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☞ Details: Public Hearing: Follow-up: Audit Reports 06-1 and 06-2, Milwaukee County Child Welfare, Department of Health and Family Services (DHFS)

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2007-08
(session year)

Joint
(Assembly, Senate or Joint)

Committee on Audit...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

Joint Legislative Audit Committee
Public Hearing
Thursday, March 8, 2007

Testimony on Milwaukee County Child Welfare Audit Report 06-1 and 06-2

Secretary Kevin Hayden
Department of Health and Family Services

William R. Fiss, Interim Administrator
Division of Children and Family Services

Denise Revels Robinson, Director
Bureau of Milwaukee Child Welfare

Thank you Senator Sullivan, Representative Jeskewitz and members of the Joint Legislative Audit Committee for inviting us here today to talk about our progress in implementing the Legislative Audit Bureau's recommendations on Audit Report 06-1 and 06-2. I also want to acknowledge the Milwaukee legislators that are here today for your commitment to improving the lives of Milwaukee's children and families.

I also want to congratulate you, Representative Jeskewitz, for your recent appointment to the Milwaukee Child Welfare Partnership Council. Your commitment to improving the lives of children and families and your expertise on issues affecting them will be a valuable addition to the Partnership Council.

I'm joined here today by Denise Revels Robinson, Director of the Bureau of Milwaukee Child Welfare and Bill Fiss, Interim Administrator of the Division of Children and Family Services, which has responsibility for the Bureau within the Department of Health and Family Services.

I will talk briefly about my recent announcement of an independent panel to review the tragic child death. Bill and Denise will talk in more detail about some key areas that the Bureau has been focusing on enhancing, including the Safety Services Program. Denise will also provide information on the child death. If time permits, and if you are interested, we can also walk you through the other items we reported on in our February 1 report to your Committee.

Keeping children safe is our top priority. I, like all of you, was deeply saddened by the death of the infant in November 2006. Recently, the Milwaukee Coroner's office ruled that the infant died due to starvation – a horrible tragedy that no child should endure. Rest assured, each and every one of us was deeply affected by this incident and we are all committed to understanding why this occurred and what we can do in the future to prevent a similar occurrence. While it's impossible for the Bureau to predict the

incomprehensible actions of adults, like the parents of this young child, we can ensure that to the best of our ability we will do whatever we can to keep children safe.

In order to help us further understand why this tragedy occurred, I appointed an independent panel to review the infant's death. Specifically, this panel will examine the policies and practices of the Bureau and identify the other agencies involved and their respective roles and impact on the case.

Most children and their families served by the Bureau are involved in multiple systems and the need for strong collaboration and communication is vital to their success. Thus, it's critical for the panel to not only review the policies of the Bureau but to also examine the responsibilities of the other systems and how we can enhance our coordinated efforts when it comes to serving vulnerable families.

The panel will be chaired by Pastor Archie Ivy, who is also here with us today. Pastor Ivy is the chair of the Milwaukee Child Welfare Partnership Council. The other panel members include Paul Vincent, Director of the national Child Welfare Policy and Practice Group, Dr. Lynn Sheets, Medical Director of the Child Protection Center at Children's Hospital, and Lindsey Draper, retired Court Commissioner. Any recommendations that the panel identifies for potential areas of improvement will be submitted to me by May 1.

Since the Bureau's inception in 1998, there have been many reviews, investigations, and audits of the system and the services that are delivered. The Bureau has always welcomed these reviews as they provide an opportunity to look closely at child welfare practice and identify areas of enhancement. If you look back over the last 10 years, the Bureau has a strong history of taking the recommendations made in the various reviews and investigations and acting on them. The Bureau is committed to evaluating our work and improving our practice and policies, if they are in the best interests of the children and families we serve.

I'd now like to turn it over to Bill Fiss who will provide you with some additional details on some key areas of improvement within the Bureau. Denise Revels Robinson will then provide you with more details on our enhancements to the Safety Services program and information on the recent child death and the Bureau's work to date on implementing corrective actions in response to her death. We are also happy to walk you through the other items reported on in the February 1 final report, if time permits.

Thank you for allowing me the opportunity to present to you today. We are happy to take any questions you have following Denise and Bill's testimony.

Bill Fiss – Interim Administrator, Division of Children and Family Services

Good morning Senator Sullivan, Representative Jeskewitz, members of the Joint Legislative Audit Committee.

We believe that the Bureau has made significant progress over the last 10 years. According to Janine Geske, arbitrator in the Jeanine B. Settlement Agreement, in her November 2006 decision "there continues to be steady progress in serving children and families, improving day-to-day practice and strengthening accountability. There are 40% fewer children in out of home care, children are reaching permanency more quickly, children in out of home care receive regular visits by their caseworkers and the incidence of maltreatment in out of home care has significantly decreased."

There are still challenges that face the Bureau, similar to those faced by other urban child welfare systems nationally. While we continue to improve and enhance our systems, we must also continue to acknowledge and address the real challenges that face the children and families we serve, and the system that is in place to assist them.

In October 2006, a Quality Service Review was conducted of the Bureau, and was led by the national Child Welfare Policy and Practice Group. The QSR looked at outcomes related to safety, stability, and permanency, and system performance outcomes such as family engagement. The Bureau performed well in its first review, surpassing many other similar child welfare systems' initial reviews. The review also found that BMCW faces challenges, consistent with those found among all public child welfare systems. The Bureau has developed and is currently in the process of implementing a quality improvement plan that addresses the recommendations included in the report for each program area. The Bureau and the Partnership Council will present regularly to the Milwaukee community on our progress towards the practice improvement items found during the review. We will conduct a similar review approximately every 15 months.

The Bureau also continues to monitor its performance as required under the federal Settlement Agreement. Since December 31, 2005, when the Bureau reached the conclusion of the third year of the Settlement Agreement, we have been released from 10 enforceable provisions after being in compliance with the required items. We will report to the community on March 19, on our progress on meeting the performance requirements on the eight remaining enforceable provisions.

According to Ms. Geske in her November 2006 arbitration decision, "the state has reached compliance on most of the required provisions and continues to make substantial improvement on most of the remaining provisions. I would also note that even during times of high turnover, BMCW made significant progress in improving services to children."

Beyond the Settlement Agreement, the Bureau continues its efforts and commitment to staff recruitment and retention. We are aware of the detrimental effects that high turnover has on achieving positive outcomes for children. Governor Doyle has prioritized case manager retention efforts by including base salary increases and enhanced training for ongoing case managers and supervisors in his 2007-2009 biennial budget. We hope that we can count on the continued support of the legislature to fully fund our initiatives to improve staff recruitment and retention in Milwaukee.

The Bureau and our partner agencies are committed to ensuring all children in care of the child welfare system are safe, that children achieve a safe and permanent home in the shortest time possible, and that children in care are healthy and performing well in school. These are challenging goals for any child welfare system but they are the right ones. The BMCW and our partner agencies have developed a contract process that encourages and rewards these positive outcomes for children and families.

In October 2006, BMCW implemented outcome based performance contracts for the Milwaukee County child welfare system. These efforts reward participating agencies for achieving positive performance and assist them in sustaining improvements in safety, permanency, and well-being for children in the foster care system. The BMCW monitors performance on a monthly basis and reports overall performance on a quarterly basis.

Denise will now walk you through details on the Safety Services Program and the recent death of the young infant.

Denise Revels Robinson, Director, Bureau of Milwaukee Child Welfare:

Good morning Senator Sullivan, Representative Jeskewitz, members of the Joint Legislative Audit Committee.

My remarks today include an update about the Safety Services program, the Department's response to the audit findings regarding safety services and information about the tragic death of baby Layunnia reported in the media a few weeks ago and the actions the Bureau has implemented in response to her death.

Safety Services Program

The Department believes the Safety Services program offers a unique opportunity to provide intensive services to families in order to keep children safe in their homes, and to prevent unnecessary out of home care placement.

The Safety Services program was originally designed as a voluntary program with the following goals:

- Prevent out of home placement while controlling for child safety;
- Stabilize the family through service interventions and linkages to formal, informal, and natural resources in the community;
- Assist the family in accessing resources that will provide support and services on an on-going basis; and
- Encourage the family to identify and access the necessary resources to control for safety and bring lasting change to the family.

In July 2006, BMCW began to refer families at risk of child abuse and neglect to Safety Services. A family "at risk" is one that faces potential threats to the safety of children that are not imminent, but are likely to occur without some form of intervention. It is our hope that by engaging families in these voluntary services, before an incident of abuse or

neglect occurs, we can prevent harm to children in the future. Between July and December 2006, risk cases made up 18.3% of the total referrals to Safety Services. 730 families received safety services during calendar year 2006.

The BMCW Program Evaluation Managers are conducting reviews of risk-referred cases on a bi-monthly basis. Preliminary findings of the risk case review suggest that poverty is one of the reasons why risk cases are referred to Safety Services. Reviews indicate that families lack a connection to W-2 and require assistance with basic resources such as food, housing, furniture and adequate clothing. As part of their involvement in the program, the families' needs are assessed, and a service plan is developed and tailored to meet their needs so that the safety of the children is assured. Based on the review, the Program Evaluation Managers found that as families received services, the risk of harm to their children was greatly reduced, their situations were stabilized, and they were able to make it on their own. As reported in the Department's February 1, 2007 written response to the Legislative Audit Committee, BMCW and our private partner agencies are collaborating with W-2 to improve cross-system efforts in providing services to children and families.

BMCW acknowledges the Legislative Audit Bureau's (LAB) finding that some Safety Service cases may have been closed prematurely. Based upon a recommendation by the LAB, BMCW changed the method in which its private partner agencies are reimbursed, which went into effect October 2006 to eliminate any incentive to close cases prematurely. Rather than receiving a fixed-rate reimbursement for a maximum of four months, agencies now receive the fixed rate for every month that a case remains open.

BMCW and our private partner agencies have established procedures and protocols regarding oversight and approval of cases in order to ensure that each family receives the services it needs while avoiding the risk of premature case closure. BMCW and our private partner agencies established and implemented criteria for cases remaining open longer than 3 months. The protocol includes an internal staffing of each case and also ensures the oversight of financial resources through monthly monitoring of Safety Service caseloads and their associated costs.

