State of Michigan
Department of Human Services

Child Fatality Reviews: 1/1/12-12/31/12
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 under court jurisdiction and placed in foster care by DHS. The fatality review process is overseen by the Office of Family Advocate (OFA), a unit within central office DHS.

OFA Review Process

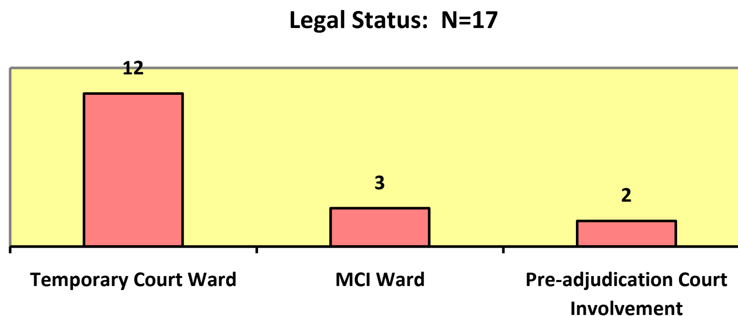
The OFA has developed guidelines to ensure that fatality reviews are consistently independent and comprehensive. Each review is completed by the OFA director or OFA departmental specialist.

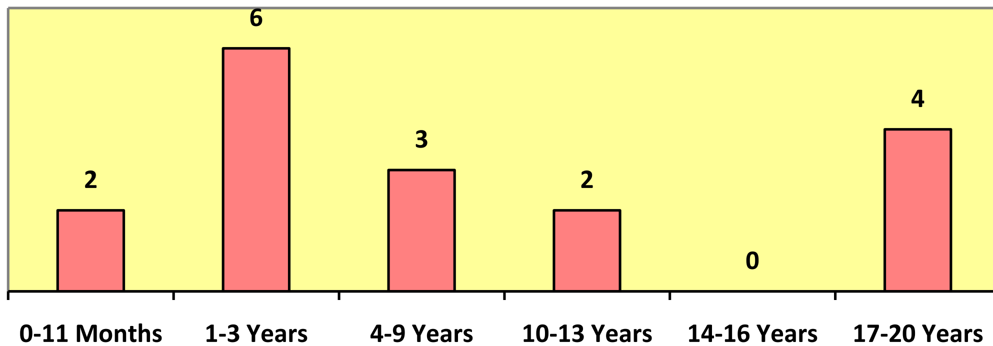
The reviewers examined relevant information, including the child's foster care and adoption file, all Children's Protective Services (CPS) complaints involving the child's foster care home(s), the foster parents' licensing file, police reports, medical, educational, and mental health documents, the child's 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 17 fatality reviews completed during this review period.





- The range of the children's age was 1 month to 19 years old. Two (12%) of the 17 children were less than six months old at the time of death.

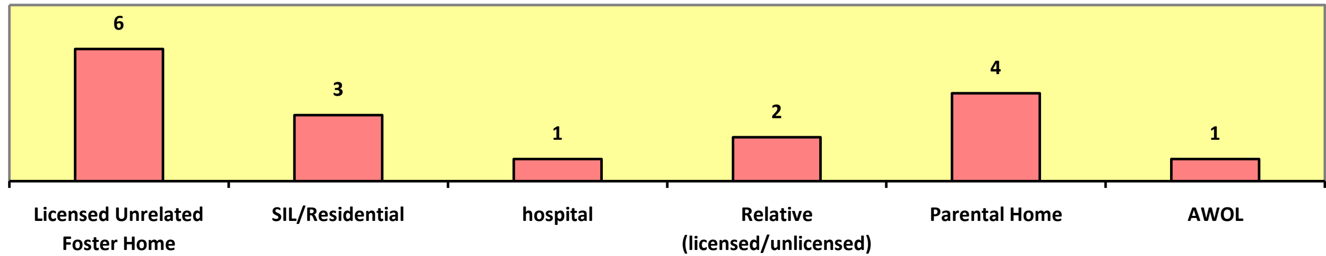
- Almost one quarter, four (24%) of the 17 children, were 17 years or older at the time of death.

