State of Michigan
Department of Health & Human Services

Child Fatality Reviews: 1/1/15-12/31/15
Office of Family Advocate Report

Introduction

The Implementation, Sustainability, and Exit Plan, goo.gl/BbvPPo, requires MDHHS 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 under court jurisdiction and placed in foster care by MDHHS. The Office of Family Advocate, a unit within central office MDHHS, oversees the fatality review process.

OFA Review Process

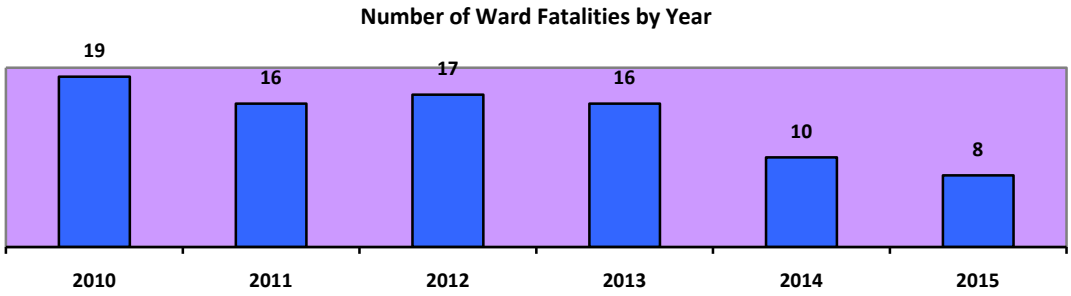
The Office of Family Advocate developed guidelines to ensure that fatality reviews are consistently independent and comprehensive. Each review is completed by the Office of Family Advocate director or departmental specialist.

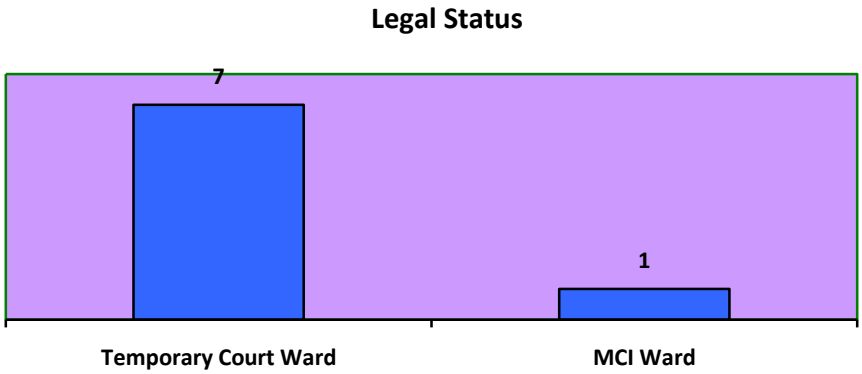
The reviewers examined relevant information, including the child's foster care and adoption file, all Children's Protective Services complaints involving the child's foster care home(s), the foster parents' licensing file, police reports, medical, educational, and mental health documents, the child's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

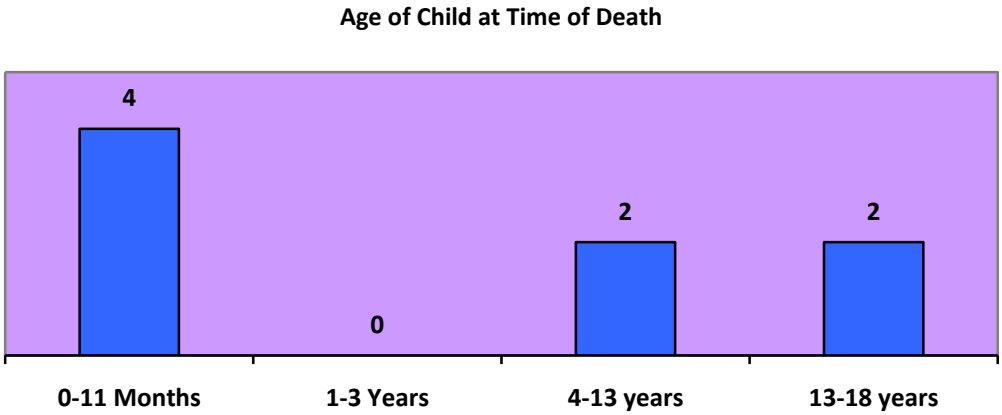
Office of Family Advocate staff completed each fatality review within six months after the child's death which involved on-site inspection of the original case file, remote inspection of exact copies of case files, or a review of the information available on the Michigan State Automated Child Welfare Information System (MiSACWIS). Each review contained a summary of the case facts, practice strengths identified during the review, and, when applicable, findings and corresponding recommendations. Office of Family Advocate staff sent all completed summaries to the involved agencies and/or appropriate MDHHS program offices for review and response, including identification of corrective action when necessary. In many cases, Office of Family Advocate staff traveled to the county/agency and met with workers involved with the case to give and obtain feedback regarding the review, the strengths, and the findings.

