affirmed the actions of the Bureau. Following is detailed information about complaints for which the OMCOW affirmed the actions of the Bureau.

#### Lack of Action by Bureau Staff (5)

- 1. Failure to facilitate recommended evaluations for adoption subsidy**  
A complainant stated that despite recommendations to do so, Bureau staff may have refused to complete all necessary evaluations of the children in order to determine accurate adoption subsidies for each child.
- 2. Inadequate assistance from staff**  
A complainant stated that Bureau staff was not assisting the mother in finding housing needed in order for the children to be returned.
- 3. Lack of contact with parent for consent for medical treatment**  
A complainant stated that the complainant's son was hospitalized and treated without the complainant's knowledge or consent.
- 4. Lack of return contact.**  
A complainant stated that the ongoing case manager and supervisor did not return phone calls.
- 5. Lack of return contact**  
A complainant stated that the case manager had not been in contact with the complainant either through phone or written correspondence. Additionally, that the case manager and the supervisor did not return the complainant's phone calls.

### **Placement Concerns (5)**

**6. Concern about the safety of a child's placement**

A complainant stated that the children remained in an abusive home despite information being provided to a supervisor that the relative caregiver was an abusive parent in the past, and that the complainant recently witnessed the caregiver physically and verbally abusing the children, but the supervisor, and later the Program Manager, did not believe the complainant.

**7. Concern regarding assessment that led to a change of placement**

A complainant stated that the children's emergency removal from the relative's foster home was not based on imminent danger to the children, but was instead the result of Bureau staff fulfilling a threat to remove the children from the relative foster home.

**8. Concern that siblings are not placed together/Disagreement with a change of placement**

A complainant stated that the children were removed from the complainant's home and believed that the children could return while an investigation was being conducted instead of being placed in separate foster homes. The complainant further stated that the children were safe in the home as the allegations of abuse were false.

**9. Disagreement with a change of placement**

A complainant stated that an infant child was removed from the complainant's care (relative caregiver) without adequate explanation being provided.

**10. Disagreement with placement decision**

A complainant stated that, five months after the child was removed from the home and placed with another foster family for adoption, the child disrupted and was moved to a third placement instead of being placed back in the original home as previously requested.

### **Issues Regarding the Bureau's Role with Taking a Child into Custody (3)**

**11. Concern about an incorrect assessment that resulted in the removal of a child**

A complainant stated that the Initial Assessment described the children as being in extremely poor condition and alleged that sexual abuse had been occurring for two years. Additionally, that it was the complainant's belief that the information must be incorrect as the Bureau had been continuously investigating the home for over a year due to a series of allegations and never previously found concerns related to the condition of the home.

**12. Entering and searching a home without permission**

A complainant stated that the Bureau entered and searched the complainant's mother's home without permission.

**13. Not providing the mother with information regarding why a child was taken into custody**

A complainant stated that the Bureau took a child into custody and that the mother was not told the reasons why the child was being taken and held.

**Visitation Issues (2)**

**14. Concern that visitation is not progressing**

A complainant stated that visitation between the mother and children had not progressed from supervised to unsupervised.

**15. Visits not occurring according to visitation plan**

A complainant stated that, despite the mother requesting that her daughter not attend visitations for two weeks, the child was brought to the visitations without any notice being provided to the mother.

**Issues with Bureau Recommendations to the Court (2)**

**16. Inaccurate information sent to the Court**

A complainant stated that the information given to the Court to determine grounds for terminating the parental rights was inaccurate in that the parent reported having followed through on all of the conditions that were ordered.

**17. Lack of verification of information sent to the Court**

A complainant stated that the Court was not informed of any progress the mother had made related to court ordered services.

**Service Delivery Issues (1)**

**18. Concern about the timeliness of service delivery/Concern about services not being provided**

A complainant stated that some services were not provided and others were not provided in a timely manner. Specifically, upon the children being taken into custody, the mother requested assistance with securing services but was told by Bureau staff that they would not arrange services until the case reached disposition. Additionally, the mother initiated and completed an AODA evaluation and requested additional AODA services, but the case manager had not arranged these services for the mother.

### **Case Planning Concerns (1)**

#### **19. Mother misinformed about permanency plan**

A complainant stated that the mother was misinformed by the Bureau regarding the children's permanency plan, in which the mother was told that reunification was a permanency goal, but the mother's attorney had informed the mother that reunification was not a possibility.

### **Concerns of Not Receiving Fair Treatment by Bureau Staff (1)**

**20.** A complainant stated that the case manager sought out information to create a report of abuse/neglect in order to prevent the return of the children to the complainant's home.

### **Notification Issues (1)**

#### **21. Not properly notifying an individual that they are a named maltreater**

A complainant stated that the Bureau did not properly inform the mother that she was a named maltreater and that the allegation of child neglect was substantiated.

### **Other (2)**

**22.** A complainant stated that Bureau staff was not willing to honor the time requested in which to decide whether to adopt the child placed in the home and instead removed the child from the home.

**23.** A complainant stated that, due to a child's medical needs, two caregivers were required at all times but on one occasion the child's foster father was observed to be the only adult present with both the child and another foster child who requires a wheelchair.

## Issues Resolved During the Ombudsman Office Review

There were two issues that were resolved and subsequently withdrawn by the complainants during the Ombudsman Office review. Following is detailed information about these complaints:

1. A complainant stated that she had concerns regarding placement, including concerns that the child had had multiple placements; that a placement was unsafe; and that relative placement was not sought.

Resolution: The complainant withdrew these issues for review as she reported having a greater understanding of the Bureau's actions and was satisfied with the outcome of the concerns.

2. A complainant stated that the child was placed in a school with a particular teacher against the parent's wishes.

Resolution: The child's school was changed.

## Violations

Of the 42 issues reviewed, there were three where violations were found. Following is detailed information regarding these complaints:

**1. Issue-**A complainant stated that the Bureau did not conduct a thorough investigation of the allegation that the child was maltreated; specifically the concern that the information from the police report of the incident was used by the Bureau without independent verification; further, that the mother and alleged maltreater was not interviewed.

**Findings-**The Ombudsman Office review found violations with regard to Wisconsin State Statute, CPS Standards, and Bureau policy in not interviewing the mother.

Wisconsin State Statute states that, in Child Protective Services (CPS) cases in which a parent is the alleged maltreater, the investigating agency shall interview this parent if possible. Wisconsin Child Protective Services Investigation Standards reiterate that investigations of abuse or neglect involving a primary caregiver statutorily require interview of this caregiver if possible. Bureau policy states that the investigating worker will complete the investigation in accordance with the "Bureau standards of practice and the Wisconsin CPS Investigation Standards".

The Ombudsman Office found no documentation in the case record of any attempts by the Bureau to contact the mother, in this case the alleged maltreater, for an interview at any time throughout the course of the investigation, nor did the Bureau document consideration of interviewing the mother. While the CPS Standards do internally allow for reasoned deviation from the requirements described above, it also states that the "case record must include the basis for the deviation from the Standard" (p. 5). In this case the Ombudsman Office found no rationale documented beyond the assertion that the mother was unavailable due to being incarcerated.

**Ombudsman Office Recommendations-**The Ombudsman Office recommended that the Bureau review with all relevant staff and supervisors the requirement that primary caregivers who are the subject of investigation for maltreatment be interviewed directly when they are available.

**Bureau Response-**The Bureau is in disagreement with these findings. The Bureau communicated to the Ombudsman Office that it is their understanding that deviations from these protocols were reasonable. Additionally, the Bureau communicated that documentation stating that the mother was inaccessible to the Bureau due to being incarcerated was not accurate and the Bureau entered a correction note regarding the incorrect documentation.

The Bureau noted that service managers were reminded of their responsibility to

review case notes prior to approving them to ensure completeness and accuracy.

