State of Michigan

Department of Health and Human Services

Children's Service Agency

CPS Fatality Reviews 01/01/14-12/31/14

Office of Family Advocate Report

Background

The following report contains information regarding child fatalities that occurred during a children's protective services (CPS) investigation, service case, or shortly after case closure. The Office of Family Advocate (OFA) is a unit within DHHS' Children's Services Agency that oversees the CPS Fatality Review Process.

OFA Review Process of Child Fatality Cases

The OFA uses the following criteria to determine when to review a child fatality:

- The child death occurred during an active CPS investigation or open CPS case.
- The child death occurred in a family that has 3 prior CPS investigations, regardless of length of time since the investigations or outcome.
- The child death occurred in a family which had a recent CPS services case close (within 3-4 months).

OFA analysts complete all reviews and carefully examine all relevant information including CPS complaints, DHHS policy procedures and protocols, and applicable state and federal laws. Each review contains a summary of case facts, identified practice strengths, and findings with corresponding recommendations to practices when applicable. Completed reviews are forwarded to the county for response, which may include the steps taken to improve practice and/or corrective action when necessary.

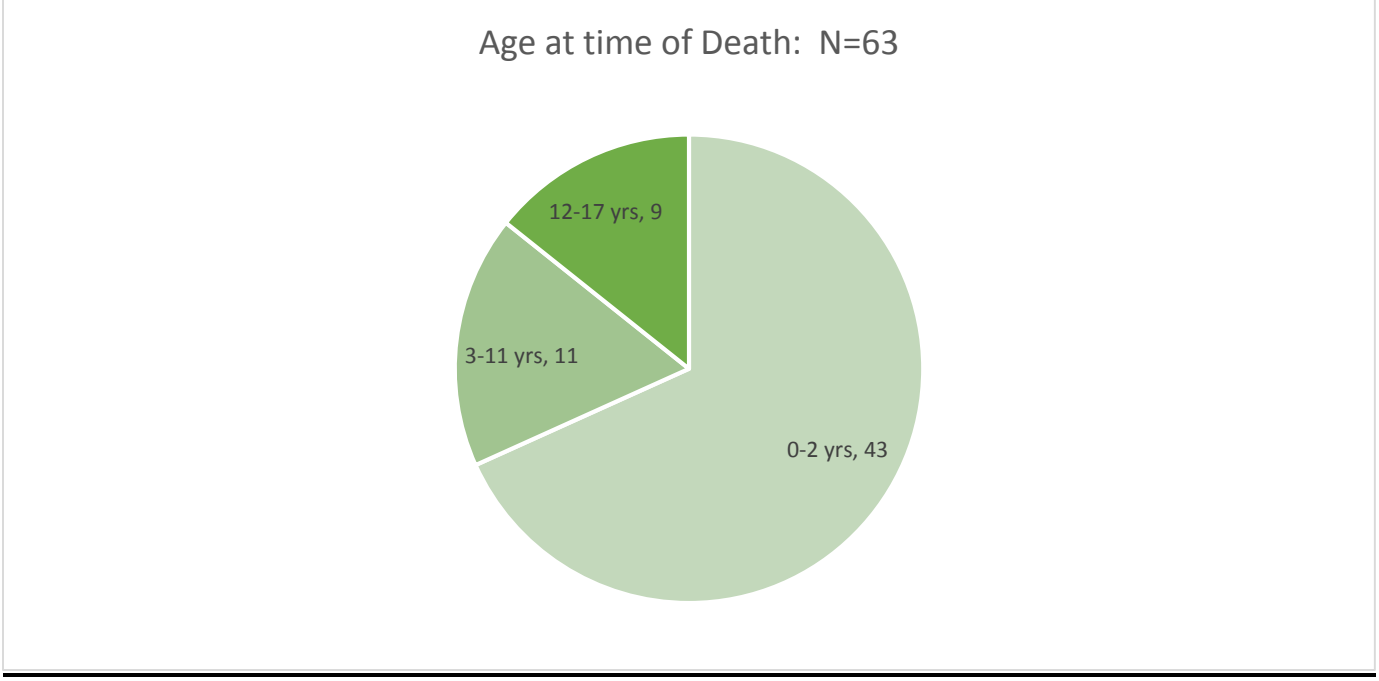
Demographics/Statistics

During the review period, 63 child fatalities met the criteria in order for completion of an OFA Fatality Review.