Counties where ward deaths occurred

County	Number of 2012 Ward Deaths
Wayne	6
Oakland	2
Genesee	2
Montcalm	1
Antrim	1
Kalamazoo	1
Jackson	1
Livingston	1
Saginaw	1
St. Clair	1
Gratiot	1
Kent	1

- The OFA reviewed 17 ward fatalities that occurred in 12 different counties. Nearly 1/3 of the deaths occurred in Wayne County.

- One death involved 2 different counties: Oakland and Livingston.

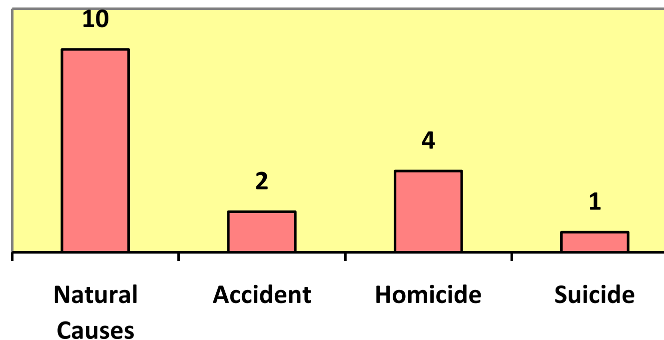


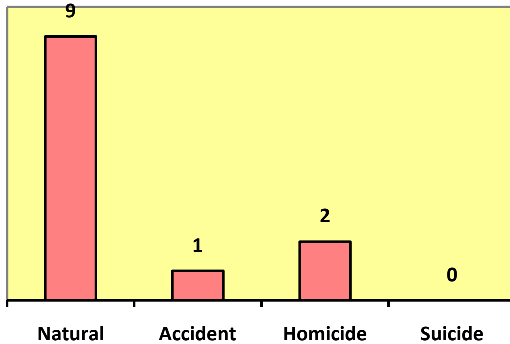
- Two of the four teens (50%) resided in a semi-independent living placement at the time of death, one of the four teens (25%) lived in an licensed unrelated foster home, and one of the four teens (25%) was absent without legal permission from placement at the time of death.

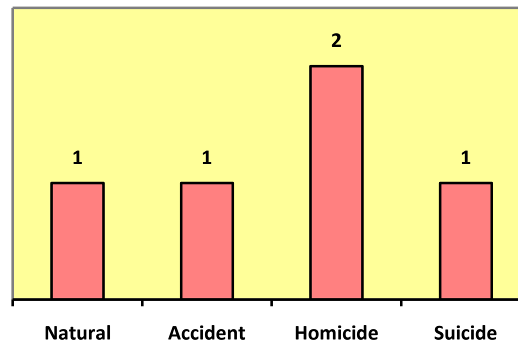
- Four (24%) of 17 children died while residing in the parental home. One (25%) of the four children died after a car accident, two (50%) of the four children died of natural causes, and one (25%) of the four children died due to homicide caused by the parent.

- Six (35%) of the 17 children died while residing in a licensed unrelated foster home. Four (66%) of the six children died of natural causes, one (17%) of the six children died of homicide related to injuries the child incurred before placement, and one (17%) of the four children died of suicide.

Manner of Death: N=17



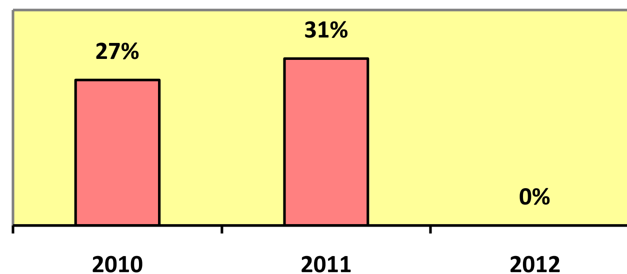




- Nine (75%) of the twelve children UNDER the age of 13 died of natural causes while only one (20%) of the five children OVER the age of 13 died of natural causes.

- The two children OVER the age of 13 that died of homicide both died after receiving a gunshot wound by non-family members. The 2 children UNDER the age of 13 that died of homicide both died after succumbing to injuries inflicted by the biological parent.