The Bureau also noted that service managers were reminded of their responsibility to ensure that workers actively discuss case situations that involve incarcerated parents to determine the Bureau's intervention.

**2. Issue-**A complainant stated that the father did not receive proper notification regarding placement of the child in an adoptive home.

**Findings-**The Ombudsman Office found the Bureau to be in violation of policies regarding changing a child's placement and a Memorandum dated 04/22/02, which refer to the requirements of State Statute and specify the need for written notification of a planned change of placement 10 days prior to the move with the exception of certain emergency circumstances which were not present at the times of the relevant changes of placement.

**Ombudsman Office Recommendations-**The Ombudsman Office recommended that the Bureau reconcile the requirements for notification of change of placement as described in Chapter 48 with an adapted policy that provides for notification of intended change of placement. This new policy would allow for notification of the change ten days prior to the change, but would not require the name and/or address of the placement resource; the policy should include instructions that parties are subsequently notified of a newly identified placement resource immediately.

**Bureau Response-**Both the Bureau and the State of Wisconsin DCFS Division Administrator were in agreement with the Ombudsman Office's finding of violation.

The Bureau modified its notification procedures to add a written notification to all parties of intent to change a child's placement, reasons why the placement is being changed, and how the new placement satisfies the objective of the treatment plan as ordered by the court.

In follow-up correspondence in January 2008, the Bureau additionally reported that the final revision was completed October 15, 2007.

**3. Issue-**A complainant stated that her youngest child was taken into custody with no reason having been provided to her and despite the fact that hospital staff told the Bureau positive things about her care of the child.

**Findings-**The Ombudsman Office found the Bureau to be in violation of a range of policies and rules in that, although the baby was taken into custody, the Initial

Assessment and contact notes related to assessment were not completed until three months later. Decision making and case planning are not reflected prior to the child being taken into custody.

Upon reviewing the Initial Assessment and related documents, it was clear that the Bureau assessed that imminent risk to the child was present and responded appropriately. However, the case record prior to the child's birth, at the time of the birth, and in the several days following the birth includes no reference to plans to take the child into custody. An Intake referral was made at the time of the baby's birth and this report did not include any information about risk to the baby. This referral was screened out. A subsequent report was made three days later which referred to significant risk to the child based upon past dangerous behavior; this referral was screened in and the Initial Assessment was initiated. The referral contained information about imminent risk that the Ongoing Case Manager had been aware of throughout the life of the case.

During the Ombudsman Office review, the Ombudsman Office had two conversations with Bureau staff who expressed uncertainty about responsibility for completing the Initial Assessment given that the case was open in Ongoing but the new Intake referred to a newborn child. At the time of those conversations, the case record did not include the Initial Assessment report or documentation of contacts regarding the Initial Assessment. Several Bureau staff were responsive to and cooperative with Ombudsman Office requests for access to court documents so that the review could move forward. The Ombudsman Office was subsequently notified when the report was completed.

#### **Ombudsman Office Recommendations-**

1. The Ombudsman Office recommended that the Bureau take measures to ensure that State and private agency staff at all levels of authority are given adequate reinforcement about the responsibility for tasks involving the assessment of new referrals in open Ongoing Case Management cases. The Ombudsman Office noted that Bureau policies already include clear and detailed procedures for this scenario.
2. Similarly, the Ombudsman Office recommended that continued efforts be made to reinforce the importance of case planning and decision making, and the documentation of those activities.

**Bureau Response-**The Bureau acknowledged these findings and recommendations and stated that, under a new Milwaukee Child Welfare Safety Plan, Initial Assessment staff will be provided with extensive training and assistance related to the responsibilities discussed above to include staff responsibilities when interacting with case open in other Bureau programs. Additionally, the Bureau reported that decision making, case planning, and accurate documentation will be covered in this training.

## Concerns

Of the 42 issues reviewed, there were nine issues in which concerns were identified regarding practice and documentation. Following is detailed information about those complaints:

**1. Issue-**A complainant stated that the Bureau did not have sufficient information to close the case without evaluating custody concerns, including the possible need to take physical custody of the child, and the need to confirm the father's custody rights.

**Findings-**The Ombudsman Office review found concerns with regard to Bureau practice and documentation.

The Ombudsman Office found documentation that both parents were in agreement to allow the child to stay with a maternal relative when the investigation began. This contributed to the Bureau's documented decision to close the case without taking custody of the child. At that time, the Bureau documented its decision not to evaluate the maternal relative, her home, or other individuals residing in the home given the Bureau staff's observation that this relative appeared appropriate. However, while the father had voiced his support for the child's placement with the maternal relative initially, he reportedly returned to the Bureau office and stated that he wanted to take his child back with him out of state, but the maternal relative would not give him his child. The Bureau staff declined to evaluate the situation or assist him in this placement matter.

It did not appear that the Bureau fully evaluated the family's potential need for further public agency intervention to ensure care and appropriate custody of the child, nor did they refer the matter to the court which may have made a decision to evaluate placement issues even in the absence of imminent safety threats.

The Ombudsman Office did not find documentation that the Bureau sought to confirm the father's custodial rights. The Bureau policies available to the Ombudsman Office do not speak to the need to verify a claim of custodial rights under these circumstances. However, the Ombudsman Office noted two concerns about the lack of documentation of the father's custody: first, that the father was allowed to give approval or permission for the child's continued "placement" with the maternal relative, which implied the Bureau's confidence that he was in fact a custodial parent with rights even in the apparent absence of documentation to support this claim, and, second, that upon learning of the father's concern that the maternal relative would not give him his child, this possible violation of his custody rights was not reported by the Bureau to law enforcement or further evaluated.

**Ombudsman Office Recommendations-**The Ombudsman Office recommended the following:

1. That the Bureau incorporate into existing policy and procedural guidelines the requirement that staff verify custodial orders. Such procedures should speak to the need to verify custodial orders even prior to a CHIPS finding.
2. That Bureau policy regarding custody matters involving children on a CHIPS order should also comply with the requirements of the Interstate Compact for the Placement of Children agreement and the Uniform Child Custody Enforcement Jurisdiction Enforcement Act.

**Bureau Response-**The Bureau disagreed with the Ombudsman Office findings. The Bureau communicated that Bureau staff are required to check the KIDS/CARES system regarding paternity of the child's father when the child is taken into custody. Additionally, that there should also be documentation entered into eWiSACWIS of the action taken by staff to verify paternity, and the results of the query.

2. **Issue-**A complainant stated that the Bureau did not appropriately evaluate the child's relatives for out-of-home placement, nor did the Bureau evaluate the continued status of a temporary stay in non-relative foster care.

**Findings-**The Ombudsman Office review found concerns with Bureau practice and documentation. Bureau policy describes the required function of case managers, including evaluation of professional recommendations and services, and incorporation of all relevant information into placement and permanence decisions. The Ombudsman Office found no documentation of follow-up recommendations, assessments, or requests for re-evaluation regarding the duration or continued advisability of non-relative foster placement. While the case record did include reference to the child's behavior and academic progress and notes the challenges of the child's behavioral functioning, the record did not include any additional follow-up regarding extended family dynamics, which were noted by the Bureau as being detrimental to the child and were cited as the basis for the placement in non-relative foster care. Additionally, the Bureau's decision not to place the child with a willing relative is not fully explained in the written Permanency Plan as is required and no updated information regarding the availability of fit and willing relatives is provided in subsequent Permanency Plans.

**Ombudsman Office Recommendations-** The Ombudsman Office recommended the following:

1. That the Bureau review and, if necessary, revise relevant policies and procedures to ensure that the workforce is provided with sufficient direction regarding the need for supervisory and other forms of consultation at times of significant decision-making.

