State of Michigan
Department of Human Services

Child Fatality Reviews: 1/1/10-12/31/10
Quality Assurance Report

Introduction

The Michigan Department of Human Services (DHS) is responsible for administering the state's child welfare program. The DHS mission includes a commitment to ensure that children and youths are safe; to sustain a higher quality of life; and to give children in Michigan permanent and stable family lives. The DHS Children's Services Administration is responsible for planning, directing and coordinating statewide child welfare programs, including social services provided directly by DHS via statewide local offices and services provided by private child placing agencies.

DHS has made significant strides to improve the quality of services to children and families in the child welfare system by:

- Reducing caseloads for its workers.
- Moving more children to permanency.
- Reducing the number of children in out-of-home care.
- Launching a continuous quality improvement system.
- Increasing oversight of contracted providers.
- Developing accurate and comprehensive data reporting capabilities.

The consent decree 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.

The Child Welfare Quality Assurance (QA) Unit was established as a part of the Federal Compliance Division in the Children's Services Administration to ensure the provision of services in accordance with DHS philosophy. The goal of the QA Unit is to ensure that children receive high quality services and achieve positive outcomes through improved service delivery, regular monitoring of case records and data trends, and improved implementation of policy. The QA Unit is responsible for analyzing the results of OFA fatality reviews and incorporating the findings and recommendations from them into relevant QA activities.

This report is a summary of the fatality reviews, completed by OFA, concerning 19 children who died between 01/01/2010 and 12/31/2010.

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 and L-letters, Michigan Child Protection Law, Bureau of Child and Adult Licensing (BCAL) Rules, and Child Welfare Contract Compliance Unit (CWCCU) Child Placing Agency letters to determine policy compliance and best practice.

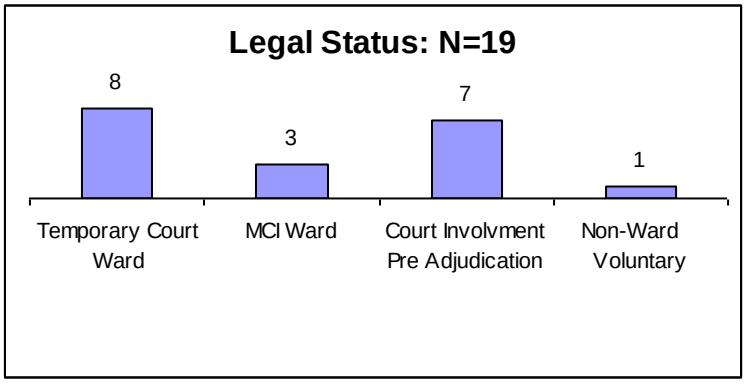
Each fatality review was completed within six months of the child's death and involved on-site inspection of the original case file or remote inspection of exact copies of case files. A summary of case facts was drafted following each review. When applicable, the summary included specific findings and corresponding recommendations in the areas of safety, permanency 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.

Each completed summary was also forwarded to the QA Unit. The QA Unit utilized the Services Worker Support System (SWSS) to derive specific demographic data such as the child's age, race, gender, and living arrangement.

