State of Michigan
Department of Human Services

Child Fatality Reviews: 1/1/11-12/31/11
Office of Family Advocate Report

Introduction

The modified settlement agreement requires DHS to ensure that qualified and competent individuals conduct a fatality review, independent of the county in which the fatality occurred, for each child who died while in the foster care custody of DHS. The fatality review process is overseen by the Office of Family Advocate (OFA), a unit within central office DHS.

OFA Review Process

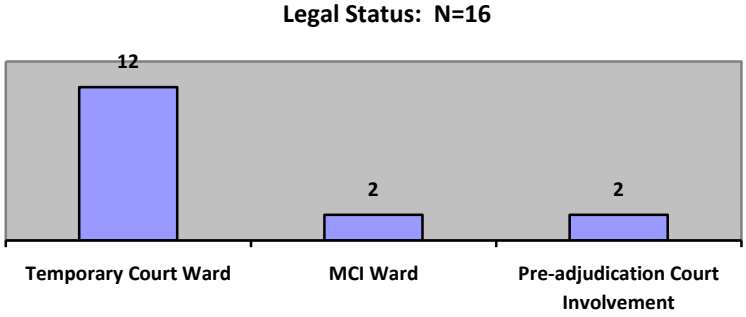
The OFA has developed guidelines to ensure that fatality reviews are consistently independent and comprehensive. Each review is completed by the OFA director or OFA department specialist.

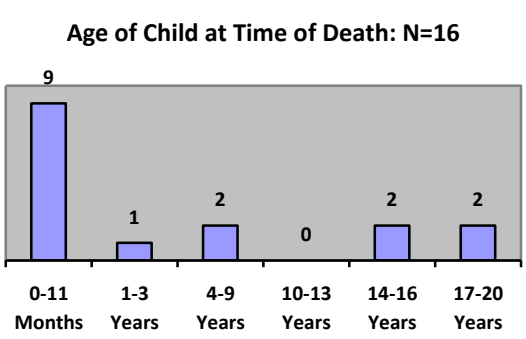
The reviewers examined relevant information, including the child's foster care and adoption file, all Children's Protective Services (CPS) complaints involving the child's foster care home(s), the foster parents' licensing file, police reports, medical, educational, and mental health documents, the child's legal file, placement history, and all available information related to the child's death. Among other tools, reviewers consulted existing DHS policy, Michigan Child Protection Law, Bureau of Children and Adult Licensing (BCAL) Rules, and Child Welfare Contract Compliance Unit (CWCCU) Child Placing Agency letters to determine policy compliance and best practice.

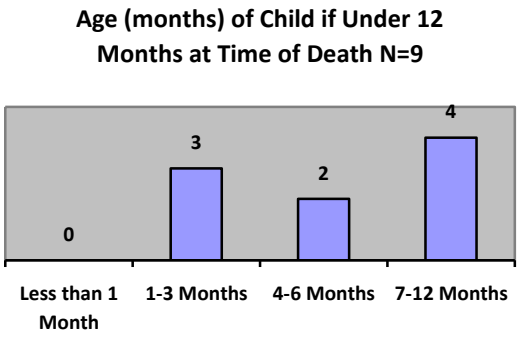
Each fatality review was completed within six months of the child's death and involved on-site inspection of the original case file or remote inspection of exact copies of case files. A summary of case facts was drafted following each review. When applicable, the summary included specific findings and corresponding recommendations in the areas of safety, permanence, and well-being. Each completed summary was sent to the involved agencies and/or appropriate DHS program office for review and response, including identification of corrective action when necessary.

Demographics

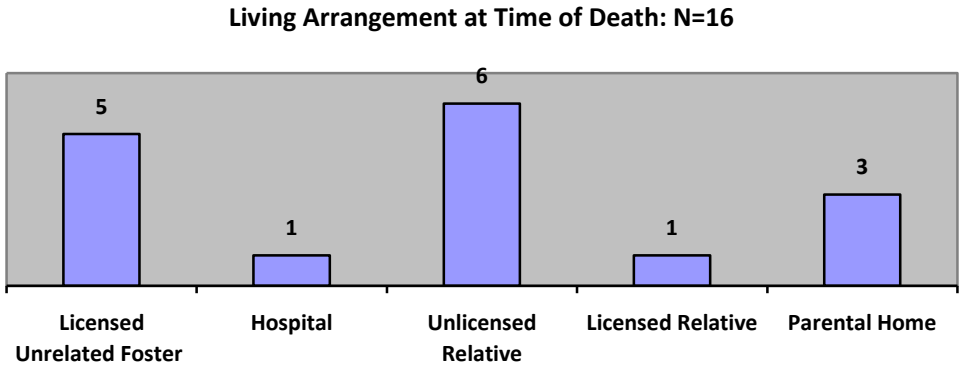
The following data was compiled for the 16 fatality reviews completed during this review period.