Based on the internal staffings conducted by BMCW state employed managers during January and February 2007, recommendations were made to extend 6 cases for an additional 60 days, and 2 cases were extended for an additional 30 days. The staffings have also been helpful in identifying barriers to serving families and solutions to address the identified barriers.

I also want to provide information to respond to concerns about children entering out of home care after their family's involvement in Safety Services.

In January 2007, 15 children who entered out of home care were removed from families involved in Safety Services during the last 12 months.

In 2006, of the 1180 children who entered out of home care, 290 children had a prior Safety Services case within 12 months of their removal.
Of the 290 children:

- 166 children were placed on average 140 days after the Safety Service case was closed.
- 124 children were removed while the case was open in Safety Services. The average number of days the Safety Service case was open was 76 days. The longest time a case was open in Safety Services was 282 days and the shortest time was 6 days.

While the goal of the Safety Services program is to ensure child safety in the home and to prevent out of home care removal, there are clearly times when children must be placed in out of home care to ensure child safety. That decision is never made lightly and is made in the best interest of each child.

Infant Child Death Case

I will now transition to discuss the tragic death of baby Layunnia in November 2006. I would like to give you information about this case, and actions we are taking in response to this tragedy.

As you know, because a child has died and officials have disclosed that the child was receiving services from the Bureau, Wisconsin Statutes [Wis. Stat. s. 48.981(7)] permit me to give you a summary of the case. The Statutes do not, however, permit me to go into all the details that may be contained in our child welfare files.

The death of any child is a tragedy and taken very seriously by all of us in the Bureau. It deeply affects the community and those working directly with the family.

On November 28, 2006, the Bureau intake unit was notified by the Milwaukee County Medical Examiner of an infant's death. The report stated she was malnourished and dehydrated. This notification was consistent with the established protocol for the Milwaukee County Medical Examiner's office to contact the Bureau to report all child deaths in Milwaukee County.

In response to the Medical Examiner's report, state employed initial assessment social workers were assigned to assess the safety of the surviving siblings in the home. Prior to going to the family home, staff checked the Bureau's WiSACWIS information system and learned the family case was open for service in ongoing case management. One child of the father was on a CHIPS court order (order of supervision). The child was living with the family after being returned from out of home care in September 2006. Based on the safety assessment conducted by initial assessment staff, the four surviving children were taken into protective custody on November 28, 2006 and placed in out of home care.

The Medical Examiner's final report issued in February 2007, ruled Layunnia's death a homicide due to parental neglect.

Referral and Background Information:
The Bureau's intake received a referral from a Milwaukee hospital on April 1, 2006 regarding baby Layunnia born on April 1, 2006 at 26 weeks gestation with severe respiratory problems described as usually fatal at the time of birth. The mother was described by medical staff as uncooperative and not following medical recommendations while the baby was in the hospital. At the time of the referral, the baby was still hospitalized. The case was referred to safety services on April 4, 2006 to assist the parents with basic parenting and preparation for the care of this very premature, fragile infant upon her release from the hospital and to assist with advocacy between the hospital and the parents.

Layunnia was discharged from the hospital on June 22, 2006. The case was open in Safety Services from April 5, 2006 – July 7, 2006. The case was closed based on the parents' request.

Key Findings and Lessons Learned from the Internal Case Staffing
The Bureau conducted an internal review of baby Layunnia's death and case situation. Based on the results of the review, the following key findings were identified:

1) Staff in Safety Services and ongoing case management were serving the family during overlapping time periods. The ongoing case management case was open from October 2005 to the present, following the physical abuse of one of the father's children. The family case was open in Safety Services from April 2006 – July 2006, following the birth of Layunnia.

2) Medical and home visiting providers did not consistently report to BMCW at 220-SAFE failed medical appointments by the birth parents. Some providers closed the case based on the family's lack of cooperation without reporting potential medical neglect to 220-SAFE.

3) Existing Bureau procedures and protocols may not have been sufficiently applied or understood in this specific case.

4) The medical needs and vulnerability of the infant were not understood and connected to a safety plan for the baby, thus a narrow interpretation of child safety was applied in this case.

5) There were missed opportunities after Safety Services ended their work in July 2006 that ongoing case management could have used to engage the parents and monitor the safety of the child.

6) Additional in-service training of direct service and supervisory staff in ongoing case management and safety services is necessary to ensure an accurate understanding of protocol and the program philosophy of safety services and its interface with an open case in ongoing case management.

7) There is a need for better understanding by staff of confidentiality laws, HIPAA and the exceptions.

8) Staff across program areas need a better understanding of the medical aspects of premature infants and the impact on child safety in their day to day work.

9) The Bureau is in the process of implementing system-wide actions to address the issues identified in this specific case. However, it is also necessary for the private agency partner to implement their own internal actions with staff, which they have willingly agreed to do, to address the case specific practice in safety services and ongoing case management.

Corrective Actions

The following actions are being implemented to address the key findings of the case review, and to strengthen child welfare practice:

1. Effective immediately, cases involving premature (born before 26 weeks gestation) and medically fragile infants require consultation and approval of the BMCW Medical Director during the initial assessment and case transfer process to discuss the medical needs of the infant that must be addressed to ensure continued child safety.

2a. The Bureau's private agencies for ongoing case management and Safety Services were directed to internally cross match the names of family cases open in Safety Services and ongoing case management to determine if the same family cases are concurrently open in both programs.

2b. The Bureau's private ongoing case management and Safety Services agency partners also were directed to internally staff all in-home supervision CHIPs cases to ensure the safety of all the children in the home is being assessed, not just the child whose name is on the court order.

3. In-service training will be conducted for current Safety Services staff to improve understanding of existing policies and procedures regarding the voluntary nature of Safety Services, parental consent and access to medical records, and participation in Bureau convened Coordinated Services Team meetings.

4. Training content for new staff will be revised to reinforce/highlight practice items listed in item #3.

5. In-service training will be held for initial assessment social workers, service managers and managers to strengthen their skills

and knowledge regarding the impact of medical conditions of children for a more comprehensive initial assessment.

6. The BMCW Medical Director will conduct in-service training for Bureau staff in initial assessment, Safety Services and ongoing case management regarding medically fragile, vulnerable infants to highlight key medical information for child welfare staff and implications for their safety assessment.

7. Training will be conducted by the Department's Office of Legal Counsel for all BMCW state and private agency staff on confidentiality and HIPAA.

8. Practice clarification memos were issued to remind Bureau staff of existing Bureau procedures and protocols regarding the purpose and expectations of the Safety Services program and the responsibility of the ongoing case manager to involve the entire family in the safety assessment and case planning.

9. The BMCW Medical Director contacted the primary pediatrician for Layunnia to discuss her actions on the case, to obtain medical information and to remind the pediatrician of the mandatory child abuse and neglect reporting requirements.

10. The home visiting nursing staff will be contacted to follow up on their actions regarding this case and to remind them of their mandatory reporting requirements. This will be confirmed in writing.

11. The Children's Hospital Child Advocacy Staff are conducting an internal review of the hospital's actions on this case and will report follow up to BMCW and through the CART (Child Abuse Review Team) interagency process.

12. The private agency partners will develop and implement their own internal action plan to address the practice concerns of their staff. The plan will describe management actions to explain and ensure their staff understand the expectations of the Safety Services program, and open in home supervision cases in ongoing case management. The state employed region manager will be involved in the implementation of the plan, and in tracking the progress and outcomes.

Communication with the Milwaukee Child Welfare Partnership Council

The Executive Committee of the Partnership Council was briefed on this case and the Bureau's response during their February 16, 2007 meeting in closed session.

Safety Services Case Review

The Program Evaluation managers recently completed a case review of Safety Services cases. This review was scheduled prior to the death of the infant. The PEMS will review a sample of open and closed cases at each of the three Bureau regions.

Child Fatality Review

An external review of the child death will be conducted by the Child Abuse Review Team (CART). CART is an interdisciplinary group of agencies in Milwaukee to coordinate child abuse and neglect investigations.

Member agencies:

- BMCW
- Milwaukee Police Department
- West Allis Police Department
- Milwaukee Health Department
- Milwaukee District Attorney's Office
- Milwaukee Public Schools
- Children's Hospital
- Task Force on Family Violence
- Sexual Assault Treatment Team
- West Allis Public Schools
- Milwaukee County Sheriff's Department

Based on the review, the team will develop recommendations to improve practice or to address policy issues. Their findings and recommendations will be presented to BMCW. The Bureau will prepare a written response to the report and take action accordingly.

The report will also be presented to the Executive Committee of the Partnership Council, and a summary will be presented to the full Partnership Council.

Independent Panel

As Secretary Hayden stated earlier, an independent panel will conduct an outside review of baby Layunnia's death. The Bureau welcomes this review and will take seriously all recommendations from the panel to help us and other agencies serve families and keep children safe.

Closing

We believe that all of the items identified in the Legislative Audit Bureau's evaluations of Milwaukee Child Welfare are areas that, as we continue to improve upon, will strengthen the effectiveness and efficiency of services for children and families. There are many individuals and agencies in Milwaukee that share our commitment to children and families involved in the child welfare system and those families who need our assistance to keep their children safely at home. With this shared commitment, we

believe BMCW will continue to make great strides in our efforts to improve our programs and the way we deliver our services.

We are now available to take any questions that you may have regarding the Safety Services Program, baby Layunnia's death, or any of the items we reported on in the February 1, 2007 report. Thank you.


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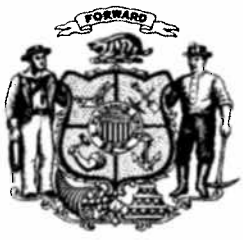

FORWARD

WISCONSIN STATE LEGISLATURE

Joint Legislative Audit Committee

Committee Co-Chairs:
State Senator Jim Sullivan
State Representative Suzanne Jeskewitz

September 18, 2007

Mr. Kevin Hayden, Secretary
Department of Health and Family Services
1 West Wilson Street, Room 650
Madison, Wisconsin 53703

Dear Mr. ~~Hayden~~ Kevin:

In March 2007, the Joint Legislative Audit Committee held a public hearing to follow-up on the Department's progress in addressing the findings of the Legislative Audit Bureau's comprehensive evaluation of the Milwaukee County Child Welfare program (reports 06-1 and 06-2). At this hearing, we also explored our mutual concerns about the tragic death of an infant whose parents were receiving services from the Department. At that time, we indicated that we would invite you to appear before the Committee and provide additional updates concerning the Milwaukee County Child Welfare program.