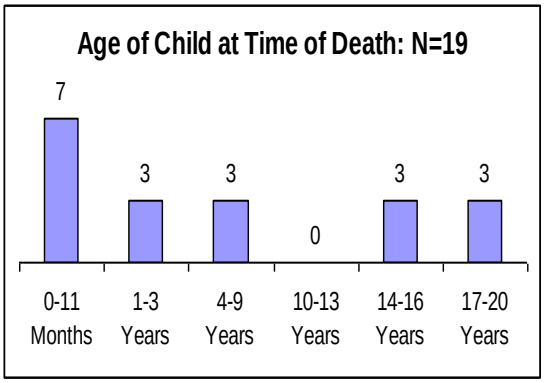
Demographics

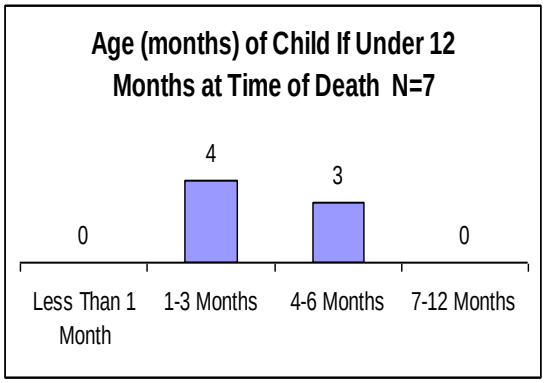
The following data was compiled for the 19 fatality reviews completed during this review period.

- Eleven (58%) of the cases were under the direct supervision of DHS while eight (42%) were under the direct supervision of private child placing agencies.
- Twelve (63%) of the children were male and seven (37%) were female.
- Thirteen (68%) of 19 children were African American and six (32%) were white.

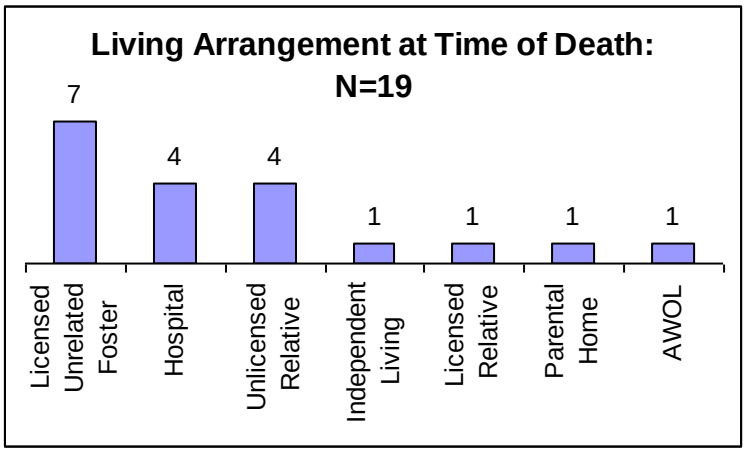


- Seven of the 19 children (37%) were in the care and custody of DHS, but had not yet been made wards of the court.

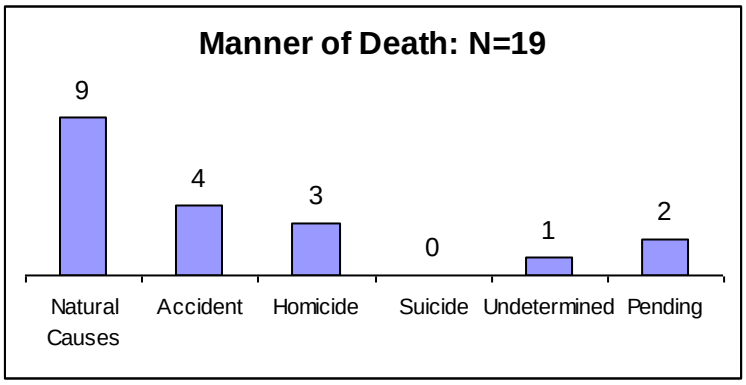




- The range of the children's ages was two months to 20 years with the average being 6.9 years old. Seven (37%) of 19 children were less than six months old at the time of death.



- Six (32%) of the 19 children were placed with a family member at the time of death. The OFA summary reports that the youth identified as absent without leave (AWOLP) had left his residential placement without approval. His mother contacted DHS to report the child had died while living in her home in Ohio.



- Nine (47%) of 19 cases reviewed included documentation that the child died of natural causes. Five of these cases were managed by DHS only, while the other four involved private child placing agencies providing direct foster care services. Each death was a result of their specific medical condition.

- At the time of review, the decision determining the manner of death was pending for two (11%) of 19 cases reviewed. One child was drug exposed, had kidney problems and other medical issues including failure to thrive, which was diagnosed following birth. This child remained hospitalized until his death. The other youth was shot while riding as a passenger in a car while in another state. This youth was still under DHS supervision; however, the youth was absent without leave from placement.