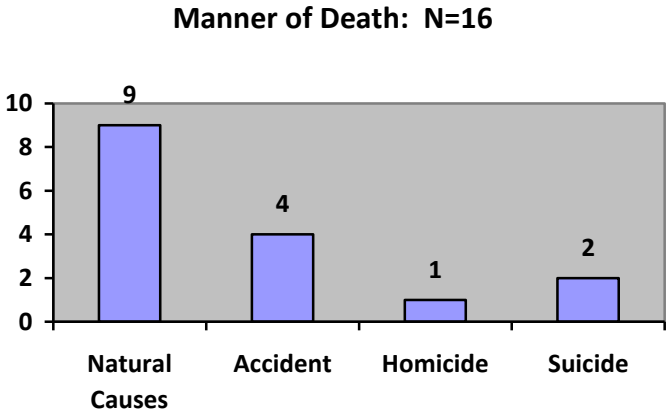




- The range of the children's age was 1 month to 18 years old. Five (32%) of 16 children were less than six months old at the time of death.



- Seven (44%) of the 16 children were placed with a family member at the time of death.



- Nine (56%) of 16 cases reviewed included documentation that the manner of the child's death was natural. Six of these cases were managed by DHS only, while the other three involved private child placing agencies providing direct foster care services. Each death was a result of the child's specific medical condition.

- Two (13%) of 16 cases documented that the child died as a result of suicide. Both youth were male teenagers who had been removed from their primary caretaker due to issues of abuse and neglect. One youth lived with an unlicensed relative and hung himself in a wooded area near the home. The other resided in a licensed foster home and shot himself just a few yards from the house with the foster parent's gun.

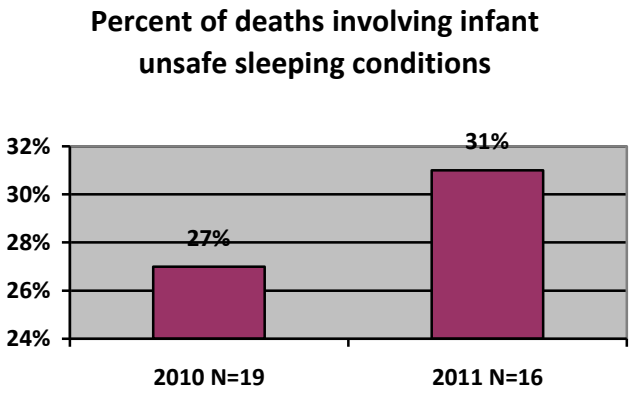
- Four (25%) of 16 cases reviewed documented that the child died as a result of an accident. All three cases involved an infant 10 months or younger who died of unsafe sleep.

Manner of death for children placed with unrelated licensed foster parent: N=6

Manner of death for children placed with parent or relatives (licensed or unlicensed): N=10

- Youth that died while placed in a licensed foster home died overwhelmingly by natural causes, though one youth died due to unsafe sleep and another by suicide, after he shot himself with the foster parent's gun.

- Youth that died while placed with a relative did so in a variety of manners, including three deaths related to unsafe sleep conditions, a homicide (not committed by the relative), and a suicide.



- Though the overall number of fatalities dropped between 2010 and 2011, the number of those that involved infant unsafe sleeping conditions rose.

OFA Findings and Recommendations

For each fatality review, the OFA attempted to identify any findings or concerns that may have adversely impacted the child's safety, wellbeing, or permanence at all stages of the child's involvement with the child welfare system. Findings do not imply that actions taken by the workers or agencies involved were factors in the child's death; rather they provide an opportunity to focus on improving overall practice at all levels of intervention.

Of the 16 completed fatality reviews, four cases resulted in no findings, meaning no areas of concern with compliance were noted. Twelve of the 16 (75%) cases resulted in findings that either impacted the child's safety, permanency, or well-being or had the potential to impact these areas and required further attention.

***Safety Findings*:**

Safe Sleep: In three of twelve cases (25%), the foster care worker missed opportunities to reinforce safe sleep practices with the caregiver. Safe sleep practices include the care and supervision requirements expected of caregivers with children under the age of 12 months. These include the baby sleeping in a crib, on his/her back, with nothing in the sleep area. Soft surfaces, pillows, and co-sleeping should be avoided. In 2010, four of ten cases (40%) had a similar finding.