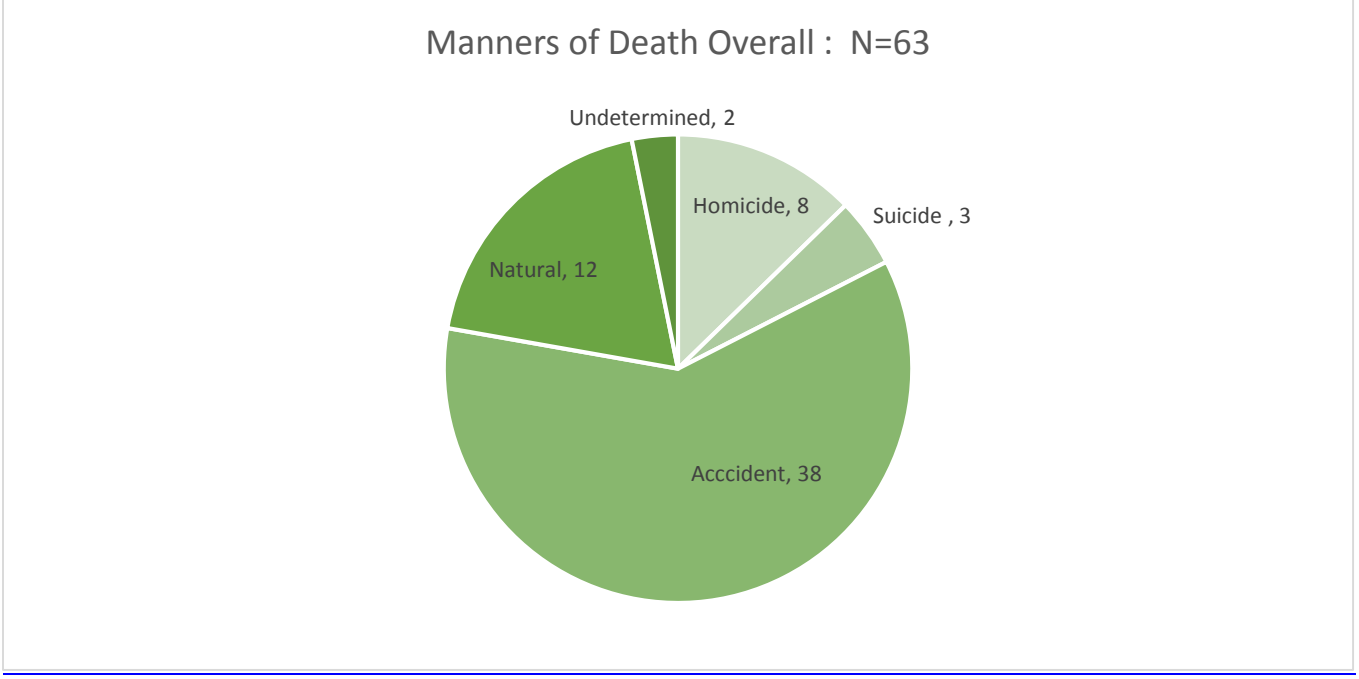
Counties Where Reviewed Fatalities Occurred

County	Number of Reviews
Wayne	23 (37%)
Genesee	5 (8%)
Ingham	3 (5%)
Jackson	3 (5%)
Oakland	3 (5%)
St. Clair	3 (5%)
18 other Michigan counties	2 or less