The Committee will hold a public hearing on Tuesday, September 25, 2007, at 10:00 a.m. in the Tommy G. Thompson Youth Center, which is located on the grounds of State Fair Park in West Allis, Wisconsin. We ask you, or the appropriate members of your staff, to be present at the hearing to update the Committee on your progress in implementing the Legislative Audit Bureau's recommendations and to respond to questions from committee members. Please plan to provide each committee member with a written copy of your testimony at the hearing.

Please contact Ms. Pamela Matthews in the office of Representative Suzanne Jeskewitz at 266-3796 to confirm your participation at the hearing. Thank you for your cooperation and we look forward to seeing you on September 25th.

Sincerely,

Senator Jim Sullivan, Co-chair
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz, Co-chair
Joint Legislative Audit Committee

Enclosure

cc: Janice Mueller
State Auditor

SENATOR SULLIVAN
P.O. Box 7882 • Madison, WI 53707-7882
(608) 266-2512 • Fax (608) 267-0367

REPRESENTATIVE JESKEWITZ
P.O. Box 8952 • Madison, WI 53708-8952
(608) 266-3796 • Fax (608) 282-3624


FORWARD

Milwaukee County Child Welfare

Legislative Audit Bureau

September 2007

1

Audit Overview

- DHFS began administering the program in January 1998, following a class-action lawsuit.
- LAB released two reports in February 2006:
  - program issues (report 06-1); and
  - finances and staffing (report 06-2).
- The Joint Legislative Audit Committee has held two prior hearings on Milwaukee County Child Welfare in March 2006 and March 2007.
- DHFS reported to the Audit Committee on March 1, 2006, October 2, 2006, and February 1, 2007.

2

Key Facts and Findings

- From January 2001 through June 2005, program expenditures totaled $493.7 million.
- In June 2005:
  - services were provided to 3,188 children who had been removed from their homes to ensure their safety; and
  - 266 families received safety services without having a child removed.
- From January 2004 through June 2005, 30.9 percent of investigations of abuse and neglect exceeded a 60-day statutory time limit.
- Early in 2005, only 27.4 percent of court-ordered services for families were provided in a timely manner.

3

Key Facts and Findings

- In 25 of 48 cases in which children were removed from their homes, we found problems in achieving permanent placements.
- 20.1 percent of children reunified with their parents reentered out-of-home care within 24 months.
- Coordination of service delivery between child welfare, Medical Assistance, and other support programs needed improvement.
- We found $677,694 in unallowable and questioned costs charged to the program by six contractors.

4

Audit Recommendations

- Improve the timeliness of investigations and the delivery of court-ordered services.
- Reduce the time children spend in out-of-home care.
- Ensure the adequacy of safety services.
- Improve service coordination with Medical Assistance, W-2, and other social services providers.

5

Audit Recommendations

- Monitor families who return for additional safety services.
- Monitor families who have children placed in out-of-home care in the 12 months following receipt of safety services.
- Ensure that all children in out-of-home care receive annual medical and dental examinations.

6

Audit Recommendations

- Continue to work to improve the retention of child welfare staff.
- Appropriately calculate compliance with performance standards specified in the settlement agreement.
- Collect and analyze information on services that contractors provide to families.

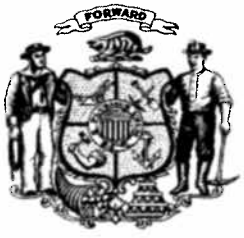
7

Audit Recommendations

- Monitor and assess La Causa's financial condition and debt.
- Require contractors to repay unallowable costs and either repay or provide additional documentation for questioned costs.
- Ensure that new staff complete pre-service training before managing cases.

8


WISCONSIN STATE LEGISLATURE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September 25, 2007

Honorable Jim Sullivan, Co-Chair
Joint Legislative Audit Committee
Room 15 South
State Capitol
P.O. Box 7882
Madison, WI 53707

Honorable Suzanne Jeskewitz, Co-Chair
Joint Legislative Audit Committee
Room 314 North
State Capitol
P.O. Box 8952
Madison, WI 53708

Dear Senator Sullivan and Representative Jeskewitz:

We are writing to thank members of the Joint Legislative Audit Committee for your continued efforts to promote accountability within the Division of Children and Family Services, particularly regarding recent child fatalities and problems within the Safety Services program. The Department of Health and Family Services will be presenting the results of its Independent Death Review Panel and Milwaukee Child Welfare Safety Plan today. We firmly believe that the continued attention of the Joint Legislative Audit Committee to child safety has resulted in better safety planning and improvements to the Safety Services program that would not have taken place without your efforts. If you had simply accepted the February 1, 2007 final report presented by the Department, there would be little progress to report today. Thank you for your vigilance on behalf of children.

The Milwaukee Child Welfare Safety Plan does offer improvements to the Safety Services program by creating "informal disposition agreements" for families that refuse to participate in Safety Service programs. The plan also addresses the need to follow-up with families who move away during the program or otherwise make themselves unavailable to Safety staff. The plan also provides direction regarding coordination of services to families with children in both Ongoing and Safety Service programs.

However, we have several concerns. First, the Independent Death Review Panel did not interview either family members or those involved with the case. There are well-known issues of discrepancy between records in Wisacwis and actual events. Federal case review processes and national standards for fatality review do not permit a paper record review for the simple reason that errors in process may be concealed by errors in the record. A more rigorous review should have been conducted. For example, the neonatal nurse for one child attended a Partnership Council meeting to try to find out about the review process as she wanted to clarify that she had made many more calls to the child abuse hotline and to case managers than appeared in the record. The paper review can

1850 N. Martin Luther King Jr. Drive • Milwaukee, Wisconsin 53212
Phone 414-344-1220 Fax 414-344-1230

only review calls that were actually recorded. As we at Kids Matter have direct knowledge of several of the children and families, we are concerned by how much is missed in this record review.

Secondly, we are concerned that while improvements are being made, much more stays the same. The Milwaukee Child Welfare Safety Plan focuses on training of staff, coordination of fragmented services, and quality improvement. We have no fewer than four banker boxes in our offices filled with reports addressing the need to appropriately train child welfare staff, to coordinate services and promote quality improvement. We had no complaints with the quality of training provided to staff. Training cannot improve outcomes unless the staff stay in their positions long enough to make use of the training. Despite a recent appropriation specifically directed to raise staff salaries above and beyond the contracted amounts, staff turnover rates may exceed 50% this year. Some children experience a 400% turnover rate in case managers annually. BMCW was in the midst of implementing one quality improvement plan in Safety Services while the increase in fatalities occurred. It is helpful that the Safety Plan adds staff to the Medical Director's office. However, this does not in any way address the fact that fewer foster children are receiving basic health exams today than when the Audit was completed.

Finally, we remain concerned that so much of what is written in reports is not implemented. The February 1, 2007 final report describes BMCW efforts to find foster homes. Yet, we have experienced one of the most dramatic decreases in the availability of foster homes in the last 20 years since that report was issued. Surely, some of these issues are national trends, and affect communities outside of Milwaukee. Just as surely, it is Milwaukee children who bear the cost. I was in a coordinated team meeting with a 13 year old girl yesterday. She has had more than 19 placements in the last few years. She has not had consistent therapy until now, due to her multiple placements. She is in 7th grade, but reads at a college level. She was in tears. "More than anything, I want a Mom." We need to remember that these are real kids depending on our efforts, not reports waiting for storage.

Sincerely,

Susan Conwell, J.D.
Executive Director


FORWARD
E PLURIBUS UNUM

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Kevin R. Hayden, Secretary

September 25, 2007

TO: Joint Committee on Audit members
FROM: DHFS Secretary Kevin Hayden
RE: Testimony related to Audit Reports 06-1 and 06-2, Milwaukee County Child Welfare

DHFS SECRETARY KEVIN HAYDEN'S REMARKS

Representative Jeskewitz, Senator Sullivan and committee members, thank you for inviting us here today to talk about the work at the Bureau of Milwaukee Child Welfare as a follow-up to the Legislative Audit Bureau's report on child welfare in Milwaukee. We are pleased to have this opportunity at this very pivotal time.

Again, I am Kevin Hayden, secretary for the Department of Health and Family Services. With me today are Reggie Bicha, division administrator for the Division of Children and Family Services, and Denise Revels Robinson, director of the Bureau of Milwaukee Child Welfare.

I want to thank Reggie for his tremendous leadership at the Department and in the child welfare system. And, I want thank Denise for her continued leadership at the Bureau. We have a child welfare workforce that is passionate and committed to the safety and well-being of children and families and that is truly a reflection on Denise.

I also want to let you know about an exciting addition to DHFS. I recently appointed Janel Hines to be the Director of Urban Development. Janel will represent the Department and help us work more collaboratively and foster stronger relationships with our community partners. Janel was most recently at the Department of Workforce Development, where she was the executive assistant.

Before we get started, I do want to let you know that, unfortunately, I will need to leave at 11 a.m. to get back to Madison for a speaking engagement. So, if I get up while we're still up here, I will leave the very capable Reggie and Denise to continue to answer your questions.

Unfortunately, we've had some very tragic deaths in the past several months – and as Secretary and as a parent myself – these are tragedies I take to heart.

We must never be satisfied with the work we do to prevent tragedies in the child welfare system. Every day, we must strive to do even more than we did the day before. We must do all we can to improve our systems and build on our strong partnerships to help ensure children's safety as much as possible.

Since we last appeared before this committee in March, the Department has done a great deal of work to examine how we ensure the safety and welfare of children in Milwaukee and how to use those findings to improve what we do.

After the death of Baby Layunnia, I appointed an Independent Review Panel to examine her case in-depth, issue findings and make recommendations.

A few months later, following the death of 19-month-old Alicia B., I instructed Reggie to lead a thorough review of open cases.

What we will present to you is what we've learned from these reviews and how we have taken the findings and recommendations to develop a Milwaukee Child Welfare Safety Plan.

The Milwaukee Child Welfare Safety Plan we have developed is organized around three key areas: (1) ensuring the safety of children, (2) promoting quality and accountability, and (3) strengthening community partnerships.

We are committed to focusing time and resources on aggressively implementing the plan to enhance our ability to protect children who are in our care. We will work closely with our community partners in Milwaukee to implement these strategies.