2. That the Bureau review and evaluate training materials which address the engagement and assessment of relatives.
3. That the Bureau ensures that supervisory consultation reinforces the role of relatives for children in care. *This recommendation has been submitted to the Bureau with regards to other reviews conducted in 2006, and the Bureau has initiated action to implement the recommendation. The Ombudsman Office has been informed that a new policy has been in place since January 2007 which responds to this concern, requiring case managers to begin assessing for relative placement earlier in the process.*
4. That the Bureau provide prospective relative caregivers with a reasonable estimate of the length of time and procedures necessary to assess their home for possible placement of children whether or not the children have been or will be placed in their care. *This recommendation has been submitted to the Bureau with regards to other reviews conducted in 2006, and the Bureau has initiated action to implement the recommendation.*
5. That the Bureau consider the complainants' request that the Bureau provide an explanation to them of why it was determined that the child would not be placed again in the relative's home and why the relative was not considered to be a potential adoptive resource. Additionally, the complainants have requested that the Bureau's concerns about the relative's behavior which may have precluded placement with her be explained to them.

**Bureau Response-**The Bureau disagreed with the Ombudsman Office findings. Diligent efforts were made by both parties to resolve this concern; however, disagreement remained. Consistent with the agreement reached between the Bureau, Private Partner Agencies, and the Ombudsman Office, this issue was forwarded to the Administrator of the Division of Children and Family Services for the purposes of resolution. The Administrator concurred with the Bureau on this issue and disagreed with the Ombudsman Office findings.

In follow-up correspondence in January 2008, the Bureau additionally reported that they have been working to enhance training and practice to include early identification of relatives and assessment of them as both a temporary and permanent placement resource. In addition to the ongoing case manager, permanency consultants engage the birth parent and relatives in discussions around the importance of permanency. The assessment of relative homes, as well as the foster licensing process, is addressed early on with relatives.

3. **Issue-**A complainant stated that visitation was inappropriately disallowed between the child and the paternal grandparent.

**Findings-**The Ombudsman Office review found a concern regarding the required

functions of case managers, specifically the requirements of evaluating professional recommendations and services, and maintaining a professional and accurate case record at all times. The Ombudsman Office found that the Bureau record did not reflect appropriate consideration of the impact of a critical professional recommendation and did not make any attempts to implement the grandparental visitation that was recommended; further documentation regarding this issue referenced altering a document and therefore did not ensure the integrity of the recommendation passed on to Children's Court.

The Ombudsman Office did not find documentation in the Bureau record of consideration of a professional's recommendation to allow visitation between the child and the paternal grandparent within the parameters outlined by the professional. Additionally, the Ombudsman Office did not find any Bureau plan or strategy to allow for the paternal grandparent to demonstrate appropriate functioning within these parameters.

The Ombudsman Office was unable to ascertain, based upon documentation, what recommendations were made to the court, and whether or not a written recommendation regarding visitation between the child and paternal grandparent by a third party was altered by Bureau staff as alleged. Subsequent dialogue with Bureau staff and administrators has indicated that in fact no document was altered, and all parties are in agreement that revisions to the content of professional recommendations must originate with the professional.

**Ombudsman Office Recommendations-** The Ombudsman Office recommended the following:

1. That the Bureau review and, if necessary, revise relevant policies and procedures to ensure that the workforce is provided with sufficient direction regarding the need for supervisory and other forms of consultation.
2. That the Bureau draft and distribute a formal memorandum to all State and contracted private agency employees clarifying that written recommendations and evaluations are not to be altered in any way, and that any revisions to such documents must be made by the author of the document.
3. That the Bureau consider the complainants' request that the Bureau review and evaluate their desire for a Visitation Plan between the child and paternal grandparent and/or to allow the grandparent other forms of contact with the child from the present time forward.

**Bureau Response-**The Bureau disagreed with the Ombudsman Office findings. This issue was forwarded to the Administrator of the Division of Children and Family Services for the purposes of resolution. The Administrator concurred with the Ombudsman Office finding of concerns.

In follow-up correspondence in January 2008, the Bureau additionally reported that, as part of the process of updating Bureau procedures, consultation with

supervisors during case work activity is being addressed to ensure it is included in the procedure.

**4. Issue-**A complainant stated that court-ordered services for the father were not appropriate and were not timely.

**Findings-**The Ombudsman Office review found concerns with Bureau practice and documentation. The Ombudsman Office found that, while early documentation in the case record contains references of the father's disabling conditions, there is not any record of concerted or coordinated effort to obtain services appropriate to his needs, nor any record of ongoing evaluation of these conditions and his response to treatment.

The Ombudsman Office did not find evidence that the Bureau effectively coordinated and documented case activities related to multiple services. Further, the Ombudsman Office did not find evidence that the Bureau effectively took the lead in coordinating clinical services for the father, and instead placed the onus of responsibility on him.

**Ombudsman Office Recommendations-** The Ombudsman Office recommended that the Bureau consider the following:

1. Provide appropriate assistance to the father regarding family court processes in preparation for case closure with the Bureau.
2. Continue to allow the father to communicate with the Bureau via e-mail as is appropriate and effective.
3. Ensure that the father is notified of any significant incidents involving his child in writing and in accordance with relevant Bureau policy (e.g., behavioral or emotional problems at the mother's home, school information, medical, and dental information, progress in therapy, etc.).
4. Ensure that all services provided to the father are conducted by professionals qualified to treat and address the range of issues which the father presents.
5. Obtain an updated evaluation of the father's psychological functioning and parental capacity. Provide services as recommended and deemed appropriate by the evaluating psychologist.
6. Collaborate with the father to identify barriers to progressive visitation and develop strategies to reduce these obstacles.
7. Consider the advisability of initiating family therapy including both parents, as had been previously requested by family members and ordered by the court, in order to resolve continued co-parenting issues.

8. Ensure regular supervisory review of the father's service delivery, visitation plan, and progress on goals. Supervisory review should include regular assessment of the need for additional or revised services.

**Bureau Response-**This issue was forwarded to the Administrator of the Division of Children and Family Services for the purposes of resolution. Both the Bureau and the Administrator concurred with the Ombudsman Office finding of concerns regarding missing documentation.

**5. Issue-**A complainant stated that one of the two children displayed some self-harming behaviors both at home and at school and the case manager had not addressed these issues. Additionally, the complainant reported that the case manager informed the judge that the child was doing well.

**Findings-**The Ombudsman Office review found a concern regarding documentation of this issue.

A case note describes a discrepancy in information provided to the court by the case manager and the complainant. The case manager stated that there were no concerns regarding the child's behavior, and the complainant stated that both children were sent home weekly due to behavioral problems at school.

In reviewing the case record, the Ombudsman Office found that the case notes did not reflect any calls made by the complainant regarding the children's behavior; however, it did find a statement in the case evaluations that the grandmother had reported behavioral problems and these problems were being addressed in therapy. There are also case notes indicating that there were conversations with the therapist and the case manager; however, no details regarding the children's behavior were noted.

During an interview with the case manager and supervisor, the Ombudsman Office learned that the therapist was working on specific behavior issues with the children. The case manager obtained this information by reviewing the therapist's progress notes online. The progress notes were not printed and had not been made part of the case record. It was also learned that the complainant informed the court that the children were having behavioral problems at school. At that time, the case manager spoke with school officials and was informed that the only behavioral issue was that the children talked back at times. The case manager reviewed the attendance record and saw that the children were not being sent home early from school. While the case manager was able to describe the details of the above information, there is no documentation in the case notes.

The specific concern identified is that the record lacks any specific detail regarding the overall functioning of the children as described by family members, the children, school officials, the therapist, the placement provider, and the case manager. When asked by the Ombudsman Office where one would find specific

detail about the children and how they function, the ongoing case manager stated, "Nowhere." Both the supervisor and case manager indicated that they believe the documentation needs to be more specific in case notes, case evaluations, family assessments, etc.