- The child OVER the age of 13 that died of suicide did so after shooting himself accidentally while playing with the foster parent's gun, the medical examiner however ruled the death a suicide.



- Though the percent of death related to unsafe sleeping conditions of an infant had been rising in past years, there were no deaths related to unsafe sleep in 2012.

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 17 completed fatality reviews, five cases resulted in no findings, meaning no areas of concern with compliance were noted. Twelve of the 17 (70%) 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*:**

For the 12 fatality reviews completed during 2012 in which findings and recommendations were identified, the OFA issued 18 recommendations as a result of 31 findings related to safety of children in care.

***Summary of the OFA Findings Related to Safety*:**
Insufficient contacts: Eight of the 31 (26%) findings involved DHS or private contracted agency providers not making sufficient contacts with family members.

Delayed intervention: Six of the 31 (19%) findings involved DHS or a private contracted agency delaying when responding to a high risk situations. The specific incidences reviewed were not necessarily the same incidences related to the child's death and could have occurred at any point of the entire case.

Incorrect dispositions: Three of the 31 (9%) findings involved CPS making an incorrect disposition following an investigation. In each case, the county corrected the disposition after review.

Standards of Promptness: Three of the 31 (9%) findings involved DHS not adhering to the standards of promptness with regards to completing an investigation and documentation.

Safety Planning: Two of the 31 (6%) findings involved a lack of safety planning. 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.

***Summary of the OFA Recommendations Related to Safety*:**
Fourteen recommendations were directed toward the DHS local county offices, three were directed toward the private agencies involved, and one was directed towards CPS program office.

- Fourteen of the 18 (78%) recommendations focused on a worker or agency reviewing or complying with a specific policy.
- Two of the 18 (12%) recommendations suggested the need for training related to safety planning.
- One of the 18 (5%) recommendations involved a request to work with the local court and provide the OFA with a plan regarding local procedures.
- One of the 18 (5%) recommendations involved a recommendation to amend current law or policy.

***Wellbeing findings*:**

For the 12 fatality reviews completed during 2012 in which findings and recommendations were identified, the OFA issued 12 recommendations as a result of 10 findings related to the well-being of children in care.

***Summary of the OFA Findings Related to Well-Being*:**

Foster Care visitation: In three of the 10 (30%) findings, the foster care agency worker did not complete the required face-to-face contacts with the foster child after placement.

Missing documentation: In two of the 10 (20%) findings, the worker did not complete documentation as required by policy.

Request to review current policy/training: In two of the 10 (20%) findings, the OFA requested DHS Central Office review current policy or training curriculum.

Policy violations: Three of the 10 (30%) findings involved other policy violations related to steps in conducted CPS investigations, though none of these violations were related in any way to the child's death.

***Summary of the OFA Recommendations Related to Well-Being*:**

Eight recommendations were directed toward the DHS local program offices, three were directed towards DHS Central Office, and one was directed to BCAL.

- Four of the 12 (33%) recommendations involved the worker/supervisor involved with a case reviewing relevant policy.
- Three of the 12 (25%) recommendations involved the local county developing a corrective action plan which ensured future policy compliance.
- Three of the 12 (25%) recommendations involved DHS Central Office reviewing current policy or training.
- One of the 12 (8%) recommendations involved a local county reviewing a CPS disposition.
- One of the 12 (8%) recommendations involved a request for BCAL to review a local county's compliance with child placing agency rules.

OFA Fatality Assessment

The Michigan Department of Human Services provides protection and care for Michigan's most vulnerable children. When a child enters into foster care, DHS assumes the responsibility to provide for the safety, well-being, and permanence of that child. Though many of the OFA findings and recommendations involve non-compliance with existing policies, none of the 17 fatalities reviewed indicate that the child's death was the direct result of actions or omissions on the part of DHS or private agency workers. They do, however, provide an opportunity for DHS to examine and improve its 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. Ten (59%) of the 17 cases reviewed by the OFA in 2012 documented the child died as a result of medical issues 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.