We'd like to thank the Milwaukee Child Welfare Partnership Council and other key community leaders, including District Attorney John Chisholm; Judge Mary Triggiano and Milwaukee Police Chief Nan Haggerty, for their support of this plan.

We are excited about the opportunity to improve communication and cooperation among all of these key agencies and other partners in the Milwaukee community – including our contract agencies that are represented here today.

When a child death occurs in a family involved with the Bureau, we always want to examine the case in-depth so we can learn if anything could have been done to prevent the death, and what we can change to keep such occurrences from happening in the future.

Baby Layunnia was born prematurely and had a low birth weight. An allegation of abuse and neglect was reported to the Bureau of Milwaukee Child Welfare and a Safety Services case was opened on the family. There were two additional reports of abuse and neglect made on June 5, 2006 and again on June 20, 2006. The Safety Services case remained open until July 7, 2006, when it was closed at the mother's request two weeks after the infant was discharged home from the hospital.

There was, however, court involvement with the father's children. Statutes governing confidentiality do not allow me to share information about that case; however, it should be noted that this family was receiving services from both Safety Services and Ongoing Case Management staff from the same contracted agency.

Last February, I appointed an independent panel to review Baby Layunnia's death. The four Panel members were:

- Pastor Archie Ivy – chair of the Milwaukee Child Welfare Partnership Council
- Lindsey Draper - retired Milwaukee County Court Commissioner
- Dr. Lynn Sheets – Medical Director of Child Advocacy and Protection Services at Children's Hospital of Wisconsin
- Paul Vincent – Director, Child Welfare Policy and Practice Group. Paul Vincent has worked with DHFS for several years to implement a statewide continuous quality improvement process

The panel reviewed all the case records, including those from BMCW programs that had worked on the case and the records of all medical professionals who had seen the mother and infant.

The panel examined the case with the following things in mind:

- The application of policies and practices of BMCW to this case;
- The medical aspects of the case and their impact on the child welfare agency's responsibilities;
- The cross-system coordination;
- The accountability of each of the agencies involved; and
- The strengths, gaps in service, and systemic issues regarding the case.

Because the Panel reviewed only this one family case, it acknowledges that its conclusions do not apply to all cases. However, the facts found in this review appear to indicate the need for a number of changes in practice, policy, and procedure.

One of the Panel's positive findings was that all providers identified a need to maintain contact with the mother and infant. Records fully describe the frequent efforts to engage and visit the family. There were many services offered to this family, and agencies were persistent in delivering services despite the parents' unresponsiveness.

The Panel made three key findings from which many of its recommendations come:

1. Communication within and between agencies serving families is too often "siloed" and needs to be shared.
2. Staff needs to have access to and understanding of medical information about medically needy children to accurately assess for safety and identify the protective capacity of caregivers.
3. A protocol for dealing with families who resist services under the Safety Service program needs to be defined.

At the heart of the circumstances, the Panel found a failure by the agencies involved to share information both within organizations and between organizations. Many professionals had concerns about this family, but understood family functioning only within the boundaries of their intervention and did not know the family's full history.

The Panel also found the need for comprehensive family assessments. In particular, the need to obtain information on the medical needs of a medically fragile child is essential to assessing the

caregiver's ability to meet these needs and to the decision-making process. In this particular case, the knowledge of the father's open case may have affected the assessment of his ability to provide support to the mother surrounding the needs of the infant.

The review also revealed a need for a protocol on locating families who move households by using collateral contacts, such as other service agencies and schools, as well as to involve the court and law enforcement when necessary.

The Panel recommended that the Milwaukee Public Health Department, the Milwaukee Police Department and the Bureau work together to identify strategies to locate individuals and families involved in BMCW. Reports of alleged child abuse/neglect on families previously reported that BMCW could not locate will be screened in for a same day response.

Additionally, the Panel also recommended that BMCW develop specific guidelines regarding the use of Safety Services with uncooperative families. The Panel proposed that two tiers or tracks be created within Safety Services, one for families genuinely desiring help and one for uncooperative families that results in court supervision of the Safety Services intervention.

Immediately following any child's death, BMCW does an internal review. BMCW's immediate review into Baby Layunnia's death lead to the following changes, all of which the Panel also had recommended.

Cases are now cross-referenced so staff are aware of the involvement of other programs with both the mother and father.

Agencies also now cross reference families between programs to ensure all staff are kept abreast of family history with the child welfare system.

Effective February 2007, the BMCW medical director is involved in consulting and staffing cases involving premature or medically fragile children during the initial assessment and case transfer process. Thus staff has the valuable input of a medical professional in assessing the caregiver's capacity to care for the child, as well as what services may be needed.

The voluntary nature of Safety Services has been redefined to imply the parents' obligation to engage in services to promote change and ensure child safety. Voluntary does not mean that parents can opt out of services without staff assessing the impact on the safety of the child. If the child is not safe, or safety cannot be assured because the parent is uncooperative in implementing the safety plan, the case is reassessed to determine whether court intervention and removal of the child from the home is necessary.

In addition to the Independent Review Panel, I called for a review of active initial assessment cases to determine if children were safe from present or impending danger threats. Under Reggie's leadership, case reviewers, primarily from the Division of Children and Family Services and the Division of Enterprise Solutions, reviewed 620 cases that were open with the Bureau of Milwaukee Child Welfare on May 17, 2007. These cases involved children age six or younger and included cases with multiple referrals on the same family.

The case review team also conducted a second review that looked at:

- 100 Child Protective Services Access reports to determine if child abuse or neglect reports were appropriately screened and responded to;
- 30 cases closed at Initial Assessment and opened with Safety Services to understand the case transfer process; and
- 43 cases closed at Initial Assessment when the family refused services and there was no court jurisdiction to determine if there were systemic barriers that may prevent the Bureau from providing services to families.

I'm going to turn to Reggie now to talk about the findings and recommendations of the internal case review and to highlight components of the Milwaukee Child Welfare Safety Plan.

DCFS ADMINISTRATOR REGGIE BICHA'S REMARKS

Thank you again Representative Jeskewitz and Senator Sullivan for giving us this opportunity to come before the Joint Committee on Audit.

I'd like to share with you what we found during our internal case review, and I will start with those areas that we found as strengths in the Bureau's case practice:

BMCW has a strong Child Protective Services Access function where good information is consistently gathered, screening decisions meet or exceed state standards and reports are quickly assigned to Initial Assessment for case assignment;

BMCW Initial Assessment social workers response to reports of child abuse or neglect consistently meets the assigned timeframe for initial contact with the family;

Cases are referred quickly to Safety Services to assist families in obtaining needed services; and

Reviewers found that case staffing between program areas and across regions occur on a routine basis to assure that needed services and supports are provided to families.

There were a number of areas that the review team found where the Bureau could improve its case practice. Those key areas are:

Initial Assessment social workers had difficulty locating families and cases were closed without contact with all family members;

In both case reviews, there was a consistent pattern of incident focused case practice where Initial Assessment social workers tended to focus primarily on the alleged maltreatment. Missing was a comprehensive assessment of individual and family conditions and dynamics in order to fully understand and analyze threats to child safety;

While families are quickly referred to the Safety Services program, the focus is primarily on resources for the family rather than on controlling threats that make children unsafe;

When Initial Assessment makes a determination that a child is unsafe, safety plans that assure children are protected are not routinely implemented in accordance with state standards; and

Reviewers found that Initial Assessment social workers are encouraged to complete their case work by the seven-day transfer meeting to the Safety Services program. This quick time frame makes it difficult to complete a thorough initial assessment in order to adequately understand the full extent of family issues that may make a child unsafe.

Overall, the review team found that children involved with BMCW were safe from present and impending danger threats. Out of 620 cases reviewed, there were nine cases where it was determined that the children were not safe from present danger threats and five cases where it was determined that children were not safe from impending danger threats. The BMCW took immediate action to follow up with those families and providers to assure the children were safe.

We also reviewed nine other sources for recommendations, including the Legislative Audit Bureau's audit, the Ombudsman report, Child Abuse Review Team child fatality reports, the Quality Service Review report and the Safety Services case review. And, we held stakeholder interviews with individuals in the Milwaukee community. Combined, these sources included more than 200 recommendations from both internal and external child welfare experts, more than 1,000 case reviews, and hundreds of stakeholder interviews.

Despite the low percentage of children who were found to be unsafe during our review, the Department and the Bureau are committed to improving and enhancing our case practice to ensure that we are doing everything we can to keep children who come to our attention safe.

Still, despite our most valiant efforts to improve our case practice and the services and supports provided to families, I think it's critical to acknowledge the very unfortunate reality that some children will still lose their lives at the hands of their parents and caregivers.

None of our systems have the capacity to predict how parents and caregivers are going to react to situations involving their children. What we can guarantee is that we will continuously evaluate and improve our practice and policies based upon sound research to ensure that for those children who come to the attention of the Milwaukee Child Welfare system, we will do our best to keep them safe.

Wisconsin has sound policies in place in Milwaukee and statewide to support and guide the work of child welfare workers. We need to ensure that our staff always has the training and technical assistance they need to adequately follow state standards and implement them in a consistent manner to deliver high-quality child welfare practice. Wisconsin has a child welfare workforce that is passionate and committed to the safety and well being of children and families. I commend the dedicated staff who work in this very difficult field, and I challenge them to continuously strive to improve their knowledge and expertise so that we may keep children safe.

Based on these findings and those of the Independent Review Panel, the Department created the Milwaukee Child Welfare Safety Plan.

As Secretary Hayden said, the plan's strategies are organized around three main themes: 1) Ensure the Safety of Children; 2) Promote Quality and Accountability; and 3) Strengthen Community Partnerships.

I'd like to highlight a few of the key strategies, under each one of these themes:

Goal 1: Ensure the Safety of Children

1. Enhance training provided across all BMCW program areas to improve understanding of threats to child safety. The Division will provide ongoing technical assistance to BMCW staff and supervisors.

2. Hire a medical liaison to support the current efforts of the BMCW Medical Director.

3. Improve the safety and ensure adequate protection of children placed in out-of-home care by implementing new procedures for assessing and supporting unlicensed relative caregivers, and reviewing licensing standards for out-of-home care providers.

4. Initiate legal jurisdiction options to maintain legal authority in attempts to control impending danger threats to child safety.