- At the time of review, three (16%) of 19 cases documented that the child died as the result of a homicide. One child sustained an injury while still in the parent's care and custody and was taken to the hospital. CPS was notified of possible abuse or neglect to the child. The youth died in the pediatric intensive care unit and the parents were placed on Central Registry as perpetrators of severe physical abuse. One youth was a non-ward. He was living on his own when he was shot while in an automobile. The police department is investigating the homicide. One child had been placed in a licensed foster home where she sustained a non-accidental injury resulting in her death. CPS investigated and found that there was a preponderance of evidence of child abuse/neglect. The foster parent was arrested and pled no contest to second degree murder.

- Four (21%) of 19 cases reviewed document that the child died as the result of an accident.

- For the seven children ages six months and younger, two children died as a result of physical abuse that occurred prior to the CPS removal, one death was listed as pending, three deaths were due to natural causes

with one mentioning concerns with safe sleep practices, and one death was the result of an accident.

The deaths occurred in eight of Michigan's 83 counties. The table below shows the number of fatalities that occurred per county, the number of active foster care cases active as of 09/30/10, and the number of fatalities per 1000 children in care.

Children in Foster Care

County Name	# of Fatalities	# of Active FC Cases (9/30/10)	Fatalities per 1000 Children
Wayne	7	4544	1.5
Kent	3	973	3.1
Oakland	3	958	3.1
Ingham	2	625	3.2
Washtenaw	1	214	4.7
Kalamazoo	1	520	1.9
Monroe	1	120	8.3
Genesee	1	1134	.9
Total for State	**19**	**16,201**	**1.2**

OFA Findings and Recommendations

For each fatality review, the OFA attempted to identify any findings or concerns that may have adversely impacted child safety, well-being, or permanency at any stage of the child's case. None of the findings concluded that the issue of non-compliance was directly implicated in the child's death. Findings were made not because they were factors in the child's death, but because they provided an opportunity to improve overall practice.

Of the 19 completed fatality reviews, nine cases resulted in no findings, meaning no areas of concern with compliance were noted. Ten of the 19 (53%) 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:
OFA identified the following findings related to child safety:

Foster Parent Training In one of ten cases reviewed, the child placing agency did not ensure that the licensed foster parent was adequately trained to care for the child's medical needs.

Safe Sleep In four of ten cases, safe sleep practices were not consistently implemented by the caregiver. Safe sleep practices are the care and supervision requirements expected of caregivers for young children. These include having an approved crib for the infant free of obstructions that may result in injury to the child.

Central Registry/Criminal Record Clearance In three of ten cases, the required background central registry and/or criminal record clearances were not completed or completed thoroughly.

Time Frame for Completion of Field Investigation In one of ten cases, timeframes for completing investigative steps were not adhered to.

Relative Caregiver Home Study In one of ten cases, proper completion of relative home studies did not occur.

Insufficient Investigation/Verification of Facts In four of ten cases, CPS did not sufficiently investigate allegations or document adequate support for the disposition reached.

Improper Placement and Referral for Licensure In one of ten cases, the unlicensed relative was not thoroughly assessed and as a result was improperly approved for placement and referred for licensure.

Medical Evaluation as part of CPS Investigation In one of ten cases, the CPS investigation of alleged abuse/neglect of the child in the foster home did not include a medical evaluation of the child's sister as required.

Assessment and Determination of Mental Health Status as it Relates to Foster Home Licensing In one of ten cases, prior to recommending a foster home license, the certifying agency did not thoroughly assess and determine how one foster parent's mental health could affect the care of foster children.

Emergency Procedures for Child Experiencing Serious Accident or Injury In one of ten cases, the private child placing agency worker did not make a report to CPS or refer the child for a medical evaluation to assess injuries and the need for treatment.