**Ombudsman Office Recommendations-**The Ombudsman Office recommended the following:

1. That the Bureau review with staff and supervisors the policy titled Family Assessment and Treatment Plan, the policy titled Case Evaluation, and the Ongoing Child Protective Services Standards and Practice Guidelines, stressing the importance of providing specific and detailed information regarding all family members related to how they function, their strengths, treatment needs, etc.
2. That the Bureau review with all staff and supervisors the policy titled Frequency and Documentation of Contacts with Children and Families.
3. That the Bureau policy be amended to include the requirement that staff document the specific content of communications as previously recommended by the Ombudsman Office.

**Bureau Response-**The Ombudsman Office received written correspondence from the Bureau stating that they would communicate the above recommendations to an ongoing workgroup currently charged with revising Bureau policy.

**6-7. Issues-**A complainant stated that the case manager was making decisions about placement without giving the complainant a chance. The complainant contacted the case manager immediately upon learning of the child's placement and requested that the child be placed with her. Complainant was told that the child would not be moved to her home because the child had been at the current placement too long and the child was happy in the current placement.

A complainant stated that, upon learning that a relative was willing to take the child, the Bureau did not expedite an assessment of the relative home, and the child remained in a non-relative home.

**Findings-**The Ombudsman Office review found concerns with regard to Wisconsin State Statute, CPS Standards, and Bureau policy. The first concern was regarding the lack of documentation in the case notes. In reviewing the case notes, it was determined that the complainant first contacted the Bureau about placement in December 2006. Between January and February 2007, the complainant left several messages with the case manager asking that her call be returned. The case notes reflect that the case manager did not return any calls until nearly the end of February 2007. Based on discussions that the

Ombudsman Office had with the complainant, the case manager, and the supervisor, it is apparent that there had been at least one conversation between the case manager and the complainant prior to the date reflected in the case note. According to the case manager's appointment book, she met with the complainant at the end of January 2007.

In August 2007, the Ombudsman Office met with the case manager and the supervisor. During that meeting, the case manager was able to provide the Ombudsman Office with a significant amount of information regarding contacts she had had with the complainant and others involved in the relative assessment process; however, most of the information shared was not documented in the case notes.

The second concern is regarding the relative assessment process and the amount of time that lapsed in making a decision about the relative placement. As stated previously, the complainant first made contact with Bureau in December 2006. According to the case notes, the case manager did not request a foster home study until nearly the end of February 2007. In the beginning of April 2007, the complainant was told that the child would not be placed in her home because "the child is currently placed in a pre-adoptive home and that placement has been established for several months." It should be noted that, at the time that the complainant requested placement of the child, the child had been in the pre-adoptive placement for only five weeks. In general, the case notes reflected minimal information to suggest that the Bureau was actively assessing the complainant's home for potential placement of the child.

**Ombudsman Office Recommendations-** The Ombudsman Office recommended the following, all of which had previously been recommended by the Ombudsman Office:

1. That the Bureau review with all staff and supervisors the policy titled Frequency and Documentation of Contacts with Children and Families.
2. That the Bureau policy be amended to include the requirement that staff document the specific content of communications.
3. That the Bureau review and evaluate training materials which address the engagement and assessment of relatives. Further, it is recommended that the Bureau ensure that supervisory consultation reinforces the role of relatives for children in care.
4. That the Bureau provide prospective relative caregivers with a reasonable estimate of the length of time and procedures necessary to assess their home for possible placement of children.

**Bureau Response-**In a written correspondence in September 2007, the Bureau reported that their policies and procedures had recently been revised and that staff training on the revised procedures would be conducted during the next two

months. In response to recommendation #1, the Bureau stated that the policy cited would be included as part of the training. The Bureau additionally stated that an amendment to the policy was not believed to be needed based on the existing language in the procedure; there is a stated requirement that the specific content of all communications regarding a case be documented in case notes.

In response to recommendation #2, the Bureau stated that, as part of the procedure review, the Bureau Director would ensure that the Milwaukee Child Welfare Partnership for Professional Development reviewed and evaluated its training content regarding the engagement of relatives. Based on this review, updates would be made to the training content. The Bureau also stated that they had recently implemented an Unlicensed Relative Caregiver Initiative to assess that relatives are fit and willing for children in the Bureau's care.

Additionally, the Bureau stated that Program Managers for Ongoing Case Management are responsible for ensuring the content of supervisory consultation as to the role of relatives for children in care. The Bureau reported that supervisory sensitivity to the importance of reviewing the role of extended family members in case and permanency planning and their role in guiding staff in these efforts had been heightened by recent training on and implementation of the Unlicensed Relative Caregiver Initiative.

In response to recommendation #3, the Bureau stated that the new Unlicensed Relative Caregiver Initiative specifically identified all procedures associated with the study of prospective relative caregivers, thus allowing the Bureau to provide an overview to the prospective caregiver of not only the process, but a general estimate as to how long the process should take, presuming full and timely cooperation on the part of the relative. (The initiative began subsequent to the case occurrences reviewed in this complaint.)

**8. Issue-**A complainant stated that a relative placement was not sought prior to the child being placed in a treatment foster home outside of Milwaukee County.

**Findings-**The Ombudsman Office review found a concern related to documentation lacking any detail regarding the identification and assessment of relatives.

In reviewing the case notes, the Ombudsman Office was unable to find documentation regarding any discussion and/or assessment of relatives that might have occurred at the time the child was placed in out of home care. Based on a conversation with the current ongoing case manager, the Ombudsman Office learned that both the maternal and paternal grandmothers were looked at for possible placement.

**Ombudsman Office Recommendations-** The Ombudsman Office recommended the following:

1. That the Bureau review with all staff and supervisors the policy titled Frequency and Documentation of Contacts with Children and Families.
2. That the Bureau policy be amended to include the requirement that staff document the specific content of communications as previously recommended by the Ombudsman Office.

**Bureau Response-**The Ombudsman Office received written correspondence from the Bureau stating that their policies and procedures had recently been revised. These revisions would be shared with staff. It also stated that the Bureau had always had the expectation that staff document specific details of each communication.

**9. Issue-**A complainant stated that the Bureau failed to act in a timely manner upon receiving a report of alleged child abuse that occurred in a foster home.

**Findings-**The Ombudsman Office review found a concern related to the lack of documentation about how the Bureau responded to the report of alleged child abuse.

Based on discussions with contracted agency staff, the Ombudsman Office learned that the ongoing case manager developed a safety plan with the foster parent and the child's therapist on the day that the incident occurred. This plan included ensuring the safety of all the children in the foster home. While details of a safety plan can be found in a case note, there was no documentation in the record of the immediate safety plan that was put in place upon learning of the allegation.

**Ombudsman Office Recommendations-** The Ombudsman Office recommended the following:

1. That the Bureau review with all staff and supervisors the policy titled Frequency and Documentation of Contacts with Children and Families, stressing the importance of documenting the specific content of communications.
2. That the Bureau remind supervisors of their responsibility to review details of the case record, ensuring that all documentation is thorough and accurate.

**Bureau Response-**The Bureau acknowledged and agreed with the Ombudsman Office findings and recommendations. The Bureau stated that the safety plan should have been committed to writing at the time it was implemented. Additionally, the Bureau stated that both recommendations would be addressed at program meetings within the next month.

## Findings Inconclusive

Of the 42 issues reviewed, there were five issues in which the findings were inconclusive. In four of the five, findings were inconclusive due to documentation issues. The fifth was due to the time lapse and inability to recreate the events.

**1. Issue-**A complainant stated that an adoptive resource was unwilling to sign papers prior to the completion of all necessary evaluations and that Bureau staff told her that if she did not sign papers agreeing to adopt all three children in question, Bureau staff would remove the children from her home.

**Findings-**The Ombudsman Office's findings were inconclusive. No information was found nor could it be confirmed as to whether or not the alleged statement was made by Bureau staff. The record contained documentation indicating that, when the complainant brought this concern to the attention of the Adoption Supervisor, and subsequently to other program staff, these staff responded in a manner which is consistent with the Bureau's Complaint Resolution Process.