Demographics

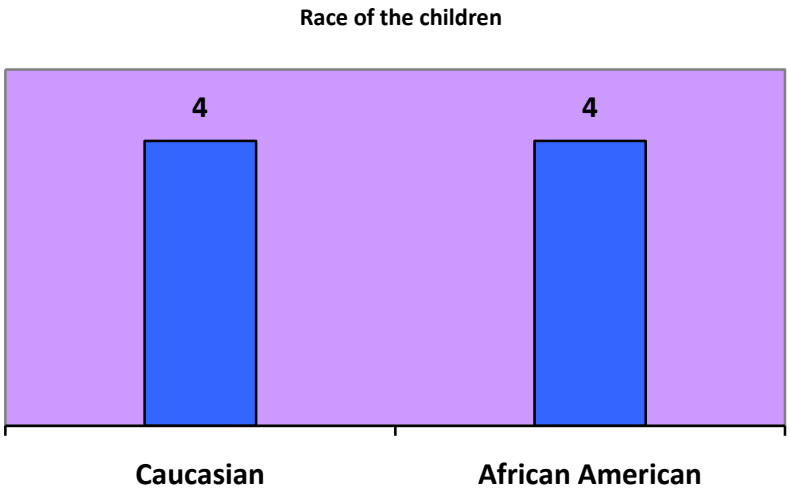
The following data was compiled for the eight fatality reviews completed during the review period.







The range of the children's age was 2 weeks to 17 years old. Four of the eight children (50%) were less than 6 months old at the time of death.



Counties where ward deaths occurred

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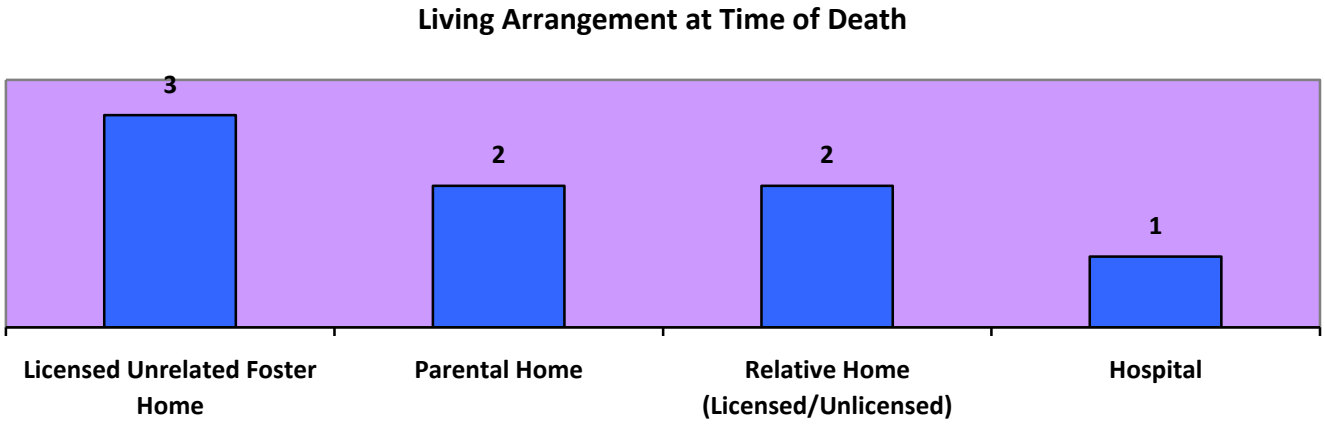
County	Number of 2015 Ward Deaths
Oakland	3
Kalamazoo	2
Oakland/Macomb	1
Midland	1
St. Joseph/Branch	1

The Office of Family Advocate reviewed eight ward fatalities that involved five different counties. Four of the eight deaths (50%) occurred in one of the six DHHS urban counties (Wayne, Oakland, Genesee, Kent, Macomb, or Ingham).