Completion of Incident Reports In one of ten cases, the incident report completed by the private child placing agency did not accurately reflect the child's injuries.

Mitigation of Foreseeable Risk In one of ten cases, the child placing agency missed an opportunity to prevent or respond to foreseeable risk.

Foster Parent not Familiar with CPR In one of ten cases, the foster parent was unfamiliar with CPR. Although foster parents are not required to be certified in CPR, the foster parent did contact 911 and was provided instructions on administering CPR; unfortunately, the child still died.

Summary of the OFA Recommendations Related to Safety:
For the 19 fatality reviews completed during 2010, OFA issued 30 recommendations as a result of the 20 findings related to safety of children in care. Recommendations were made to various service providers and DHS program offices. Fourteen recommendations were directed toward the DHS local offices, six were directed toward the private agencies involved, five were directed toward BCAL, three were directed toward the CPS program office, and two were directed toward the foster care program office.

- Twenty-one of 30 (70%) recommendations focused on reviews of specific policies and the worker's adherence to those policies.
- Six of 30 (20%) recommendations involved amending policies requiring workers to provide Safe Sleep information to caregivers and to monitor the caregiver's ability to consistently abide by approved practices.
- Two of 30 (6.7%) recommendations related to training for child welfare staff.
- One of 30 (3.3%) recommendations suggested the need for an increased requirement by BCAL that all licensed foster parents be certified in CPR.

Permanency Findings:
OFA identified the following findings associated with permanency:

Placement In two of three cases, placement decisions were not consistent with the child's needs or best interest.

Permanency Planning Conferences In two of three cases, permanency planning conferences were either not conducted or documented as required.

Foster Care Case Closing In one of three cases, standard of promptness was not met in terms of foster care case closure.

Summary of the OFA Recommendations Related to Permanency:

For the 19 fatality reviews completed during 2010, the OFA issued five recommendations related to permanence for the child. Four of the recommendations were directed toward the DHS local offices, and the other was directed toward the private agency involved. The respective agencies responded by providing Corrective Action Plans.

- Two of the four (50%) recommendations made to DHS local offices involved a review of the practices involving Permanency Planning Conferences.
- Two of five (40%) recommendations were relative to a review of workers' attention to contacting the parent of the child as required. One of these recommendations was directed to a DHS local office and the other directed to a private agency.
- The remaining recommendation suggested a review of procedures designed to identify adoptive homes for teenaged children and to decrease the number of children exiting the foster care system without permanency.

Well-Being Findings:
OFA identified the following findings associated with child well-being:

Education Needs In one of five cases, the child was not provided educational stability in care.

Worker and Sibling Visitation In two of five cases, a plan for sibling visitation was not documented and the agency worker did not make required visits to the child in placement.

Referral to Early On In one of five cases, a referral to the Early On Program was made, but not followed up on to ensure service delivery. Early On provides developmental assessments and services to children age zero to three.

Medical Record Maintenance/Medical Passports In one of five cases, the child's pertinent medical information was not documented on the Medical Passport or foster care Initial Service Plan.

Educational, Medical, and Therapeutic Needs In two of five cases, medical, educational and/or therapeutic needs of the child were not met.

Behavior Management Methods In one of five cases, the child's behavior management plan did not document the need for use of a backpack-style harness restraint or identify guidelines describing appropriate use by the foster parent.

Updated Service Plan Content and Completion Requirements In one of five cases, the updated service plans lacked sufficient documentation of the child's

participation with medical providers, prescribed medications, and developmental progress.

Summary of the OFA Recommendations Related to Well-Being:
For the 19 fatality reviews completed during 2010, the OFA issued 11 recommendations related to well-being of the children in care. Recommendations were made to various service providers and DHS local offices. Seven of the recommendations were directed toward the DHS local office, two were directed towards BCAL, one was directed toward FC program office and the other was directed toward the private agency involved with the child's case.