**2. Issue-**A complainant stated that information given to Bureau staff regarding how to manage the child's behavior without the use of restraints was not shared with the child's caregivers and service providers.

**Findings-**The Ombudsman Office's findings were inconclusive due to the limitations in documentation. Documentation in the case record included minimal information and lacked any detail regarding the content of the communication. Because the record did not provide a clear reference to information shared, it was not possible to determine that all critical information was shared. This content is described as essential within Bureau policy.

**Ombudsman Office Recommendations-**The Ombudsman Office recommended the following:

1. That the Bureau review with all staff and supervisors the policy titled Frequency and Documentation of Contacts with Children and Families stressing the importance of documenting information obtained through contacts within three working days.
2. That the Bureau policy be amended to include the requirement that staff document the specific content of communications.
3. That the Bureau review with all staff and supervisors the policy titled Case Management Responsibilities by Ongoing Services stressing that all documentation in the case record and eWiSACWIS must reflect the current status of the case.

**Bureau Response-**The Bureau responded to the Ombudsman Office findings with the following:

“We will explore the recommendation that the policy titled Frequency and Documentation of Contacts with Children and Families be amended and reviewed with all staff and supervisors. An existing policy and procedure workgroup will review the procedure to determine if a more meaningful description of required case note content can be accomplished and whether or not it appropriately addresses professional standards in documentation specifically, as referenced in Other Findings and Recommendations. In the event a policy revision is deemed appropriate, the revised policy will be re-issued with a written communication of the changes to all staff and supervisors.”

**3. Issue-**A complainant stated that the child was not allowed to remain in the foster home due to the Bureau not approving treatment foster care as the level of care for the child despite the foster parents’ desire to maintain placement of the child.

**Findings-**The Ombudsman Office’s findings were inconclusive. The Ombudsman Office was unable to make a finding due to the time that had elapsed between when the child was placed in the complainant’s home (2001-2002) and present day.

**4. Issue-**A complainant stated that the mother gave Bureau staff Christmas presents for her son in December which she later learned were not delivered to him until February.

**Findings-**The Ombudsman Office’s findings were inconclusive. The Ombudsman Office did not find sufficient information to reach a determination regarding the Bureau’s conduct.

**5. Issue-**A complainant stated that the Bureau had not ensured the safety of the child.

**Findings-**The Ombudsman Office’s findings were inconclusive. The Ombudsman Office was unable to make a finding due to the lack of documentation about the foster home and the foster parents’ capacity to protect the child.

**Recommendations-**The Ombudsman Office recommended the following:

1. That the Bureau review with all staff and supervisors the policy titled Frequency and Documentation of Contacts with Children and Families,

stressing the importance of documenting the specific content of communications.

2. That the Bureau remind supervisors of their responsibility to review details of the case record, ensuring that all documentation is thorough and accurate.

**Bureau Response-**The Bureau agreed with the Ombudsman Office finding.

## Other Findings

The Ombudsman Office identified four additional concerns (designated as “Other Findings”) that were not part of the original complaint. These findings include concerns regarding professional standards and accuracy in documentation, physical restraint of children while in Bureau custody, referring new incidents of maltreatment, and screening intake information as primary vs. non-caregiver referrals.

**1. Findings-** The Ombudsman Office found concerns related to professional standards in documentation and inaccuracies in documentation. The Ombudsman Office found personal information about the case manager’s own family. Additionally, the case manager documented inaccurate information indicating doubts that a child was placed in a specific foster home despite reference to the placement found in the record.

**Ombudsman Office Recommendations-**The Ombudsman Office recommended that the Bureau review with all staff and supervisors the policy titled Case Management Responsibilities by Ongoing Services, stressing that all documentation in the case record and eWiSACWIS must always reflect professional standards.

**Bureau Response-**The Bureau communicated that they would explore this recommendation that the policy be reviewed and amended with all staff and supervisors. Additionally, that an existing policy and procedure workgroup would review the procedure to determine if a more meaningful description of required case note content could be accomplished and whether or not it appropriately addressed professional standards in documentation. In the event a policy revision was deemed appropriate, the revised policy would be re-issued with a written communication of the changes to all staff and supervisors.

**2. Findings-**The Ombudsman Office found concerns regarding staff’s knowledge of restraints and/or holds both in how the terms were defined as well as the level of detail that was sought by staff of treatment providers regarding an incident when restraints and/or holds were used. During the Ombudsman Office’s interview with Bureau staff, the case manager was asked about what she was told regarding the use of restraints in the child’s treatment at the treatment facility. The Bureau staff person stated that she was not aware that the child was restrained but was aware that the child was put in holds as a way to manage aggressive behavior toward other children. In reviewing the case record, the Ombudsman Office did not find any notes written by Bureau staff or sent from the treatment facility detailing incidents when the child was restrained or put in a hold; however, in case notes, information was provided to the Bureau that the child was put in holds throughout the day and had a mark on her forehead resulting from a hold, yet no follow-up questions were asked.

**Ombudsman Office Recommendations-**The Ombudsman Office recommended the following:

1. That Bureau and contracted private agency staff are trained in, or provided information regarding, physical restraints of a child.
2. That the Bureau require incident reports whenever a child is restrained from all service providers that are providing services to children involved with the Bureau. These reports should include but not be limited to details about what behavior led to the need for the restraint, how the child was restrained, and strategies to address the child's behavior.

It is the Ombudsman Office's contention, in keeping with the standards of practice in the field, that whenever hands are put on a child, regardless of the terminology used (hold, restraint, etc.), the situation is treated as a critical incident that warrants close investigation by the assigned staff and consultation with the supervisory staff.

**Bureau Response-**The Bureau communicated that the policy and procedure workgroup would identify which current policies and procedures relate to the handling and documentation of incidents of hands being placed on a child for behavior management purposes. The workgroup would determine if a more meaningful description of requirements could be accomplished without changing or compromising essential instructions. For example, amending or creating policies and procedures related to "investigating" and "critical incident" in which hands are put on a child must not create confusion for staff regarding their responsibility as a mandated reporter or their role in the independent investigation process and should not dilute the message that the physical restraint of children by any out of home care provider or service provider is strictly prohibited. In the event a policy revision is deemed appropriate and/or additional training is determined to be necessary, the Bureau will proceed accordingly.

- 3. Findings-**In gathering information about the context of the initial complaint, the Ombudsman Office reviewed the record of the incident that gave rise to the complainant's contact with this office. The record indicates that a significant altercation involving the mother and caregiver took place in the caregiver's home in the presence of two children; one of the children called the police, who responded. The mother and the caregiver had made mutual allegations that the other was the aggressor. The mother allegedly sustained injuries in the altercation. The mother subsequently reported to the Ongoing Supervisor and the Program Manager her concern that her children were being abused in the home and gave specific information, minus dates, of abusive acts she had witnessed. The Ongoing Supervisor documented that she informed the mother that if the

mother was concerned for her children's safety she could call Intake herself; the mother reported that the Program Manager also stated she could call Intake herself. Neither employee themselves reported the allegation of maltreatment or the known violent incident that took place in the children's presence. The mother's concern about possible maltreatment of her children was reported by the mother to Intake approximately two weeks after her concerns were first expressed to ongoing staff.

**Ombudsman Office Recommendations-**Ombudsman Office staff brought this concern about staff not having initiated a referral upon learning of both the mother's allegations about the caregiver and the violent incident that was witnessed by two children in care to leadership at the contracted private agency responsible for the case.

**Bureau Response-**In communication to the Ombudsman Office, the following response to the concern was offered by the contracted private agency:

"We have reviewed this matter at the management level, and agree that a referral should have been made, regardless of the history of how poor or accurate an historian the parent has been, given our lack of data to rule out the assertion of the parent. We agree that, in the future, under similar circumstances, a referral should be processed again, on the basis of being unable to rule out an allegation of maltreatment as inaccurate or false."