Safety Planning: In one of twelve cases reviewed, the foster care worker did not develop a safety plan. An effective safety plan identifies specific actions that the youth or caretaker can immediately take to prevent or respond to foreseeable risk factors such as depressive symptoms, homelessness, or domestic violence.

Incomplete CPS investigation: In one of the twelve cases reviewed, the CPS investigator did not interview all required parties before assigning a disposition.

Licensing re-evaluations not complete: In one of the twelve cases, an agency did not complete licensing re-evaluations of a foster home in full compliance with child placing agency rules.

Improper case closure: In one of the twelve cases, after confirming child abuse and identifying a need for services, CPS prematurely closed its case.

Lack of representation: In one of the twelve cases, DHS did not have an attorney-client relationship with the prosecuting attorney's office or any other attorney to represent the department's interest regarding a case.

Missed opportunities to act: In one of the twelve cases, CPS was requested to consider if a request for removal should have been made sooner given the family circumstances.

Lack of appropriate assessment: In one of the twelve cases, CPS did not assess the appropriateness of the home environment.

***Summary of the OFA Recommendations Related to Safety*:**

For the 12 fatality reviews completed during 2011 in which findings and recommendations were identified, the OFA issued 11 recommendations as a result of 10 findings related to safety of children in care. Four recommendations were directed toward the DHS local program offices, four were directed toward the private agencies involved, two were directed towards CPS program office, and one was directed to BCAL.

- Four of the 11(36%) recommendations focused on a worker's/agency's adherence to specific policies.
- Three of the 11 (27%) recommendations involved amending current law or policy.
- Two of the 11 (18%) recommendations involved an agency identifying steps to comply with policy concerning providing Safe Sleep information.
- One of the 11 (9%) recommendations suggested the need for training related to developing behavioral safety plans.
- One of the 11 (9%) recommendations requested BCAL to determine whether an agency violated identified licensing rules.

***Wellbeing findings*:**

Visitation standards were missed: In two of the twelve cases, the foster care agency did not adhere to face-to-face visitation standards.

Missed opportunities to intervene: In one of the twelve cases, the foster care agency missed opportunities for meaningful therapeutic intervention.

Incomplete assessment: In one of the twelve cases, the certifying agency did not complete a thorough assessment of the foster home.

Missing collateral contacts: In one of the twelve cases, the CPS worker did not document contact with collateral sources needed to monitor parents' participation and benefit from services.

Missing referral: In one of the twelve cases, a referral to Early On was not made.

Missing medical information: In one of the twelve cases, the foster care worker did not contact the pediatrician or any treating medical staff and documentation lacked details regarding the child's medical status and condition.

No appeal: In one of the twelve cases, the foster care agency did not appeal a court order.

Summary of the OFA Recommendations Related to Wellbeing:

For the 12 fatality reviews completed during 2011 in which findings and recommendations were identified, the OFA issued 8 recommendations as a result of 8 findings related to the well-being of children in care. Six recommendations were directed toward the DHS local program offices and two were directed toward the private agencies involved.

- Six of the 8 (75%) recommendations focused on a worker's/agency's adherence to specific policies.
- Two of the 8 (25%) recommendations involved an agency/worker responding appropriately to a need.

Permanency findings:

ICWA not followed: In one of the twelve cases, policy governing Native American children was not followed.

Lack of coordination: In one of the twelve cases, the local county and child placing agency did not adequately coordinate efforts to place children with identified relatives.

Summary of the OFA Recommendations Related to Permanency:

For the 12 fatality reviews completed during 2011 in which findings and recommendations were identified, the OFA issued 3 recommendations as a result of 2 findings related to the permanency of children in care. Two recommendations were directed toward the DHS local program offices and one was directed to both the DHS local program office and the private agencies involved.

- All three of the 3 (100%) recommendations focused on a worker's/agency's adherence to specific policies.

OFA Fatality Assessment

The Michigan Department of Human Services provides protection and care for Michigan's most vulnerable children. Children who enter into the foster care system do so for a variety of reasons and face a number of challenges as a result of their removal from the home. None of the 16 fatalities reviewed indicate that the child's death was the result of actions or omissions on the part of DHS or private agency workers. Though many of the OFA findings and recommendations involve non-compliance with existing policies, they provide an opportunity to ensure and improve delivery of service, training, and supervisory oversight.