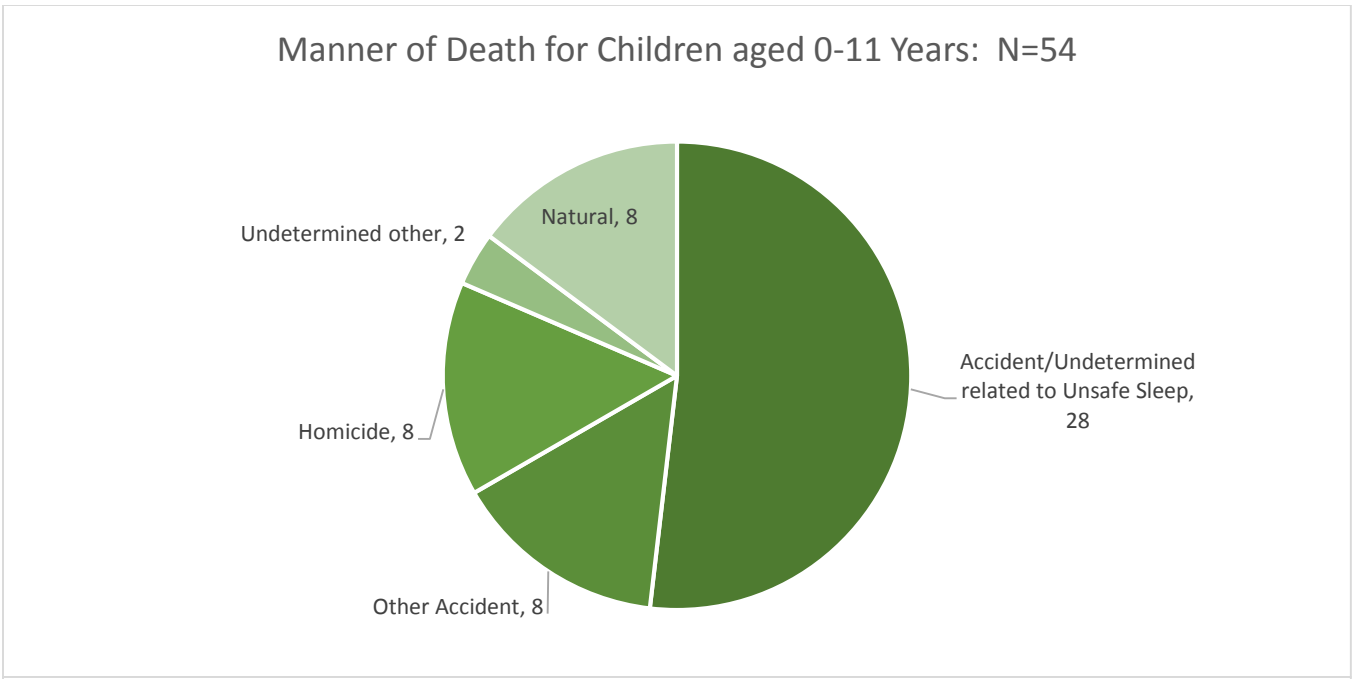
- The 18 other counties were Alpena, Bay, Berrien, Branch, Gratiot, Hillsdale, Ionia, Kent, Macomb, Mecosta, Roscommon, Washtenaw, Wexford, Calhoun, Midland, Newaygo, Ottawa, and Saginaw.