- Two of 11 (18%) recommendations involved a review of the practices for maintaining sibling contacts.
- One of 11 recommended a review of the efforts made to ensure educational stability.
- One of 11 recommended a review of the efforts made to follow through on referrals to Early On.
- One of 11 recommended identification of the steps necessary to ensure all pertinent medical information is documented on the Medical Passport.
- One of 11 recommended development of policies related to providing hormone supplements to children in foster care.
- One of 11 recommended a review of compliance with licensing rules related to behavior management methods.
- One recommendation suggested the worker consult directly with medical providers to obtain a child's medical information rather than rely solely on information provided by the child's foster parent.

QA Unit Assessment

The Michigan Department of Human Services provides protection and care for Michigan's most vulnerable children. Children enter foster care for a variety of reasons and face numerous challenges. None of the 19 fatalities reviewed indicates the child's death was the result of actions on the part of DHS or private agency workers. Many of the OFA findings and recommendations involved non-compliance with existing policies and provide an opportunity to improve case management, training, and supervisory oversight.

Eleven (58%) of 19 cases reviewed by OFA in 2010 documented the child was medically fragile. Eight of the 11 deaths were the result of the child's medical condition and not related to the services provided by DHS.

DHS intervention could not have prevented tragic events such as one child's drowning and fatal gunshot wounds to two children.

There were two cases concerning children who died as result of physical abuse by their caregiver. One child was fatally abused by her parents before coming to the attention of CPS. The other child was fatally abused by a licensed foster parent. OFA findings related to that child's death were submitted to the agencies involved and other units within DHS for response. As a result of review and oversight, the agency responsible for the child's placement implemented corrective action steps to address each specific finding and improve future practice.

Trends related to safe sleep practices, providing training for foster parents, completing required background checks, and improving documentation of medical needs/treatments, have all been identified in prior reviews with recommendations proposed. Action steps have been developed to improve quality of care and outcomes for children. Medically fragile and very young children are especially vulnerable. Proper training for foster parents and accurate, complete documentation and application of medical treatments are vital to promoting a child's quality of care, overall health and well-being. Policy and procedural changes have been implemented to improve practices in this area.

QA Unit Follow-up of Past Findings and Recommendations

Since the publication of the previous fatality report, *Child Fatality Reviews: 4/1/09-12/15/09, Quality Assurance Report*, DHS has taken the following steps to improve practices:

Foster Care Program Office:

A recommendation was made to issue policy clarification regarding documentation requirements for collateral contacts with treatment and service providers. In June 2010, DHS revised policy FOM 722-6, Foster Care-Developing the Service Plan, to clarify documentation requirements. Contacts with treatment providers must now occur monthly and be documented in social work contacts and the service plan report.

A recommendation was made to ensure all time frames are consistent for medical documentation in policies including Foster Care-Developing the Service Plan (FOM 722-6) and Placement Resources: Placement Agency Foster Care (PAFC) Contracted Foster Care (FOM 913-1). In June 2010, DHS revised policy FOM 913-1 to direct that private agency contractors use policy timeframes for medical documentation consistent with FOM 722-6.

A recommendation was made to increase requirements for the documentation of child welfare caseworker contacts including the observation of Safe Sleep practices and to remind providers of their importance. In June 2010, DHS revised the policy titled Foster Care-Developing the Service Plan (FOM 722-6) to enhance safe sleep guidelines. Also, new DHS caseworker visit forms were

developed to guide caseworkers on key elements of quality visits, including sleeping arrangements, medical issues, and education. During the summer of 2010, DHS presented training on caseworker visitation for child welfare workers as part of an ongoing effort to improve Child and Family Service Review outcomes in the areas of caseworker visitation and family engagement. Additionally, DHS workers were mandated to attend training on the role of parent/child visitation in achieving timely reunification. This training, provided by the State Court Administrative Office, was aimed at increasing reunification timeliness and the number of children who achieve permanency through reunification.