Many children entering the foster system do so with medical conditions. The conditions may be naturally occurring or a result of the abuse/neglect they suffered before entering care. Eight (50%) of the 16 cases reviewed by the OFA in 2011 documented the child had medical issues. Six of the eight deaths were the result of a medical condition and not related to the services provided by the DHS.

DHS intervention could not have prevented tragic events such as the fatal shooting of one child. Two of the 16 cases reviewed (13%) involved teen males committing suicide despite DHS providing numerous services to the youth. One of those youth had been in out-of-home care just a few months and the other youth for a number of years.

Despite a drop in the number of ward fatalities in 2011 compared to 2010, the number of deaths involving unsafe sleeping conditions rose to five total. Four of the 16 deaths in 2011(25%) were ruled accidental and all involved unsafe sleeping environments. One death (6%) was ruled natural but involved unsafe sleeping conditions which may have contributed to the infant's health issues and subsequent death. Two of the 16 deaths involving unsafe sleeping conditions occurred in a relative home, one in the birth parent's home, and two in a licensed foster parent's home. Policy and training has been implemented to improve DHS practice and education regarding safe sleep for foster parents, unlicensed relatives, and parents.

Follow-up of Past Findings and Recommendations
Since the publication of the previous fatality report, *Child Fatality Reviews: 1/1/10 – 12/31/10, Quality Assurance Report*, DHS has taken the following steps to improve practices:

<u>Foster Care Program Office:</u>
A recommendation was made to review policy to determine if DHS staff can conduct Law Enforcement Information Network (LEIN) checks for private agency staff in order to approve a placement setting, or amend policy to require private agencies to conduct criminal history checks via the Internet Criminal History Access Tool (ICHAT).

MCL 28.214(2) et. seq. states that DHS "shall not disclose information from the Law Enforcement Information Network to a private entity for any purpose..." including private

foster care agencies. Current policy does not require a private agency to conduct criminal history checks via ICHAT, though it is considered standard practice. The Child Welfare Training Institute currently instructs all workers to utilize ICHAT, the Offender Tracking Information System (OTIS), the Michigan State Police Sex Offender Registry (PSOR), as well as a number of other public resources to locate clients and identify their past criminal history.

Field Services Administration:
A recommendation was made to develop a plan to require close monitoring by the local offices to ensure compliance with caseworker visit requirements, especially in the cases of very young and medically fragile children.

DHS has developed data reports that enable local offices to monitor compliance with meeting investigative and ongoing face-to-face contact requirements. DHS is monitoring local county office performance on a monthly basis. DHS has also implemented monthly case conferences between CPS workers and first-line supervisors to address barriers pertaining to compliance with existing policy, including timely face-to-face contacts.

Children's Protective Services Program Office:
A recommendation was made to update policy to incorporate safe sleep practices and require each child's caregiver to demonstrate understanding of safe sleep practices and commit to consistent implementation.

The DHS CPS Program Office has worked in conjunction with the Office of Children's Ombudsman, the Office of Family Advocate, the CPS Advisory Committee, and the Child Fatality Citizen Review Panel to strengthen CPS policies for investigating child deaths. Policy changes now address parent/caregiver substance abuse, child supervision, and the environmental conditions in the home as factors related to the child death complaint investigations. It is anticipated that new policy will improve consistency in the investigative process and complaint disposition. Additionally, amended CPS policy will be released in 2012 requiring that CPS workers address safe sleep requirements with relative caregivers at the time of initial placement.

OFA Unit Recommendations

Foster Care Program Office:

- Consider developing a suicide prevention/depression education initiative for foster parents and case managers working with at-risk adolescent wards which will focus on identifying and intervening with suicidal ideation and depression issues.

Family Preservation Program Office:

- Consider developing a suicide prevention/depression education initiative for the family preservation programs, including the Family Reunification Program which

works with temporary court wards, to identify and intervene with at-risk youth affected by suicidal ideation and depression issues.

Child Welfare Training Institute:

- Institute in-service training for CPS and FC which instructs staff how to develop and document behaviorally based safety plans which address the immediate risks of a client including adolescent and other high risk groups.

- Take steps to determine if the current PRIDE training curriculum includes sufficient information and resources regarding suicide prevention and depression management for applicants interested in fostering at-risk adolescent wards.

Child Protective Services Program Office:

- Continue to seek ways to educate out-of-home placement providers, including unlicensed relatives, regarding safe sleep practices prior to or at the time of placement.