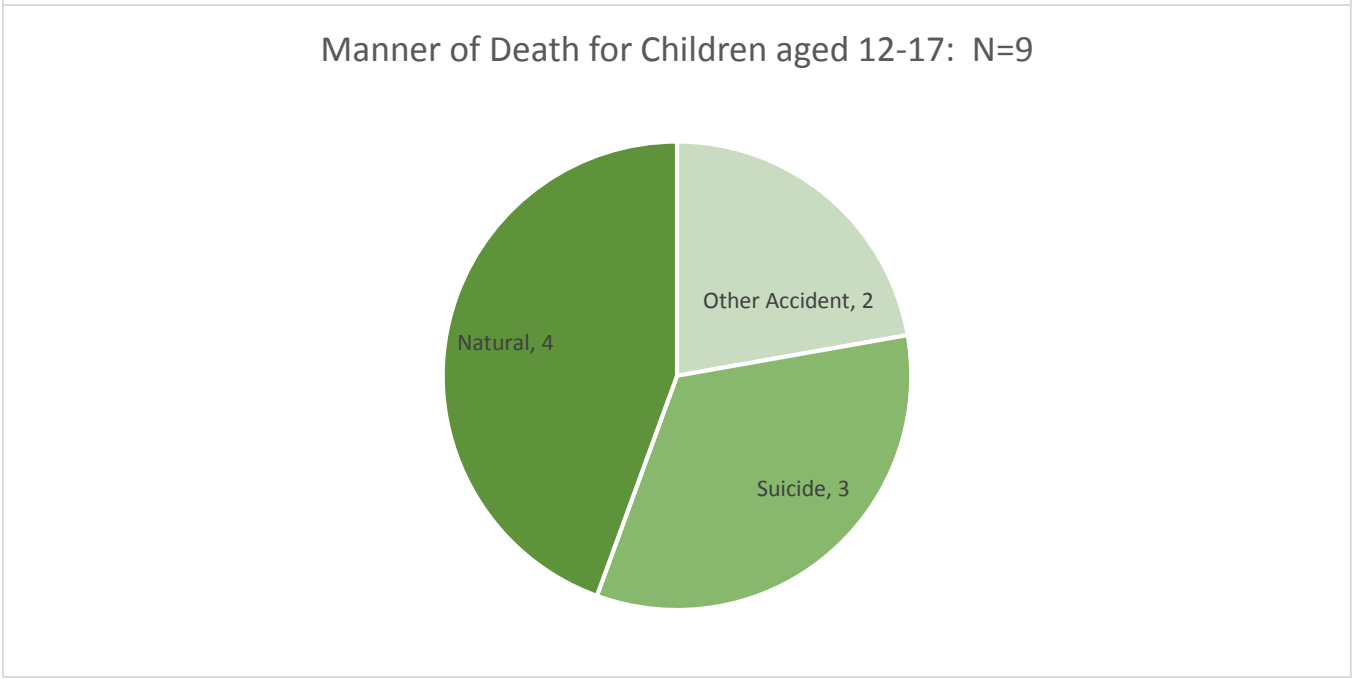


- Children 0-2 years of age represent 68% of the total number of fatalities. Their number is greater than all other age groups combined.
- Children 12-17 years of age represent 14% of the total numbers of fatalities.