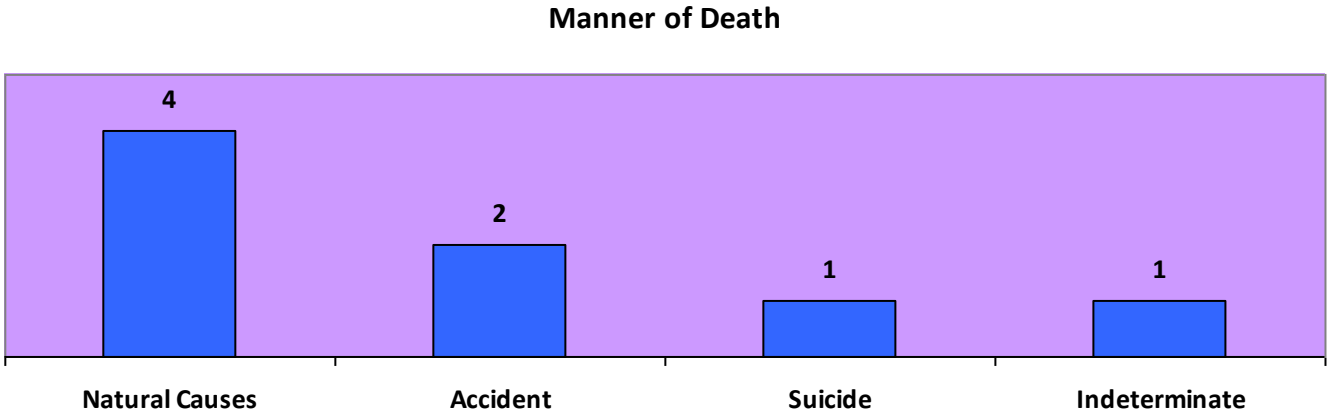
Two of the deaths involved multiple counties.



Three of the eight children (38%) died while living in an unrelated foster home. Two of those children died because of chronic medical issues which existed prior to placement, the other died from an accidental drowning.

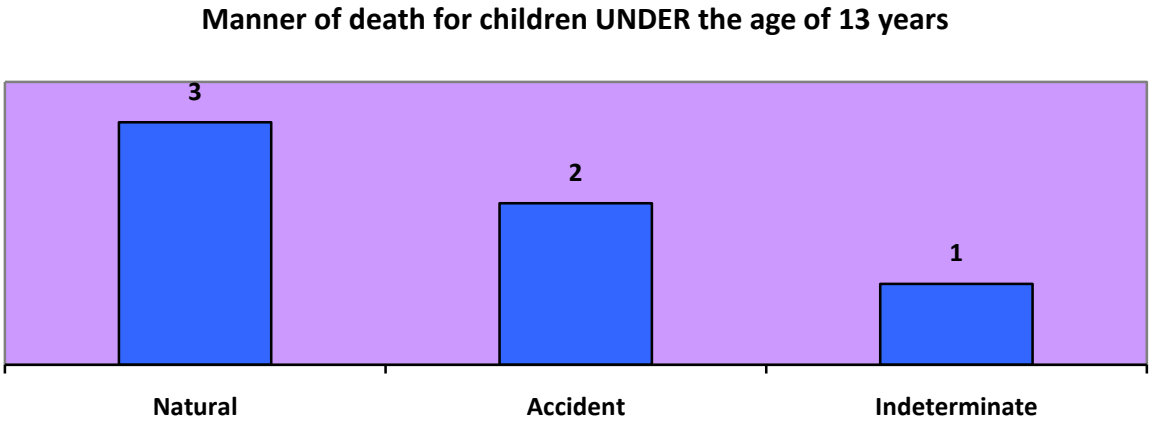
Two of the eight children (25%) died while living with a biological parent. One of the children died of medical issues which existed prior to placement, the other died after the parent placed the child in a compromised sleeping position.

Two of the eight children (25%) were teenagers. One of the teens died of medical issues which existed prior to placement, the other died by suicide.



Individual autopsies were used to determine the manners of death for all eight children.