A recommendation was made that the foster care program office consider amending the policy titled Foster Care-Developing the Service Plan (FOM 722-6), to require that each foster home visit with a child under 12 months include providing the unlicensed relative or foster parent with written or verbal information describing safe sleep practices, worker observation of the child's sleeping arrangement, and a discussion with the provider on his/her responsibility and commitment to consistently follow safe sleep practices. This recommendation was addressed through implementation of the case worker visit forms. The scheduled March 1, 2011 foster care policy release addresses the foster care worker's role in discussing safe sleep guidelines with the child's caregiver and the steps that must be taken to increase the likelihood that caregiver's are consistently implementing safe sleep practices. DHS also maintains a web site with an extensive array of safe sleep resources, including professional references, brochures and videos.

A recommendation was made to review and implement a training curriculum in conjunction with the new DHS medical director for workers assigned to cases involving medically fragile children. On September 2, 2010, DHS issued L-Letter L-10-111-CW announcing that the DHS Child Welfare Training Institute, in collaboration with the Children's Services Administration's Medical Director, Dr. Zakia Alavi, MD., will offer statewide training to assist child welfare workers and supervisors to more effectively identify and meet the medical and mental health needs of children involved with the child welfare system. These training sessions were open to all child welfare workers and supervisors and attendees were eligible for required in-service training hours. Multiple sessions were provided for each topic and topics included: Failure to Thrive/Reactive Attachment Disorder, Bi-Polar Disorder, Pervasive Developmental Disorder, and Medically Fragile Children. Additional sessions addressing the needs of Medically Fragile Children are scheduled for multiple dates in 2011.

CPS Program Office:

A recommendation was made to improve documentation by caseworkers, including verification that the worker discussed safe sleep practice with the

child's caregivers and observed that safe sleep arrangements were in place. In August 2010, DHS revised policy to implement this recommendation. New DHS caseworker visit forms were also developed by the Federal Compliance Division to emphasize key elements of quality visits. During the summer of 2010, DHS presented training on caseworker visitation for child welfare workers as part of an ongoing effort to improve Child and Family Service Review outcomes in the areas of caseworker visitation and family engagement DHS also operates a safe sleep web site with an extensive array of safe sleep resources including professional references, brochures and videos.

A recommendation was made to amend policies to prohibit placement of a child with a relative if an adult member of the relative's household was previously confirmed as a perpetrator of child abuse or neglect in another state. It was also recommended that the first section of the Initial Relative Safety Screen (DHS-588) be amended to capture whether the caregiver was previously substantiated as a perpetrator of child abuse or neglect in another state. Action is being taken to address this recommendation as DHS is reviewing how best to modify the Initial Relative Safety Screen document.

Bureau of Children and Adult Licensing (BCAL):

A recommendation was made to update rules requiring training for foster parents on infant safe sleep practices. As a result of the recommendation, BCAL now requires bedrooms contain specific requirements for Safe Sleep and foster parent training incorporates information on safe sleep. Additionally, the Initial Foster Home/Adoption Evaluation (BCAL-3130) now requires documentation that the licensing/certification worker ensured the caregiver is in compliance with safe sleep.

Child Welfare Training Institute (CWTI):

A recommendation was made to review and implement a training curriculum in conjunction with the new DHS medical director for workers assigned to cases involving medically fragile children. In conjunction with the DHS Medical Director, the Child Welfare Training Institute (CWTI) has plans to develop, schedule, and implement training regarding the needs of medically fragile children during late spring/early summer 2011.

Recommendations were made to review existing training materials regarding medical documentation and implement a continuing education curriculum for specialists and supervisors in regard to documenting medical information. CWTI has reviewed existing training materials and developed a continuing education curriculum regarding medical documentation.

QA Unit Recommendations

Foster Care Program Office:

- Review policy to determine if DHS staff can conduct 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 themselves via the Internet Criminal History Access Tool (ICHAT).

Field Services Administration:

- 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.

Children's Protective Services Program Office:

Update policy to incorporate safe sleep practices. Require each child's caregiver to demonstrate understanding of safe sleep practices and commit to consistent implementation.