Goal 2: Promote Quality and Accountability:

1. Institute a quality improvement initiative that includes a focus on contract agency efforts to ensure child safety.

2. Develop and implement a scorecard on child safety across all program areas that can be shared with the Milwaukee community on an annual basis.

3. Review workload and case assignment strategies at initial assessment

4. Devote new quality assurance staff and expand oversight of cases closed at initial assessment and access.

5. Empower the Partnership Council, through designation as a Citizen Review Panel, to review child welfare performance and provide quality advice and direction to the Bureau and Division of Children and Family Services.

Goal 3: Strengthen Community Partnerships:

1. Develop a community response pilot program to meet the needs of children who are screened out at Access.

2. Convene a task force of medical providers to develop a standardized process for reporting, discharging and initiating protective measures for children at risk of maltreatment.

3. Expand existing collaborative relationships with the Milwaukee Police Department and other area law enforcement agencies to identify strategies on locating families involved with the Bureau.

4. Collaborate with the Judiciary and Milwaukee District Attorney's office to refine processes regarding Children's Court cases and family location strategies.

These are several of the key strategies that we have identified to ensure that children are safe. Secretary Hayden and I have made a personal commitment to assure the strategies identified here are implemented in a timely manner and that we continuously strive for accountability and excellence so that the Bureau of Milwaukee Child Welfare can keep children safe from further harm by a parent or caregiver. However, we cannot do this alone. This plan also serves as a Call to Action to many of our community partners to join with us and share in the responsibility and hard work of ensuring the safety of Milwaukee's children.

During the last decade, the Bureau has made significant progress to improve the lives of the children and families in Milwaukee. Since the state assumed responsibility for Milwaukee child welfare almost 10 years ago, the Department has made significant investments to continuously improve practice, which takes time and flexibility. We are constantly strengthening our practice and operations to provide the best services possible for the children and families we serve and to be responsive to the needs of this community.

The Bureau of Milwaukee Child Welfare is rooted in a federal settlement, with very specific requirements of how the child welfare system should perform. I envision us evolving our child welfare system in Milwaukee to a delivery system designed to meet the unique needs of the children and families who live here.

The focus of the Milwaukee Child Welfare Safety Plan is on enhancing child safety. There are other very important issues that we also need to address. We need to ensure that children have access to health care; that they are well-educated; and that families are getting stronger as a result of being involved in our system.

All of these things will be irrelevant if we cannot make sure that children are safe. We have to get safety right first.

Thank you again for your time this morning. We are happy to answer your questions at this time.

Full copy of the report –

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Kevin R. Hayden, Secretary

September 21, 2007

Milwaukee Child Welfare Safety Plan

A Commitment to Partnership and Improvement for Milwaukee's Children

The Department of Health and Family Services' mission is to protect and promote the health and safety of the people of Wisconsin. The Bureau of Milwaukee Child Welfare impacts the lives of thousands of children each year. Today, Secretary Kevin R. Hayden is presenting the Milwaukee Child Welfare Safety Plan, which helps ensure the safety of the children in the Bureau's care and custody.

Since the State assumed responsibility for the Bureau of Milwaukee Child Welfare on January 1, 1998, we have made significant progress in improving the lives of the children and families involved in our system. Our goal is to provide the best services possible for the children and families we serve and be responsive to the needs of our community. In addition, Milwaukee has a child welfare workforce that is passionate and committed to the safety and well-being of children and families.

We must never be satisfied with the work we do to prevent tragedies in the child welfare system. Every day, we must strive to do even more than we did the day before. We must do all we can to improve our systems and build on our strong partnerships to help ensure children's safety as much as possible. Therefore, we have devised a plan organized around three key areas: (1) ensuring the safety of children, (2) promoting quality and accountability, and (3) strengthening community partnerships.

This comprehensive plan is based upon two extensive reviews of the Bureau, and it provides recommendations to improve the safety and care of children that are involved with the agency. It provides us with a renewed opportunity to improve communication and cooperation among law enforcement, medical professionals, service providers, and child welfare professionals in the Milwaukee community.

Milwaukee Child Welfare Safety Plan

The Department is committed to focusing time and resources on aggressively implementing the strategies and recommendations identified in the two comprehensive case reviews to enhance our ability to protect children who are in our care. We will work closely with our community partners in Milwaukee to implement these strategies.

The strategies are organized around three main goals:

1. Ensure the safety of children
2. Promote quality and accountability
3. Strengthen community partnerships

Ensure the Safety of Children

The Bureau will improve case practice in key program areas to emphasize the safety of children, improve communication between staff at partner agencies at all points of the case process, and ensure compliance with state standards. This will be done through a variety of means, including:

- **Enhance Training and Technical Assistance**: provide additional staff training through a variety of means, including the UW Training Partnership, to ensure best case practice, as well as ensure they are adhering to state standards and collecting adequate information that is critical to making timely decisions.
- **Expand Medical Director Capacity**: establish protocols for effective communication between the medical community and the Bureau. The Bureau will also hire a Medical Liaison to support the efforts of the Bureau's Medical Director to ensure that cases that involve a medically fragile child are reviewed prior to transferring it to another worker/agency or closing the case.
- **Improve Out-of-Home Care Services**: improve the safety and ensure adequate protection of children placed in out-of-home care by engaging relative caregivers in how the Bureau can provide them with a better support network, as well as enhancing licensing standards and contract requirements for treatment foster care providers.
- **Initiate Legal Jurisdiction Options**: initiate informal disposition agreements or other legal jurisdiction options to address threats to a child's safety when a family does not voluntarily participate in safety services.
- **Allocate Emergency Service Fund**: identify and allocate funds to address the immediate needs of families who lack basic essentials, such as cribs for infants, food and/or bus passes necessary to get to work or medical appointments.

Promote Quality and Accountability

The Bureau will instill quality improvement initiatives agency-wide to promote consistency of best practices and high quality services to achieve safe environments for children that are at risk for harm.

- **Promote Quality Improvement**: focus on contract-agency quality in ensuring a child's safety, including reviewing vendor contracts to verify child safety outcomes are clear and stated in measurable terms.
- **Review Workload and Case Assignments**: review case assignments and distribution of Bureau resources to assure that quality initial assessments are completed in a timely manner.
- **Monitor Access and Initial Assessment**: conduct on-going reviews of cases to ensure staff is making appropriate decisions regarding child safety.
- **Develop Child Safety Scorecard**: develop and implement benchmarks that will be used by contract agencies and key partners, as well as ways to share and solicit feedback from the community.
- **Empower Partnership Council Review**: empower the Partnership Council to review selected child welfare records in order to bolster the Council's ability to provide quality recommendations for continued improvement to case practice across all Bureau and partner program areas.

Strengthen Community Partnerships

The Bureau will build upon existing relationships and forge new partnerships with Milwaukee County agencies and key stakeholders to collaboratively increase child safety and improve services provided to families.

- **Launch Community Response Pilot**: develop a community response pilot program to meet the needs of children who do not face a safety threat, but the family needs other supportive resources.
- **Conduct Community Child Safety Trainings**: conduct child safety trainings, including mandated reporter responsibilities, for organizations that play a key role in the Milwaukee child welfare system.
- **Establish Communication Protocols with Medical Community**: implement improved protocols throughout the medical community regarding reporting, discharging, and initiating protective measures for children at risk of maltreatment.
- **Implement Police Department Joint Protocols**: develop Memorandums of Understanding and joint protocols with the Milwaukee Police Department and Bureau for locating individuals and families.

- **Advance Legal Partner Collaboration**: collaborate with the Judiciary and Milwaukee District Attorney's Office to refine processes regarding Children's Court cases and family location strategies.
- **Expand Child Abuse Review Team Participation**: incorporate new representatives, such as medical providers, into the Child Abuse Review Team.
- **Track Coordinated Service Team Participation**: ensure provider partner participation in Coordinated Service Team meetings.
- **Produce Safety Plan Progress Report**: update the Milwaukee Child Welfare Partnership Council on the status/progress of the Milwaukee Child Welfare Safety plan.

Bureau Case Review

In May 2007, following the death of Alicia B., Secretary Hayden immediately demanded an internal review of any contacts the Bureau had with the family. He ordered a full report regarding referrals of abuse or neglect to the Bureau which involved the most vulnerable children, including a critical assessment of how those referrals were handled by the Bureau. Secretary Hayden assigned Reggie Bicha to oversee this review and recommend the implementation of the any measures that would ensure any systemic issues are addressed. Bicha serves as the Division of Children and Family Services Administrator within the Department, and he has 15 years of child welfare experience, including serving as the Director of the Pierce County Department of Human Services. He has been a leader in child welfare, including chairing the Child Welfare Case Process Committee from 2005-2007, which establishes policies statewide for how child welfare cases should be handled.

The case review analyzed all active cases for children age six or younger, as well as all active cases involving multiple referrals on the same family. It also included a review of calls that came into the 414-220-SAFE hotline from October 2006 to May 2007 that were investigated and then closed without further action or services.

The case review found that, generally, children involved with the Bureau were safe from both present and impending danger threats. Reviewers found that in the majority of cases reviewed, social workers met or exceeded the response time in investigating threats to the child.

The review also noted that more thorough information gathering an analysis is needed in assessing a child's risk for present or impeding harm. It also identified a need for the Bureau and District Attorney's Office to work more closely together to clarify and reach a consensus on the documentation needed to support legal actions in order to assure that children are safe and protected. Although calls were screened and investigated in a timely manner, reviewers found that investigations were too often incident-focused, even in cases where the Bureau had contact with the family in the past.