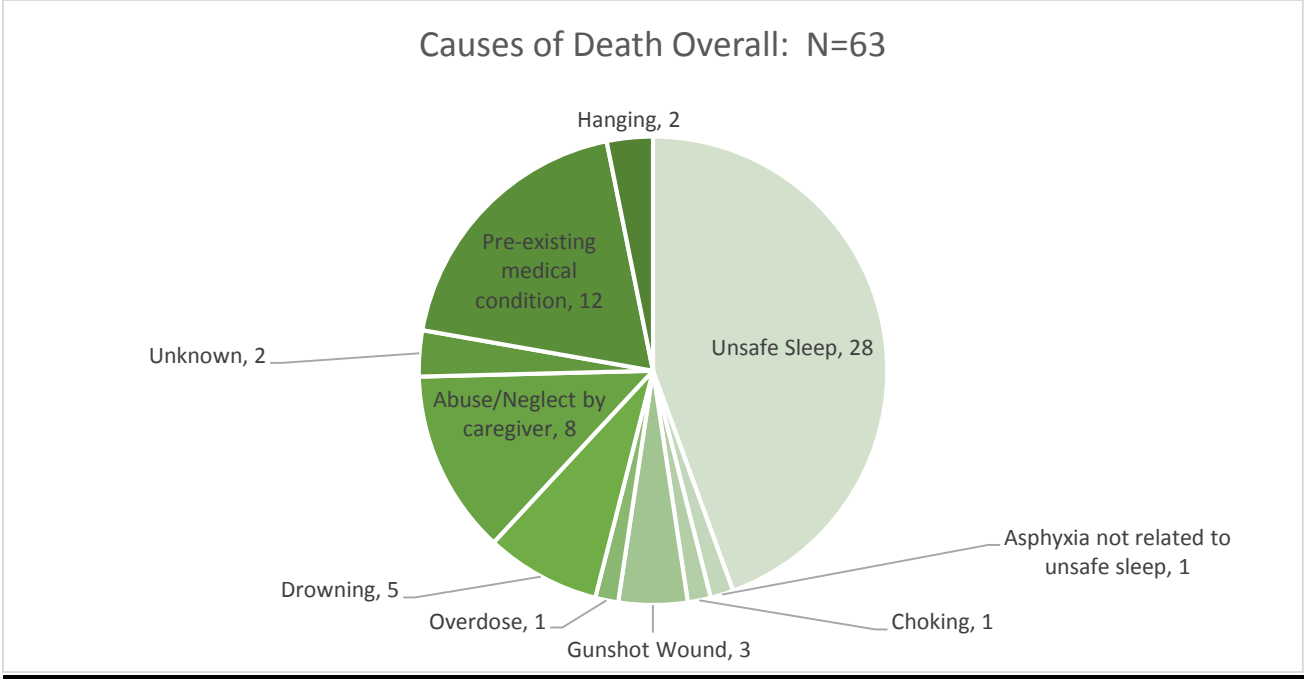


- Accidents made up the majority (60%) of manners of death. Accidental deaths include those that result from placing an infant in a compromised sleeping position (unsafe sleep). Natural deaths followed next (19%) and then homicide by a caregiver (13%).





- Children in different age ranges tended to have different manners of death. Accidental deaths account for 60% of the total number of deaths, however far more children under the age of 11 (63%) died from an accident than children over the age of 12 (22%).
- One third of the reviewed deaths involving children 12 and above were from suicide.
- The children that died from homicide did so after suffering from abuse inflicted by a parent or caregiver living in the home.



- In the overwhelming majority of unsafe sleep fatalities, a CPS worker had discussed the tenets of safe sleep with the parents prior to the death and in some cases more than once.
- 19% of the children died from a pre-existing medical condition, in some cases the child's death was expected.
- Two of the three suicides were committed by females and both hung themselves. The one male used a gun.
- One child died from asphyxia after he snuck out of his house and a neighbor found him in a parked car.

Summary of 2014 CPS Fatality Reviews

Overall Strengths in 2014 reviews

The Office of Family Advocate identifies practice strengths in every CPS Fatality Review. These strengths highlight efforts a worker, supervisor, or local county employee made in relation to the case to ensure child safety. In 2014, the OFA cited the following practice strengths:

- 57% of CPS Fatality Reviews cited efforts made by staff in identifying and making referrals to services and program which met a family's or individual's needs.
- 40% of the CPS Fatality Reviews cited staff engaging parents with safe sleep education.
- 25% of the CPS Fatality Reviews cited workers engaging in comprehensive safety planning with the family.

Overall Findings in 2014 Reviews:

For each CPS Fatality Review, the OFA may identify findings or concerns that may have adversely impacted the child's safety or wellbeing during the time the family was involved with

the child welfare system. Because the OFA 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 63 Fatality Reviews, 22 (35%) resulted in no findings, meaning no areas of concern with compliance were noted. 41 of the 63 Reviews (65%) 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. In 2014, the OFA cited the following findings most often:

- 7 of the 41 Fatality Reviews with findings (17%) had missing standards of promptness (i.e. overdue reports).
- 7 of the 41 Fatality Reviews with findings (17%) had missing required face to face contacts, most often with a non-custodial father.

Overall Recommendations in 2014 Reviews:

OFA Unit Recommendations

- For 17 of the 28 (60%) unsafe sleep deaths, at least one DHHS/CPS worker had already provided education to the parents about unsafe sleep prior to the death. Currently, there is no standard DHHS job aide or recommended lesson plan for workers to follow when giving safe sleep education. The OFA recommends DHHS further research and develop a job aide which highlights best practice and information regarding educating parents/caregivers as to the tenets of safe sleep.

- The OFA recommends CPS 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 investigations involving a child fatality. 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, and regular reminders to the field through monthly contact at child welfare supervisory meeting.