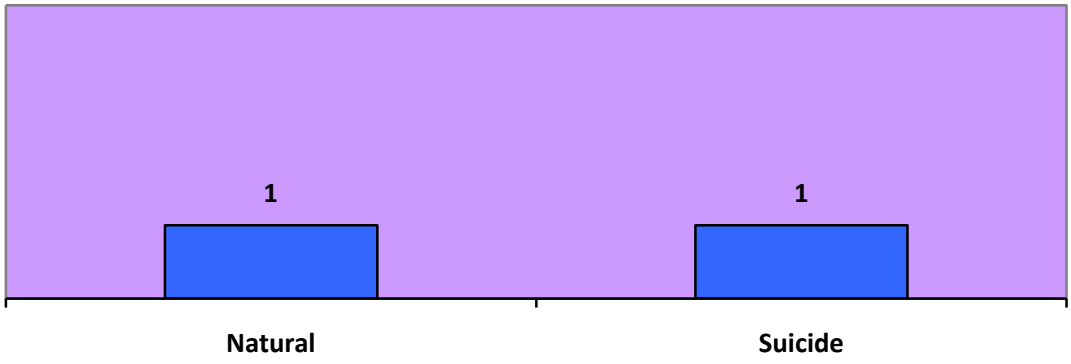
The causes of death range from various medical issues unrelated to abuse or neglect in four cases, positional asphyxia (unsafe sleep of infants) in two cases, accidental drowning in one case, and hanging in one case.



Only three of the six children (50%) under the age of 13 died from natural causes.

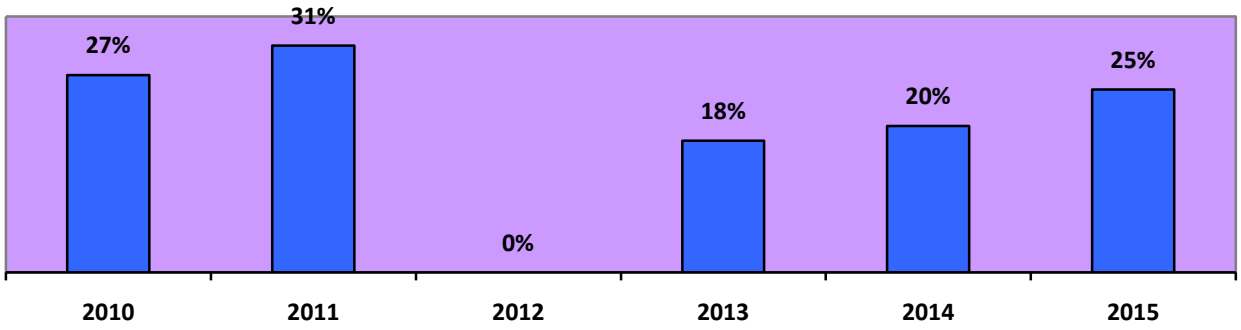
One of the accidental deaths and the one indeterminate death were both caused by a caretaker putting an infant in a compromised sleeping position, the other accidental death was a drowning.

Manner of death for children OVER the age of 13 years



One of the two children (50%) over the age of 13 died by suicide. The other child died from medical issues that existed before the child entered care.

Percent of ward deaths involving infant unsafe sleeping conditions



One of the two children (50%) that died from positional asphyxia in 2015 did so after an intoxicated parent shared an adult bed with the newborn. The other occurred when a relative caregiver did not adhere to safe sleep practices.

Both children that died of positional asphyxia were African American.

Office of Family Advocate Identified Strengths:

In 2015, the Office of Family Advocate continued to identify strengths related to exceptional practice taken by child welfare staff. Strengths may include an action taken by

the worker or other staff member that went above and beyond general expectations or an exceptional practice that contributed to the child's well-being or safety.

Reviewers identified strengths in five of the eight fatality reviews; in total there were six strengths identified.

Identified Strengths:

Exceptional documentation: Five of the six cases (83%) with identified strengths involved DHHS, most often the Maltreatment-in-Care unit, and private agency foster care staff completing detailed documentation exceeding required standards.

Excellent coordination with numerous agencies and entities: One of the six cases (17%) with identified strengths involved MDHHS successfully coordinating efforts with numerous outside agencies, such as law enforcement, adoption agencies, and Immigration and Customers Enforcement.