**4. Findings-**An additional concern the Ombudsman Office found that is not a part of the original complaint is as follows:

The original intake was screened in and assigned as a non-caregiver referral. The Child Protective Service Investigation Standards state that the non-caregiver standard for sexual contact between children "does not apply to siblings, step siblings or half siblings or children who regularly or intermittently share the same dwelling. (See discussion of Who "Share The Same Dwelling"? in Introduction to Primary Caregivers.)"

In the Introduction To Primary Caregivers under the section titled Who "Share The Same Dwelling"? it states, "for the purpose of these Standards, dwellings are family or family-like settings which do not depend solely on professional care providers. Thus, dwellings include private residences shared by family members, foster families and unrelated individuals."

Based on the information stated above, the referral should have been screened in and assigned as a primary caregiver referral. The completion of a primary caregiver assessment would have required the worker to interview all family members, which might have provided the information needed to address the concern noted in this complaint.

**Ombudsman Office Recommendations-**The Ombudsman Office recommended that the Bureau review the Child Protective Service Investigation Standards with Intake and Initial Assessment staff and supervisors.

**Bureau Response-**The Bureau disagreed with the Ombudsman Office findings. The Bureau staff maintained that this report was screened as a non-caregiver referral as the alleged “maltreating” child was identified as a grandchild of the foster parent. There was no information in the report to indicate that this grandchild resided in the same home, but rather the referral information indicated that he was a visitor to the home. If it was later learned that the grandchild did reside in the home, it would have been incumbent upon the Initial Assessment social worker to complete a primary caregiver assessment, given the newly learned information.

## **Communication**

### **Bureau and Contracted Private Agencies**

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

### **Partnership Council**

The Partnership Council, established by Wis. Stats. S.15.197(24)., was created in 1995 to advise the DHFS and the Legislature regarding child welfare services in Milwaukee County. The Ombudsman Office reports publicly at Partnership Council meetings on the Ombudsman Office's general activities. The Ombudsman Office Director presented the 2006 Annual Report to the full Partnership Council in July 2007.

### **Brochure**

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

### **Committees and Associations**

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

### **Website**

The Ombudsman Office developed a website ([www.ombudsmanmilw.org](http://www.ombudsmanmilw.org)) that allows browsers 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 DHFS and Bureau have a link on their website under the Bureau Complaint Resolution Process to the Ombudsman Office.

(<http://dhfs.wisconsin.gov/Bureau/progserv/AboutBureau/complaint-appeal/complaint-process.htm>)

## **Looking Forward to 2008**

The following are areas of focus for the Ombudsman Office in 2008:

- Provide ombudsman services for all children and families served by the Bureau of Milwaukee Child Welfare.
- Continue to promote the independence and impartiality of the ombudsman program.
- Continue support for improving child welfare practice in Milwaukee and Wisconsin.
- Collaborate with organizations and policymakers that are working toward making Milwaukee and Wisconsin safe and supportive for children and families involved in the child welfare system.
- Track and report progress on Ombudsman Office recommendations made to the Bureau.
- Continue outreach efforts targeting to key stakeholders.
- Enhance outreach efforts to include non-traditional resources.

## **Appendices**

Appendix 1: Staff

Appendix 2: Process Overview

Appendix 3: Timeline Goals

Appendix 4: Complaint Categories

Appendix 5: Screening Criteria

## Appendix 1

### Staff

The 2007 Ombudsman Office Staff consisted of the Ombudsman Director, an Associate Ombudsman, a part-time Consultant, a .5 FTE Administrative Assistant/Intake Coordinator, and an attorney to consult regarding legal matters.

The Ombudsman Director, Lisa Drouin, has been with the Ombudsman Office since March 2005. She has more than a decade of experience working in social services and child welfare. Ms. Drouin served in a senior management position as the Quality Assurance Manager in the child welfare system in Milwaukee, and holds a Master's Degree in Social Work from the University of Wisconsin-Milwaukee.

#### Associate Ombudsman

- Mary Pat Bohn worked with the Ombudsman Office from March 2007 through October 2007. She has over two decades of experience working in Child Welfare and holds a Master's Degree in Marriage and Family Therapy from University of Wisconsin Stout.
- David Scholl began with the Ombudsman Office in November 2007. He has over seven years of experience working in child welfare, including roles as a trainer, case manager, CST Facilitator, and supervisor for Safety Services and Ongoing Case Management. Mr. Scholl holds a Master's Degree in Social Work from the University of Wisconsin-Milwaukee.

#### Administrative Assistant/Intake Coordinator

- Fletcher Mixson worked with the Ombudsman Office from May 2005 through September 2007. He has over a decade of experience in social services in administrative roles, and attended Milwaukee Stratton Business College.
- Michelle Doneis began working with the Ombudsman Office in November 2007. She has six years of administrative experience and will receive her Bachelor's Degree in Human Services Management from Cardinal Stritch in May 2008.

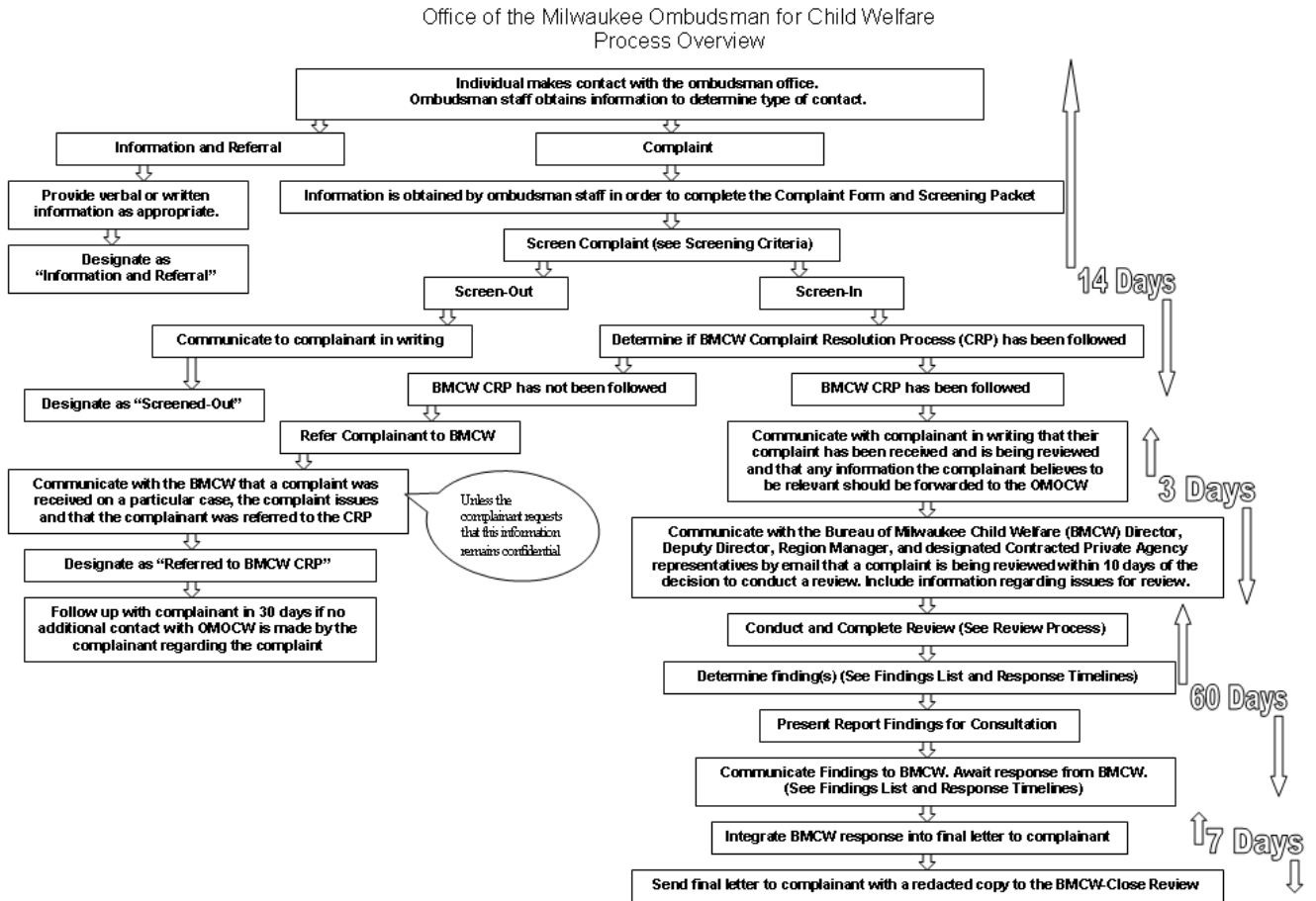
The Ombudsman Consultant, Deb Rosen, worked with the Ombudsman Office from March 2006 through December 2007. She has over a decade of experience working with children and foster and adoptive caregivers involved in the child welfare system. Ms. Rosen served as a trainer, manager, and administrator for child welfare in Milwaukee and holds a Master's Degree in Social Work from the University of Wisconsin-Milwaukee.