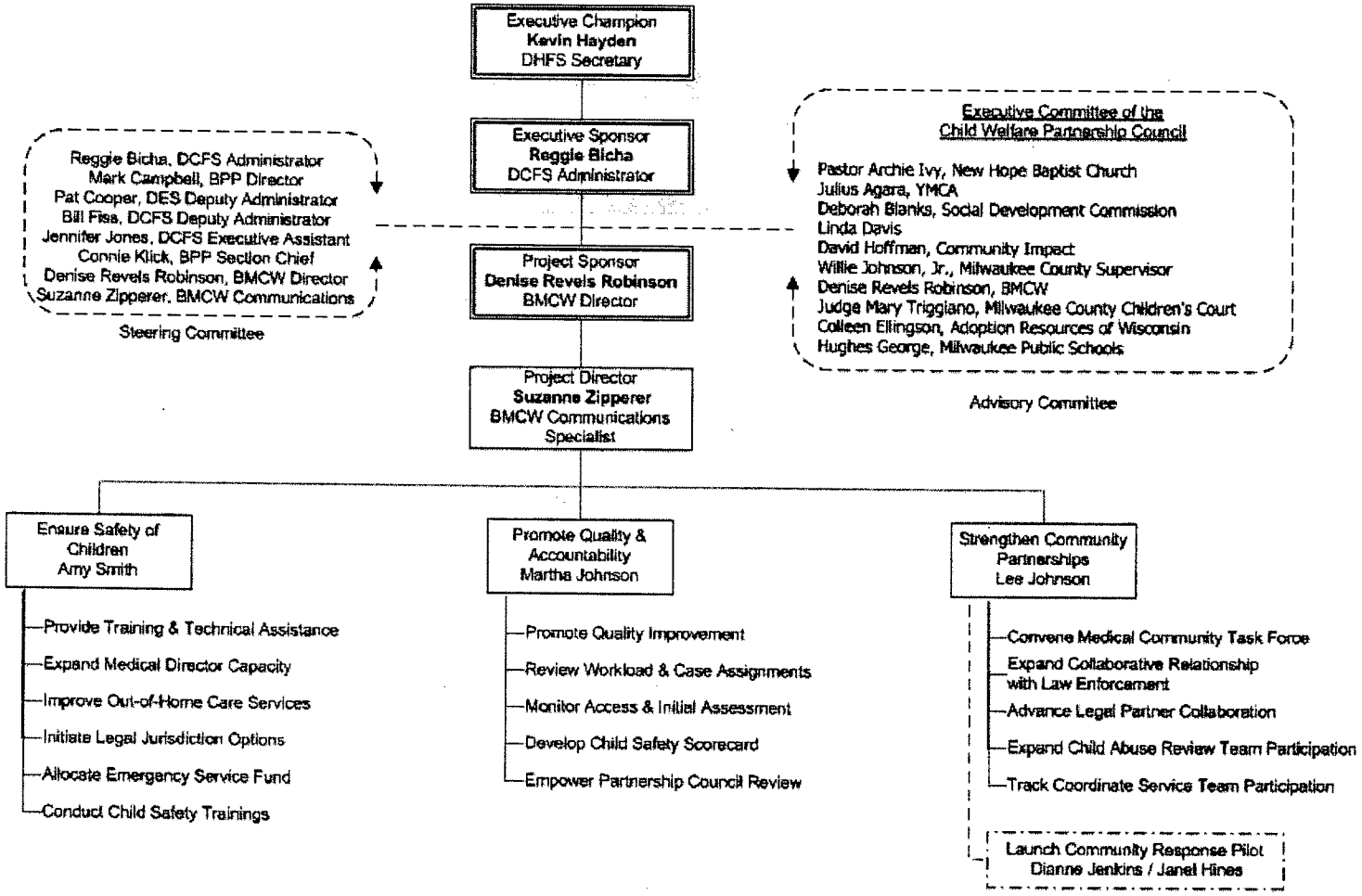
Independent Review Panel Analysis

In February 2007, Department Secretary Kevin Hayden appointed an Independent Review Panel to examine how the case of Layunnia L. was handled and to make recommendations for improvements to child welfare practice. The panel consisted of the following independent members: Paul Vincent, Director - The Child Welfare Policy and Practice Group, Pastor Archie Ivy, Chair - Milwaukee Child Welfare Partnership Council, Dr. Lynn Sheets, Medical Director - Child Protection Center at Children's Hospital and Lindsey Draper, retired Court Commissioner.

The Independent Panel found that all providers involved with the family worked diligently to maintain contact with the mother and infant. Records fully describe the frequent efforts to engage and visit the family. Many services were offered to the family, and agencies were persistent in delivering the services, despite the parent's unresponsiveness. The effectiveness of these interventions was impeded by a failure of the agencies to share information, both within the organizations and between each other.

- END -

Department of Health and Family Services
Milwaukee Safety Plan for Children in the Child Welfare System



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Milwaukee Safety Plan
for Children in the Child Welfare System

	<<< Back to Goals		
3	**Strengthen Community Partnerships**	**Build upon existing relationships and forge new partnerships with Milwaukee County agencies and key stakeholders to collaboratively increase child safety and improve services provided to families.**	
	Strategy	***Action Steps***	***Work Plan Activities***
3.1	**Launch Community Response Pilot** Develop a community response pilot program to meet the needs of children who are screened out at Access/Intake.	**Develop Pilot** Work with the Milwaukee community to develop and implement a Community Response pilot program to meet the needs of children who are screened out at Access/Intake. This will be an expansion of the Bureau's current efforts to serve children at risk of maltreatment.	
3.2	**Conduct Child Safety Trainings** Conduct child safety trainings, including mandated reporter responsibilities, for key community leaders that have a role in the Milwaukee child welfare system.		
3.3	**Convene Medical Community Task Force** Convene a task force to develop and educate around a standardized process to be implemented throughout the medical community regarding reporting, discharging, and initiating protective measures for children at risk of maltreatment.		
3.4	**Expand Collaborative Relationship with Law Enforcement** Expand existing collaborative relationship with Milwaukee Police Department and other area law enforcement to discuss and identify strategies to locate individuals and families involved in BMCW investigations and open cases.	**Expand Collaboration** Identify how law enforcement can assist in locating individuals and families involved with the BMCW. Based on joint discussions, identify any additional ways to collaborate with police departments.	

3.5	**Advance Legal Partner Collaboration** Collaborate with the Judiciary and Milwaukee District Attorney's Office to refine processes regarding Children's Court cases and family location strategies.	**Pick-up Orders** BMCW, the Judiciary and the Milwaukee District Attorney's Office will refine the criteria needed to pursue pick-up orders when BMCW is unable to locate the family; train and inform staff in BMCW and DA's office on expectations for pick-up orders; and monitor the process to determine the effectiveness and refine when necessary.	
		Juvenile Court Intake Policy Collaborate with Milwaukee Children's Court in their effort to revise the Juvenile Court Intake Policy with a focus on child safety.	
3.6	**Expand Child Abuse Review Team Participation for Child Fatality Case Reviews.** Incorporate new representatives into the Child Abuse Review Team (CART) for child fatality case reviews.	**Incorporate New Members** BMCW recommends that the Child Abuse Review Team (CART) involve medical providers, and BMCW staff for child fatality case reviews.	
3.7	**Track Coordinated Service Team Participation** Ensure provider partner participation in Coordinated Service Team (CST) meetings.	**CST Participation** BMCW will request and support the participation of all provider partners in CST meetings.	
		PEM Oversight The PEMs will monitor and track CST meetings to ensure that all the necessary partners were invited to the meetings.	
3.8	**Produce Safety Plan Progress Report** Report to the Milwaukee Child Welfare Partnership Council on the status/progress of the Milwaukee Safety plan.		

Independent Death Review Panel
Bureau of Milwaukee Child Welfare
Summary

September 10, 2007

Overview

On February 23, 2007, Wisconsin Department of Health and Human Services Secretary Kevin Hayden appointed an independent panel to review the death of an infant whose family was served by the Bureau of Milwaukee Child Welfare. Appointed to the Panel were:

Lindsey Draper - retired Court Commissioner
Pastor Archie Ivy - Milwaukee Child Welfare Partnership Council
Dr. Lynn Sheets – Medical Director, Child Advocacy and Protection Services at Children's Hospital of Wisconsin
Paul Vincent – Director, The Child Welfare Policy and Practice Group

The Panel was asked to:

- Examine policies and practices of BMCW;
- Review the medical aspects of the case and their impact on the child welfare agency's responsibilities;
- Identify other agencies (hospital, physician and in-home visiting nurse) involved and the respective roles and impact on the case and outcome;
- Look at cross system coordination issues regarding the work of BMCW and other agencies involved with the child and family;
- Identify and separate child welfare accountability from that of other agencies, describe accountability of other involved agencies; and
- Identify strengths gaps and systemic issues regarding the case.

Panel Review Methodology

The Panel conferred with the Bureau's director and Bureau staff and reviewed the following case records:

Child's Bureau case record
Sibling Bureau case record
Bureau Intake records
Bureau Initial Assessment record

Bureau Safety Services records
Health Care Provider files
Contract Service Provider files
Court documents
Visiting Nurse Association files
Center for the Blind and Visually Handicapped Children files (birth to three provider)
Autopsy Report

The Panel did not interview any of the professionals in the case, including the Safety Services Manager, health care providers or any of the family members. And it reviewed only one family's case. As a result, the Panel acknowledges that it cannot assert that the conclusions made in this report are universally applicable. However, the facts found in this review do appear to have relevance to the need for a number of changes in practice, policy and procedure, some of which the Bureau has already begun to address.

Case Overview

Family History

The infant was born April 1, 2006 and died November 28, 2006. Death was due to dehydration and malnutrition secondary to parental physical and medical neglect.

The infant was born prematurely and had a low birth weight. An allegation of abuse and neglect was reported to the Bureau of Milwaukee Child Welfare and a Safety Services case was opened on the family. There were two additional reports of abuse and neglect made on June 5, 2006 and again on June 20, 2006. The Safety Services case remained open until July 7, 2006, when it was closed at the mother's request two weeks after the infant was discharged home from the hospital.

The infant's family is composed of the infant's mother and her four other children, ages 2, 7, 9, and 10, and the infant's father and 3 of his children.

It is useful to note in regard to the concurrent ongoing case, another Bureau contract provider was supervising visitation between the father and two of his children who were in out-of-home care. The Panel does not have access to all of the records that may exist, but provider notes do not reference any knowledge of the concurrent Safety Services case.

Also, during April 2006, the same provider assisting the infant's mother with in-home services was also providing services to another of the father's children under court supervision. Some of the visits were in the infant's home. Provider records available to the Panel on this child do not reflect knowledge of the Safety Services case. However, the Bureau's permanency plan for the father's children dated November 20, 2006 notes that the father has two other cases with the Bureau at this time.