Office of Family Advocate Findings and Recommendations

For each fatality review, the Office of Family Advocate may identify findings or concerns that may have adversely impacted the child's safety or wellbeing at all stages of the child's involvement with the child welfare system. Because the Office of Family Advocate looks at a case in its entirety, a finding might relate to a policy or action not related in any way to the child's death and should be viewed as an opportunity to focus on improving overall practice at all levels of intervention.

Of the eight completed fatality reviews, one case (13%) resulted in no findings, meaning no areas of concern with compliance were noted. The other seven cases (87%) resulted in findings that either impacted the child's safety or well-being or had the potential to impact these areas and required further attention.

***Fatality Review Findings*:**

For the seven fatality reviews completed during 2015 in which findings and recommendations were identified, the Office of Family Advocate issued findings related to areas affecting a child's safety and well-being and made recommendations to the MDHHS local county, central office, and private foster care agencies. In six of the seven Fatality Reviews with findings, the Office of Family Advocate made multiple findings and recommendations.

***Summary of the Office of Family Advocate Findings*:**

Insufficient contacts: In six of the seven Fatality Reviews with findings (86%), a child welfare worker did not make sufficient contacts with children, family members, and/or collateral contacts while monitoring services. Most of the findings involved missed visitation with the child during their first 60 days of placement.

Incorrect child protective services disposition: In three of the seven Fatality Reviews with findings (43%), the Office of Family Advocate made a finding that child protective services made an incorrect disposition following an investigation.

Failure to document safe sleep information: In two of the seven Fatality Reviews with findings (29%), the worker did not document observing an infant's sleeping arrangement or providing education to foster/biological parents regarding a safe sleep environment for infants under 12 months of age.

Inadequate documentation: In two of the seven Fatality Reviews with findings (29%), the Office of Family Advocate made a finding that the case lacked required documentation. In one case, the agency had not completed a Closing Updated Service Plan.

Failure to follow policy: In two of the seven Fatality Reviews with findings (29%), the Office of Family Advocate found that an agency involved with the case did not adhere to child welfare policy. In one case, the agency did not adhere to the "Absent Without Legal Permission" policy, the other involved the agency missing mandatory timeframes.

Premature closure of child protective services on-going case: In one of the seven Fatality Reviews with findings (14%), the Office of Family Advocate made a finding that the county prematurely closed a Children's Protective Services on-going case without ensuring the family had participated or benefitted from services.

Lack of safety planning: In one of the seven Fatality Reviews with findings (14%), the Office of Family Advocate made a finding that the agency did not develop a safety plan for a child in an unsafe situation.

Failure to recommend removal of a child: In one of the seven Fatality Reviews with findings (14%), the Office of Family Advocate determined Children's Protective Services should have included a request for removal of the child from the parent when they filed for jurisdiction with their local court.

Inappropriate placement: In one of the seven Fatality Reviews with findings (14%), the Office of Family Advocate cited a foster care private agency for placing a child with medical needs into a home that lacked specialized training.

***Summary of the Office of Family Advocate Recommendations*:**
The Office of Family Advocate made 18 recommendation for the seven cases where the Review had findings. Recommendations were directed towards the MDHHS local county offices, the private agencies involved, and child protective services program office.

- Ten of the 18 recommendations (50%) required the DHHS local or private agency to review a policy or practice with workers and develop a plan to ensure consistent compliance. The policy most recommended for review was PSM 713-01 "*CPS Investigation – General Instructions and Checklist*"

- Five of the 18 recommendations (28%) requested the DHHS local or private agency to review an action or decision they made during a case to determine if it was correct. If not, the Office of Family Advocate requested the local/agency develop a plan to ensure future compliance with the related policy. None of the actions or decisions the Office of Family Advocate requested be reviewed were directly involved in the death of a child.
- One of the 18 recommendations (6%) required a county to facilitate a case review using a random sample to determine if a non-compliance was case specific or indicative of broader or widespread practice within the county.
- One of the 18 recommendations (6%) required the agency to complete a required form.
- One of the 18 recommendations (6%) required an agency to consider disciplinary action against its staff and compliance with a corrective action plan issued by the Department of Child Welfare Licensing.