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.

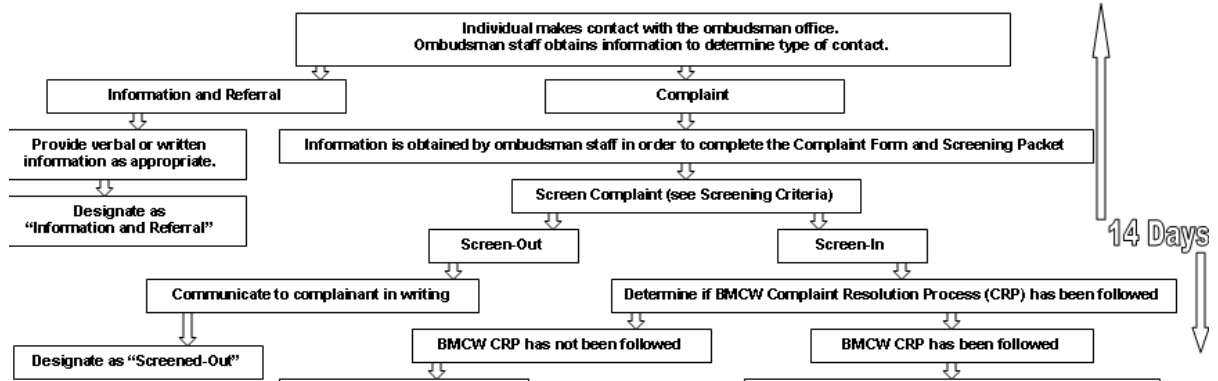
## Appendix 2

### Process Overview

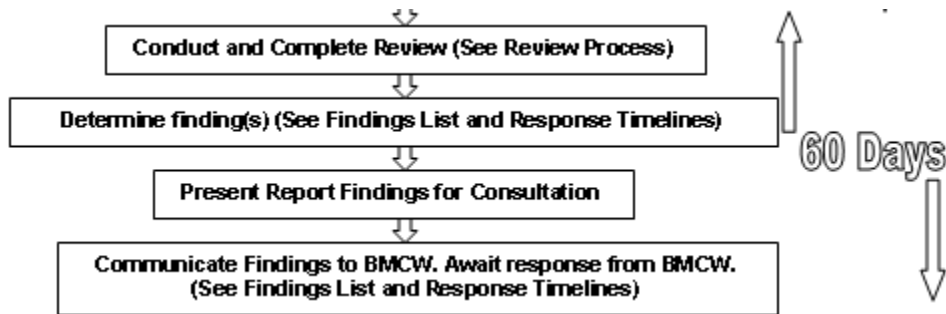


Revised-11-01-07

### Appendix 3 Timeline Goals

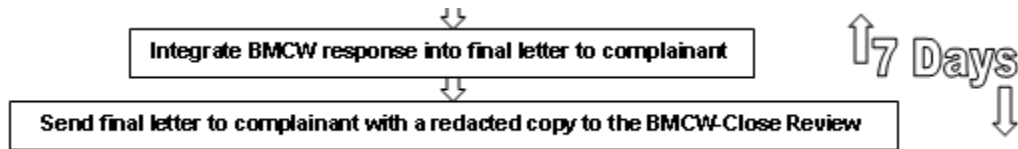


Timeline goals from when an individual contacts the Ombudsman Office to completing the screening process and determining if the Bureau CRP has been followed is 14 calendar days. For nearly 96% of contacts, this process was completed within the timeline established. The average number of days this process took in 2007 was two. For 37 contacts, this process was completed the same day the individual contacted the Ombudsman Office. Challenges with making contact with the complainant to obtain information necessary to complete this process led to this timeline being exceeded for four complaints.



The goal for the completion of the OMCOW review is 60 calendar days from the time correspondence is sent to the complainant and the Bureau that a review will take place until the time that the Ombudsman Office sends the Bureau its findings of the review. For those complaints opened and closed in 2007, 100% of the reviews were completed within the 60 day timeline goal with the average completion time being 39 days.

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



The goal 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 2007, 100% of the final findings correspondences were completed within the seven day timeline goal with the average completion time being two days.

#### Process from Contact to Final Correspondence

For complaints received in 2007 and where the review was completed in 2007, from the date of contact to the date of the final findings correspondence was sent to the complainant was an average of 89 calendar days. This accounts for time awaiting the Bureau's response to the Ombudsman Office findings and any additional correspondence that was needed.

## Appendix 4

### Complaint Categories

Complaint Category	Number
<p><b>Lack of Action by Bureau Staff</b></p> <ul style="list-style-type: none"> <li>▪ Lack of return contact (10)</li> <li>▪ Inadequate assistance from staff (9)</li> <li>▪ Lack of follow-up on a report of child abuse or neglect on an open case (7)</li> <li>▪ Lack of follow through by staff regarding concerns (5)</li> <li>▪ Lack of obtaining and documenting appropriate information for decision making (3)</li> <li>▪ Lack of timeliness in initiating the initial assessment (3)</li> <li>▪ Lack of contact with parent for consent for medical treatment (2)</li> <li>▪ Lack of timeliness in completing the initial assessment (2)</li> <li>▪ Information withheld by staff (2)</li> <li>▪ Lack of interviewing parent during initial assessment (2)</li> <li>▪ Lack of follow through regarding decisions made for medically fragile child (1)</li> <li>▪ Lack of response to police request regarding the custody of a child (1)</li> <li>▪ Lack of utilizing health care providers covered by parent's private health insurance (1)</li> </ul>	<b>48</b>
<p><b>Placement Issues</b></p> <ul style="list-style-type: none"> <li>▪ Concerns regarding the safety of a child's placement (8)</li> <li>▪ Relative placements not sought (8)</li> <li>▪ Concerns that siblings are not placed together (4)</li> <li>▪ Disagreement with a change of placement (4)</li> <li>▪ Placement not being appropriately monitored (3)</li> <li>▪ Concerns regarding the conduct of a caregiver (2)</li> <li>▪ Concerns regarding the placement of the children with relatives against the mother's request (2)</li> <li>▪ Concern about the quality of care in the placement (2)</li> <li>▪ Concern about the appropriateness of the placement (2)</li> <li>▪ Concern that child is not placed with relative as requested (2)</li> <li>▪ Concerns that a child has had multiple placements (1)</li> <li>▪ Concerns regarding the appropriateness of the level of care (1)</li> </ul>	<b>39</b>
<p><b>Concerns of Not Receiving Fair Treatment by Bureau Staff</b></p> <ul style="list-style-type: none"> <li>▪ Retaliatory/threatening/hostile behavior by staff (14)</li> <li>▪ Staff giving misinformation (6)</li> </ul>	<b>33</b>