Analysis

System Strengths

Although all of the systems involved would probably agree that improvements are needed in the way this case was handled, there were some strengths in the system that should be recognized. First, all providers seemed intent to maintaining contact with the mother and infant. Records fully describe the frequent efforts to engage and visit the family. All the professionals realized that the missed appointments were worrisome and where medical care was involved, could jeopardize the infant's health. There were many services offered to this family and persistence in delivering services despite the parents' unresponsiveness. And at times, medical providers attempted to alert the Bureau of concerns by making new protective service reports to workers who had been on the case previously. The use of Coordinated Service Team meetings was an appropriate response to the case situation and could have improved information sharing, assessment, coordination and decision making if they had included all the professionals involved and met more often. As will be mentioned in more detail later, the Bureau has conducted its own case review and is making changes to training and policy in response to the lessons learned from this case.

Information Sharing

At the heart of the circumstances that impeded the effectiveness of intervention in this child's case is a failure by the agencies involved to share information both within organizations and between organizations. Many professionals had concerns about this family, but understood family functioning only within the boundaries of their intervention. Little was known of the full history of this family to most of those involved.

There was some sharing of information between organizations, but it did not appear to be systemized and driven by protocols that would be especially useful in cases where there are children with serious medical needs. There were several Coordinated Service Team meetings, which would be an excellent forum for exchanging information within the team, interpreting behavior and forming a unified family assessment; however, the medical community was not a part of these meetings. The Bureau informed the Panel that all providers are to be invited to Coordinated Service Team meetings, but there is no evidence that happened in this case. It appears that almost all the agencies working with the family experienced missed appointments and an inability to locate the family at times, but concerns about this practice were not routinely shared with the Bureau and other partners.

Assessment

Where the Bureau is concerned, it is useful to look at practice in Safety Service cases in the context of voluntary child welfare services across the country. Consistently, the

standards for the breadth and depth of assessment in voluntary cases nationally are less rigorous than in ongoing cases, and Milwaukee is no exception.

It appears that initially Safety Services was not aware of the father's history. However, further assessment explorations might have yielded that information. This became especially critical when the confidence to serve this family voluntarily, that is, through Safety Services was based in part on the father's perceived ability to share the caregiving. The father appears to get minimal attention during the course of intervention.

There were a number of obvious cues about the parents' unwillingness to accept help. Since this was a voluntary case, Safety Service supports should have raised concerns about the parents' willingness to effectively utilize help. In addition, the parents' refusal to give consent to collateral contacts significantly impaired their ability to make sound decisions.

Good assessments, regarding the status of the case should consider all the life domains of family members, including: family; living situation; educational/vocational; social; psychological/emotional; medical; legal; and safety. It is possible that some of these were considered in completing risk assessment checklists, but no detail was provided. In addition, assessments should be informed by the full family team. As was mentioned earlier, much of the information known collectively by the team was little if minimally known by individual members.

Planning

Practice in Safety Services with families should move from engagement of the family, to assessment, from the assessment, development of a plan of intervention and coordination with other partners and team members. Tracking of progress and adjustment to planning should be continuous. The plan reviewed by the Panel reflects little assessment information and a list of services to be provided.

Unfortunately, many child welfare systems use case plan templates that limit or at least impede individualization and flexibility in what is addressed. The field's effort to limit time spent on paperwork and to automate as much of the record keeping as possible, both laudable goals, can foster one-size fits all plans and check-box analysis. It would have been helpful for the infant's plan to:

Begin with a clear, written working agreement with the family, ideally addressed through a Coordinated Service Team meeting in which the team

- Identifies the family's strengths and needs (based on a thorough assessment of parents, siblings and infant);
- Matches services and steps to needs;
- Structures tasks in terms of behavior change, not just participation in activities;
- Clearly assigns responsibility for implementation throughout the team; and

- Routinely obtains releases for medical records of the index child and other children in the home when there are medical or safety issues.

The Panel is not recommending that all Safety Service cases assume the formality and consequences of a case under court supervision. Obviously the more informal nature of Safety Services is useful in enlisting genuine parental commitment to a mutually agreed on plan of action. But the thoroughness of assessment and the attention to progress should be uniform regardless of who is supervising the case – the Bureau or the court.

Policy

The Panel did not review all of the Bureau's policies on Child Protective Services or Safety Services. However, several specific Safety Services practices that are perceived as policy need attention. There is no requirement that parents agree to permit information from collateral resources to be shared with the Bureau as part of Safety Services participation. Staff appeared to believe that they could not access medical records in Safety Services, in particular, without consent. The Bureau believes that it has since clarified for staff that State statute permits access to medical information without parental consent when access is sought for purposes of a child abuse or neglect investigation or to assess the safety of a child. The Panel is not sure that the medical community agrees with this legal interpretation and believes that many medical providers would be reluctant to share medical information without a clear consent by the patient/parent.

Second, there is not clarity about appropriate action to be taken when a parent requests the termination of Safety Services even though the parent has not cooperated and some level of risk remains (this issue was also raised in the findings of the 2006 Qualitative Service Review – QSR - in Milwaukee). Several Safety Services staff interviewed in the QSR mentioned the tension between Safety Services and IA in such circumstances where risk remained and parents weren't gaining parental capacity, but there didn't seem to be sufficient evidence to merit another IA involvement. In the case under current review, there was clearly sufficient information and concern to open a new intake.

A third area related to the cross-referencing of cases within BMCW is also problematic. For reasons not clear to the Panel, for some portion of the time the Safety Services case was open, neither the ongoing worker nor the Safety Services worker knew of their co-worker's involvement with the family. This is an issue the Bureau reports that it has already begun to address.

The files indicate that the Bureau had difficulty in locating the parents on multiple occasions. The files do not indicate an effort to locate the family through collateral contacts. Rather, there are continued efforts to visit at the same address and phone the parents at the same phone number, unsuccessfully. Some systems have a formal protocol for "Unable to locate" cases that included contacting schools, contacting the W-2 agency and contacting the police. Relatives are also a likely source of information. If the Bureau doesn't have such a protocol, one seems indicated.

When new concerns are shared with BMCW workers, those concerns should be re-routed as a new intake. Medical providers with new concerns should be instructed to call in those concerns to 220-SAFE so that a new report is generated. In regard to safety concerns expressed by hospital personnel, the Bureau reports that The Children's Hospital Child Advocacy Staff will be conducting an internal review of the hospital's actions in this case and will report findings to BMCW and through the Child Abuse Review Team interagency process. The Bureau reports that private agency partners are being asked to assess the actions of their organizations as well. The Panel is unaware of the actions of other providers in this regard.

Safety Services

Many of the observations regarding areas of system performance mentioned previously relate to Safety Services; however the involvement of Safety Services is so critical in cases such as this one that a specific focus on Safety Service functioning is warranted. Several major questions arose in the Panel's review. Why was this case accepted as a Safety Services case to begin with? The Panel found no evidence that there was specific policy guidance in Safety Services to guide staff in decision making about medically fragile children and uncooperative parents.

Why were Safety Services terminated so soon after the infant's discharge from the hospital? By that time there had been considerable evidence that the parents were firmly resistant to participating in Safety Services, were often unavailable for appointments with the Bureau and providers. The decision to conclude Safety Services was staffed with a supervisor, so are supervisors clear about how to assess risk factors?

In addition, the Panel noted a pattern of practice in this case that suggests that the intense family focus by Safety Services seemed to outweigh the child focus necessary to assure protection. Family focus is vital in the use of the Safety Services model, as strengthening parental care giving capacity is essential to achieving child safety. However, voluntary services like Safety Services require the skills to view child safety as primary while working to strengthen the family. This tension over balance is a common challenge in systems providing voluntary services.

Recommendations

Milwaukee Bureau of Child Welfare Response to the Infant Death

The Bureau has taken action in response to the findings of its own review of performance in the infant's case. A copy of the action steps is located in the Appendix. The Panel commends these actions and notes that several crucial issues are addressed in the Bureau's plan. Effective in February 2007, cases involving premature or medically fragile children require the consultation and approval of the Bureau's Medical Director during the initial assessment and case transfer process. The Medical Director will also oversee the decision to refer such children to Safety Services or out-of-home placement.

The Medical Director will track all premature or medically fragile children involved with the Bureau.

The Bureau's private agencies providing case management and Safety Services were directed to cross reference all cases against both programs. In-service training was provided to Safety Services staff on current policy, policy on medical consent and access to medical records and parent participation in Coordinated Service Team meetings. Home visiting staff are to be contacted to remind them of their mandatory reporting obligations and the Children's Hospital Advocacy staff are conducting an internal review of the Hospital's actions.

Panel Recommendations

The Panel makes the following recommendations in addition to the corrective actions already taken by the Bureau. In response to the Panel's draft report, the Bureau provided the following updates on attention to issues raised by the Panel, which are underlined after each recommendation.

1. It is possible that the Bureau is addressing this matter in its new training and policy, but the Panel recommends that there be more specific criteria about the type of cases appropriate for Safety Services. Additionally, the Panel recommends that BMCW develop specific guidelines regarding the use of Safety Services with uncooperative families. We propose that two tiers or tracks within Safety Services be created, one for families genuinely desiring help and one for uncooperative families that results in court supervision of the Safety Services intervention.

   <u>The BMCW will request the District Attorney and other legal partners to take action in case situations when it is determined that the child must be removed from their home to ensure child safety.</u>

   <u>A number of initiatives to enhance Safety Services include: Refining the parameters of who will be served to include children and families who face risks to safety that are not imminent but are likely to occur without some form of intervention:</u>

   - <u>Changing the payment structure so agencies are now paid on a monthly basis for every month that a case remains open rather than receiving a fixed rate reimbursement;</u>
   - <u>Monitoring and staffing cases that are open longer than three months to determine when it is best to close the case and avoid premature case closure; and</u>
   - <u>Implementing performance-based contracting with agencies providing Safety Services.</u>

- The Bureau will convene a meeting with the Deputy District Attorney and his staff to discuss issues and to develop strategies to address these issues.

In-service training on the voluntary nature of safety services has been conducted with emphasis on the following:

- Services are voluntary as long as parents are actively cooperating to keep the child safe.
- Voluntary does not mean that parents can opt out of services without staff assessing the impact on the safety of the child.
- If the child is not safe, or safety cannot be assured because the parent is uncooperative in implementing the safety plan, the case must be referred to Initial Assessment to determine whether court intervention and removal of the child from the home is necessary.
- The Bureau is in the process of revising its procedures regarding the use of safety services with uncooperative families. The safety service training curriculum content was revised in June. Safety services and initial assessment staff are currently being trained on the revised content. As part of the revision, a script was developed for safety services and initial assessment to discuss with parents referred to safety services, to describe what voluntary means and does not mean, and what is expected during safety services participation.