Although there was a slight increase in the number of ward fatalities in 2012 compared to 2011, none of the deaths in 2012 were related to issues involving unsafe sleeping conditions. This year, DHS' Family Preservation programs joined Child Protective Services and Foster Care by instituting requirements that mandate workers to educate parents of children 12 months or under on the tenants of safe sleep practice.

Follow-up of Past Findings and Recommendations
Since the publication of the previous fatality report, *Child Fatality Reviews: 1/1/11 – 12/31/11, Office of Family Advocate Report,* DHS has taken the following steps to improve practices:

Foster Care Program Office:
A recommendation was made to 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.

Though DHS foster care has not undertaken any formal suicide prevention/depression education initiative, foster care policy requires "a*ll children entering foster care are required to have a mental health screening within 30 days of removal. The mental health screening is to be performed during initial and subsequent periodic or yearly well child exams (FOM 802, p. 1).* The policy also outlines the specific role of the caseworker in

completing the mental health screen and what steps should be taken to follow up should a mental health concern arise.

Additionally, the Bureau of Child Welfare, Permanency Division has participated in a work group for Youth At Risk established by Michigan Department of Community Health's (MDCH) Injury and Violence Prevention Section. MDCH applied for a grant to develop and implement statewide and tribal suicide prevention and early intervention strategies. To date, DCH has not received notice of the grant being awarded and a date for the work group has not been scheduled.

Family Preservation Services:
A recommendation was made to 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.

Though DHS Family Preservation Services (FPS) has not undertaken any formal suicide prevention/depression education initiatives, the FPS Program Office is presently working with the Child Welfare Training Institute to enhance training for workers who work with adolescents affected by depression and suicide.

Child Welfare Training Institute:
A recommendation was made to develop 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.

In the past year, CPS Program Office teamed with the Office of Family Advocate to develop a 'Safety Planning and Assessment' training. Representatives from each unit conducted the training in a number of counties and DHS' Child Welfare Training Institute has used the script to develop an on-line E-learning course and on-going workshop specifically focused on safety planning. CPS Program Office and the Office of Family Advocate will continue to offer the training to individual counties that request it in the upcoming year.

Children's Protective Services Program Office:
A recommendation was made to 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.

Nearly 150 Michigan infants die every year as a result of being placed in an unsafe sleep environment. The majority of these parents have been provided guidance at the time of the birth of their child that the decision to bed-share, or place their child in an unsafe sleep environment could be harmful to their children.

CPS Program Office has made great strides in educating DHS workers, service providers, and the general public about safe sleep practices for infants. This past year, in partnership with the MDCH, DHS spread the message about putting infants to sleep in a safe

environment through coordination with local county DHS offices, press events, the development of a 9 minute public service announcement, and enlisting the efforts of Michigan's First Lady Sue Snyder.

BCAL:
A recommendation was made to take steps to determine if the current PRIDE training curriculum includes sufficient information and resources regarding suicide prevention, depression management, and accessing mental health services for applicants interested in fostering at-risk adolescent wards.

Though no formal steps were made to evaluate the current PRIDE training, the Office of Family Advocate in conjunction with BCAL and CWTI has begun the process of revamping BCAL training for new licensing workers. As the three units work together to update training, attention will be paid in the upcoming year as to the tenets of PRIDE training as it relates to suicide and depression management for new foster parents.

OFA Unit Recommendations

Business Service Centers:

- Work with county directors and local office management to ensure child welfare staff complete timely and quality home visits as outlined in policy during the first 60 days after a child enters foster care.

Foster Care Program Office:

- Continue to consider the development of a suicide prevention/depression education initiative for foster parents and case managers working with high-risk adolescent wards.

Family Preservation Program Office:

- Continue to consider developing a suicide prevention/depression education initiative for the family preservation programs, including the Family Reunification Program which works with temporary court wards.

Child Welfare Training Institute:

- Continue efforts to roll out on-line and classroom training for all DHS child welfare staff concerning behaviorally based safety plans and structuring for safety in high risk situations.

BCAL/Child Welfare Training Institute:
- Continue to take steps to determine if the current PRIDE training curriculum includes sufficient information and resources regarding suicide prevention and depression management.