Complaint Category	Number
<ul style="list-style-type: none"> <li>▪ Disrespectful treatment/lack of professionalism from staff (5)</li> <li>▪ Unsympathetic behavior by staff (3)</li> <li>▪ Bias against father (2)</li> <li>▪ Bias against mother (2)</li> <li>▪ Bias against other-family members (1)</li> </ul>	
<p><b>Visitation Issues</b></p> <ul style="list-style-type: none"> <li>▪ Concern that visitation with parent is not occurring (6)</li> <li>▪ Concern that Bureau is canceling/suspending visits (4)</li> <li>▪ Concern regarding location of visitation (4)</li> <li>▪ Concern that visitation is not progressing (3)</li> <li>▪ Concern that visitation with extended family is not occurring (3)</li> <li>▪ Concern that visits should be unsupervised (2)</li> <li>▪ Lack of understanding of why visitation is supervised (2)</li> <li>▪ Concern that a child is missing visits (1)</li> <li>▪ Concern that a parent is missing visits (1)</li> <li>▪ Concern that no visitation plan is in place (1)</li> <li>▪ Concern that siblings are not able to visit with each other (1)</li> <li>▪ Concern regarding a child's safety during supervised visitation with violent parent (1)</li> <li>▪ Concern that plan for visitation is not being followed (1)</li> </ul>	<b>30</b>
<p><b>Service Delivery Issues</b></p> <ul style="list-style-type: none"> <li>▪ Not addressing needs as requested (3)</li> <li>▪ Lack of timeliness of service delivery (3)</li> <li>▪ Concerns about service providers (2)</li> <li>▪ Conflict between recommendations of service provider and Bureau (2)</li> <li>▪ Not addressing needs as court ordered (2)</li> <li>▪ Not providing services (2)</li> <li>▪ Disagreement with Bureau requiring services to be completed (2)</li> <li>▪ Not addressing special needs of a child (1)</li> <li>▪ Not addressing medical needs of a child (1)</li> <li>▪ Not addressing basic needs of a child (1)</li> <li>▪ Concern regarding language barriers (1)</li> <li>▪ Concern that religious beliefs/instructions were not being followed (1)</li> <li>▪ Concern that services needed to be repeated due to staff error (1)</li> <li>▪ Concern that staff is not realistic regarding services and the parent's work schedule (1)</li> </ul>	<b>24</b>

Complaint Category	Number
<ul style="list-style-type: none"> <li>▪ Concern that Bureau staff is cancelling and rescheduling services without the complainant's permission (1)</li> </ul>	
<p><b>Issues Regarding Bureau's Role with Taking a Child into Custody</b></p> <ul style="list-style-type: none"> <li>▪ Concern that a child was taken into custody and should not have been (6)</li> <li>▪ Lack of information/understanding of why a child was taken into custody (4)</li> <li>▪ Concern that a child should have been taken into custody and was not (3)</li> <li>▪ Incorrect assessment that resulted in the removal of a child (3)</li> <li>▪ Concern that the Bureau entered and searched a mother's home without permission (2)</li> <li>▪ Concern that the Bureau did not consider a child being witness to domestic violence as a safety concern (1)</li> <li>▪ Disagreement with a Screen-Out decision (1)</li> </ul>	<b>20</b>
<p><b>Issues with the Bureau Recommendations to the Court</b></p> <ul style="list-style-type: none"> <li>▪ Inaccurate information provided to court (8)</li> <li>▪ Concern/disagreement with recommendations made (5)</li> <li>▪ Lack of verification of information sent to the court by staff (2)</li> </ul>	<b>15</b>
<p><b>Other- Within Scope</b></p>	<b>10</b>
<p><b>Confidentiality Concerns</b></p> <ul style="list-style-type: none"> <li>▪ Inappropriately releasing confidential information (7)</li> <li>▪ Concern that the name of the reporter of maltreatment was released (1)</li> <li>▪ Concern that a conflict of interest may have existed with the assigned worker and relatives prior to their involvement in the case (1)</li> </ul>	<b>9</b>
<p><b>Case Planning Concerns</b></p> <ul style="list-style-type: none"> <li>▪ Concern that the parent was misinformed of the permanency plan for the children (2)</li> <li>▪ Concern that the parent has met all conditions for return of the children, yet there is no plan for their return (2)</li> <li>▪ Concern that Coordinated Service Team (CST) meetings are being held without inviting all of the involved family members (1)</li> <li>▪ Concern about the location of CST meetings (1)</li> </ul>	<b>7</b>

Complaint Category	Number
<ul style="list-style-type: none"> <li>▪ Concern that CST meetings are not being held on a regular basis (1)</li> </ul>	
<p><b>Issues with Bureau Record</b></p> <ul style="list-style-type: none"> <li>▪ Inaccurate information in the Bureau record (4)</li> <li>▪ Concern that the Bureau lost information that should have been part of the record which resulted in the parent being required to retake services (1)</li> <li>▪ Lack of verification of the Bureau record (1)</li> <li>▪ Concern that a parent was informed she was not permitted access to her complete case record and was only given copies of limited information to review (1)</li> </ul>	<b>7</b>
<p><b>Notification Issues</b></p> <ul style="list-style-type: none"> <li>▪ Not receiving proper notification regarding a change of placement (3)</li> <li>▪ Not receiving proper notification regarding taking a child into custody (2)</li> <li>▪ Not receiving proper notification regarding termination of parental rights (1)</li> </ul>	<b>6</b>
<p><b>Issues Outside the Scope of the Ombudsman Office</b></p> <p>Attorney Related Concerns (5)</p> <ul style="list-style-type: none"> <li>▪ Attorney not providing adequate services (4)</li> <li>▪ Attorney not providing information (1)</li> </ul> <p>Court Related Concerns (5)</p> <ul style="list-style-type: none"> <li>▪ Disagreement with court decisions (4)</li> <li>▪ Lack of understanding regarding court process (1)</li> </ul> <p>Licensing Concerns (5)</p> <ul style="list-style-type: none"> <li>▪ Foster home licensing concerns (3)</li> <li>▪ Adoption home licensing concerns (1)</li> <li>▪ Treatment foster home licensing concerns (1)</li> </ul> <p>Payment Related Issues (5)</p> <ul style="list-style-type: none"> <li>▪ Lack of payment for care of a child (2)</li> <li>▪ Concern regarding timeliness of payment (1)</li> <li>▪ Lack of payment for items as promised by Bureau (1)</li> <li>▪ Disagreement with adoption subsidy amount (1)</li> </ul> <p>Provider Network Issues (2)</p>	<b>27</b>

Complaint Category	Number
<p><b>Issues Outside the Scope of the Ombudsman Office Continued</b></p> <ul style="list-style-type: none"> <li>▪ Personnel Related Issues (2)</li> </ul> <p>Other (5)</p> <ul style="list-style-type: none"> <li>▪ (One instance each of the following: W-2 Concerns, Issues with Family Court, Childcare certification concern, Concern regarding probation officer, barriers to community supports/resources not connected with Bureau)</li> </ul>	

## Appendix 5

### Screening Criteria

The following criteria are used in order to determine if a complaint is screened in or out:

1. The complaint is within the scope of issues the Ombudsman Office reviews.  
  
The Ombudsman Office does not review complaints regarding concerns about attorneys, court related decisions, licensing concerns, personnel related issues, or payment related issues.
2. The complaint involves a specific child and/or family involved with the Bureau (either currently or in the past 90 calendar days).
3. The issue(s) being complained about occurred within the past year, or it is not clear at this time 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.