2. The Safety Services agreement with the family should be made a more formal document, clearly addressing the changes in behavior needed, actions expected by the parties, expectations about contact with collaterals and consequences if risks are not addressed. The Bureau reports that it has taken this step.

3. The Bureau reports that it has clarified policy related to the ability of Bureau staff to interview collateral contacts and obtain medical records of other children in the home in Safety Services cases even if parents refuse to give consent, if needed to protect the child from abuse or neglect. The Bureau believes that it has statutory authority to obtain medical records in these instances. The Panel believes that this opinion is not shared by all of the medical community and recommends that the Bureau meet with medical professionals to assure that there is common agreement on this legal interpretation. In addition, cases where Safety Services families refuse consent for interviews with collateral contacts should be referred to senior Bureau management for review.

BMCW clarified that Wisconsin statutes allow access to children's medical records without parental consent when access is sought for purposes of a child abuse or neglect investigation, or when requested to perform a legally authorized function, such as to assess the safety of the child when the case is open in Safety Services.

Training on confidentiality and access regarding medical records/information will be conducted in August for all program staff within BMCW (safety services, initial assessment, and ongoing case managers). The training will be conducted by the Chief Legal Counsel and BMCW Chief Medical Director. Separate training sessions by program area will be held to emphasize the role of the Bureau Staff by program area.

4. The fact that so many important medical concerns about the mother's care-giving appear in case notes, with only a small number being reported to the Bureau suggests that Bureau workers need to be educated that they are also mandated reporters. When new concerns are shared with BMCW workers, those concerns should be re-routed as a new intake. Medical providers with new concerns should be instructed to call in those concerns to 220-SAFE so that a new report is generated.

5. The Division and the Bureau should examine the current assessment and planning process for Safety Services and provide for a more thorough child and family assessment and more behaviorally specific, individualized plan. This plan should routinely include authorization for release of records on all children in the home whenever health or safety is an issue. Such authorizations would meet the needs of medical providers who disagree with the Bureau's interpretation of access to medical records.

6. The Bureau should maximize the participation of all provider partners and team members in Coordinated Service Team meetings, especially when child vulnerability is high and parental commitment to the intervention is limited. Frequent Coordinated Service Team meetings should be an expectation for cases where risks to vulnerable children remain unresolved. In addition, the Panel recommends that the working agreement with the family become an early step in all team meetings. To increase the consistent participation of partners in team meetings, the Bureau should:

    - Use phone or personal contacts to invite participants to team meetings, not just written communications;
    - Negotiate meeting dates and times, where possible;
    - Address the expectation for participation in Coordinated Service Team participation in provider contracts; and
    - Collect participant input in advance from members unable to be present.

At the Bureau's request, the Bureau's private agency partners established a centralized system to track CST meeting notices and invitees. The Bureau will review this tracking process to ensure it is effective in generating timely CST notices and that required participants are identified and invited. Strategies include:

- Developing supervisors' skill in observing, evaluating and coaching staff preparation for and facilitation of CST process;
- Expanding the participants to include the family's informal supports and essential professional partners such as school personnel, to become an integral part of the team;
- Preparing families for their initial team meeting in advance by providing an overview of the facilitation process, discussion of who the family wants to join the team, discussion of family strengths and needs, and determining scheduling and location of meetings; and
- Ensuring that important information about the child and family, such as the case plan, is routinely shared with all team members.

In order to maximize participation of W-2 agency representatives at CST meetings, the Bureau established an agreement with leadership of the Milwaukee W-2 agencies that the Bureau case manager will provide at least two weeks advance notice (in writing) of the first CST; and that subsequent CST meeting dates will be scheduled by the meeting participants at the end of the current meeting. The Bureau procedures were revised to reflect this agreement. Written notification was sent to Bureau staff on July 31, 2007.

7. All children who are suspected of being physically abused where there are specific concerns about abuse should be medically evaluated.

   Staff are directed to involve medical providers in documenting, evaluating, and treating physical injuries. BMCW has a Medical Director who is to be consulted in cases involving fragile children.

   The position description of service managers was revised to include a requirement for supervisors to access, seek and use medical consultation during the intake assessment process. This is one of the formal areas that is evaluated to ensure accountability.

   The BMCW Medical Director is providing medical consultation to staff across all BMCW programs regarding chronic medical conditions of children, medically fragile and premature infants; and the health supervision of these children. She also serves as an ambassador/liaison to medical providers regarding communication and problem resolution issues impacting the identified medical care of children involved with BMCW.

By September, the Medical Director will have automated report data on the names of children with medical conditions and medically fragile infants so that she can track and monitor the care/health needs of these children.

8. To its credit, the Bureau has adopted the Qualitative Services Review to examine its practice. A second review is scheduled for early in 2008. The Panel recommends that the Bureau consider over-sampling in Safety Services, so that more Safety Services cases are examined to assess the degree to which recent and anticipated changes in Safety Services operations are having an effect on practice.

9. Information on the findings and recommendations of this Child Death Panel review should be made available to the medical providers who were involved in the cases reviewed.

   As required in the Child Fatality Review protocol, the BMCW director and DCFS Division Administrator will report to CART on what actions BMCW has taken and plans to implement in response to the findings and recommendations in the Child Fatality Report. The BMCWs response will also be presented to the Milwaukee Child Welfare Partnership Council.

10. VNA should develop a written protocol regarding reporting unresponsive families in active Bureau cases and decisions on case closure.

    The Medical Director has discussed this issue with VNA and requested attention to this issue.

11. The Milwaukee Public Health Department, the Milwaukee Police Department and the Bureau of Milwaukee Child Welfare should collaborate on the development of joint protocols to locate individuals and families.

    The Bureau is in the process of scheduling meetings with external partners to discuss this protocol. A meeting with the Police Department was held at the end of July.

    Staff are informed to use the court system (obtaining a pick up order) to access police assistance in locating families.

    BMCW will request the District Attorney and other legal partners to take action in situations when it is determined that the child must be removed from their home to ensure child safety.

12. BMCW should develop systems and procedures to routinely access medical, social service and law enforcement records as a part of an Initial Assessment investigation.

13. The inability to locate a family should not be the primary factor in a BMCW decision to close a case. Safety Service Managers should investigate collateral information and to consider different options when unable to locate a family such as contacting the District Attorney's office for a Pick-up Order. The Bureau reports that current policy provides for this and if so, training should highlight this expectation. If the case is closed due to their inability to locate, then subsequent referrals should be given the most urgent response times.

    The Bureau re-issued its procedure regarding Unable to Locate families and is in the process of doing refresher training regarding diligent efforts that must be implemented to locate families in order to assess child safety.

14. BMCW should conduct a retrospective review of cases that were closed due to inability to locate or failed safety plans to determine if trends exist in the subsequent outcomes of those cases.

15. BMCW should initiate procedures to insure that:
    a. Statements made by those under investigation are verified.
    b. Discrepancies between facts given by reporters and investigators are resolved.
    c. Comprehensive family histories are gathered during investigations.

    Intake procedures to screen-in cases previously open but closed due to family whereabouts being unknown were changed to assign a same-day response time. In-service sessions were conducted to reinforce understanding and compliance by cross training staff regarding existing Safety Service procedures, including reinforcing verifying statements during investigations, gathering comprehensive family histories, and resolving discrepancies in information obtained.

16. BMCW Intake should consider past history when assigning response times.

    This is required by BMCW intake procedures. The Bureau has reinforced this requirement with intake staff and supervisors, and is monitoring day-to-day practice.

Appendix

Milwaukee Bureau of Child Welfare Corrective Actions

I. The following actions are being implemented to address the key findings and to strengthen practice:

Systemic/Bureau wide-actions:

1. Effective immediately, cases involving premature (born before 28 weeks gestation) and medically fragile, infants require consultation with the BMCW Medical Director during the initial assessment to discuss the medical needs of the infant that must be addressed to ensure continued child safety.

   The referral decision from initial assessment to safety services or out of home placement, on cases involving premature or medically fragile infants requires approval of the BMCW Medical Director for the health supervision case planning of the infant.

   A health supervision case planning staffing with the Medical Director is required as part of the case transfer process to include the referring initial assessment social worker and service manager, and the receiving program staff (safety services or ongoing case management).

   The BMCW Medical Director will track 100% of all premature medically fragile infants, through participation in all internal case staffings, review of medical records and information from health providers about the baby's care and progress, communication with the infant's primary pediatric provider, and planned consultation with Bureau staff.

   A policy memo was issued to initial assessment, ongoing case management, and safety services staff describing this new policy directive.

2. The Bureau will request the District Attorney and other legal partners to take action in case situations when it is determined that the child must be removed from their home to ensure child safety.

3. Children's Family and Community Partnerships (CFCP) and La Causa were directed to internally cross match the names of family cases open in safety services and ongoing case management to

determine if the same family cases are concurrently open in both programs.

Family cases identified will be internally staffed to share critical case information, including child safety issues and to consolidate the case plan for the family that reflects input from safety services and ongoing case management program staff.

The state-employed region manager will be responsible for monitoring the implementation and progress and outcome of this strategy.

4. CFCP and La Causa were directed to internally staff all in-home supervision CHIPs cases to ensure the safety of all children in the home is being assessed, not just the child whose name is on the court order. The results of their internal review is due February 16, 2007.

   The state employed Region Manager will be responsible for monitoring the implementation, progress and outcomes of this strategy.

5. In-service training will be conducted for current safety services staff to improve understanding of existing policies and procedures:

   a) Voluntary Nature of Safety Services:
   Services are voluntary as long as parents are actively cooperative to keep the child safe. Voluntary does not mean that parents can opt out of services without staff assessing the impact on the safety of the child. If the child is not safe, or safety cannot be assured because the parent is uncooperative in implementing the safety plan, the case must be referred to initial assessment to determine whether court intervention and removal of the child from the home is necessary. Safety services is deemed voluntary as long as the child is safe and the parents are taking all steps necessary to protect the child and engage in services necessary to ensure the safety of the child.

   b) Parental Consent:
   Access to Medical Records:
   Although medical records are generally confidential and cannot be released without parental consent, Wisconsin statutes allows the Bureau to access children's medical records without parental consent when access is sought for purposes of a child abuse or neglect investigation or when requested to perform a

legally authorized function, such as to assess the safety of the child when the case is open in safety services.