Office of Family Advocate Fatality Assessment

The Michigan Department of Health and Human Services provides protection and care for Michigan's most vulnerable children. When a child enters into foster care, MDHHS assumes the responsibility to provide for the safety, well-being, and permanence of that child and often provides numerous services to them and their families.

Since the inception of the federal consent decree in 2008, MDHHS has made great strides in improving or exceeding compliance in areas that directly impact the care of children in the system. It is important to remember that cases involving fatalities are a very small subset of overall cases and the trends identified in this report cannot be generalized to all practice or all counties across the state.

In many instances, the children died from tragic events that MDHHS could not have prevented. In 2015, four of the eight cases (50%) involved a child dying from chronic medical issues that existed prior to placement in out-of-home placement. One of the eight cases (12%) involved a teenager dying by suicide after he hung himself. Two of the eight cases (25%) involved a caretaker putting an infant in a compromised sleeping position, leading to death. One of the eight cases (12%) involved a child dying from an accidental drowning.

As outlined above, the Office of Family Advocate identified some common errors in these cases, though none of the errors directly led to the death of a child. Insufficient contacts, incomplete investigations, and lack of safety planning continue to be challenges in cases involving a fatality. While there is no clear correlation between these errors and the death of a child, when they occur it could be an early warning sign of potential risk in the case.

Follow-up of Past Findings and Recommendations

Since the publication of the previous fatality report, *Child Fatality Reviews: 1/1/14 – 12/31/14 Office of Family Advocate Report,* MDHHS has taken the following steps to improve practices:

Threatened Harm: Last year, the Office of Family Advocate recommended the MDHHS Children's Services Agency consult with the Michigan Domestic and Sexual Violence Prevention and Treatment Board and the Office of Workforce Development and Training to develop policy and training which clarifies for CPS staff how to better recognize, document, and utilize 'threatened harm,' especially regarding investigations involving domestic violence.

In 2015, MDHHS' Children's Services Agency began revising the MiTEAM Practice Model Manual. The revision includes detailed guidance for licensing workers on how to assess potential caregivers and effective strategies they can use to assess and intervene when domestic violence is identified as a risk to child safety.

Additionally, MDHHS began statewide implementation of the MiTEAM Enhancements regarding domestic violence, based on David Mandell's Safe and Together Model. Implementation will span over approximately 18 months and includes elements of virtual learning, structured activities, practice support, resources and feedback for all levels of the organization. The enhancements will change the fundamental way Michigan child welfare workers engage the perpetrators and survivors, safety plan, and respond as a system to those impacted by domestic violence.

Secondary Trauma: Last year, the OFA recommended MDHHS Children's Services Agency consider developing a statewide initiative to educate child welfare supervisors around identifying and supporting workers experiencing secondary trauma as a result of cases which end in a fatality or severe injury.

From March to September 2015, MDHHS initiated a pilot involving a secondary traumatic stress training in Business Service Center 2. Conducted in partnership with Dr. Jim Henry, Director of Western Michigan University's Children's Trauma Assessment Center, the key components of the secondary trauma stress training included: training of directors and program managers, training of front-line staff by the Office of Workforce Development and Training (OWDT), development and implementation of Secondary Traumatic Stress Teams for staff to process secondary trauma on a peer-to-peer level, follow-up calls and emails to assist with challenges and barriers of pilot implementation, and collaboration with the Office of State Employer Employee Services Program to assist with providing employees support outside of the office.

A number of positive outcomes, including reports of a happier, healthier, and more supportive work environment, have contributed to the notion that conducting this training statewide would be of great benefit to child welfare leadership and staff. The Children's Services Agency is currently exploring opportunities to be able to expand this package of training to child welfare workers statewide.

Additionally in 2015, MDHHS sponsored the first annual Suicide Prevention Conference along with the Michigan Association for Suicide Prevention. Dr. Jim Henry presented at the

conference on secondary trauma and its impact on social workers, especially with cases where a fatality occurs.

Office of Family Advocate Unit Recommendations:

1. The Office of Family Advocate recommends Foster Care Program Office, Child Welfare Field Operations management, and the Children's Welfare Training Institute consider strategies to improve field compliance with standards of promptness and face to face contacts, especially related to children who have newly entered the foster care system. Those strategies may include considering additional training approaches, such as web based trainings and podcasts, trainings for staff on how to utilize the MiSACWIS Book of Business, training of the findings and trends identified in this report, and regular reminders to the field.