State of Michigan
Department of Human Services

Child Fatality Reviews: 1/1/13-12/31/13
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

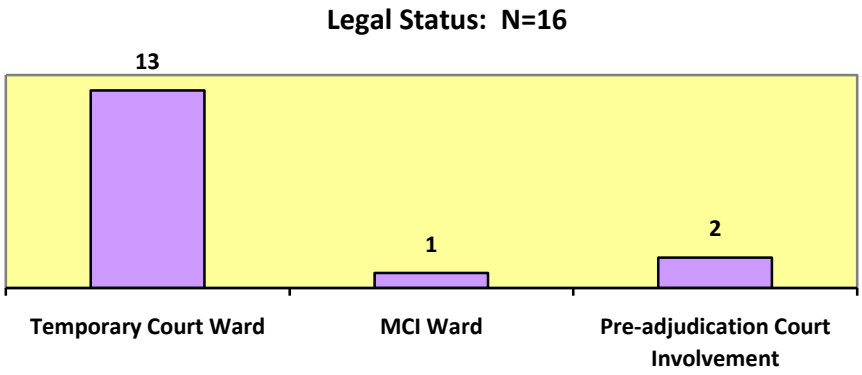
The OFA has developed guidelines to ensure that fatality reviews are consistently independent and comprehensive. Each review is completed by the OFA director or OFA departmental specialist.

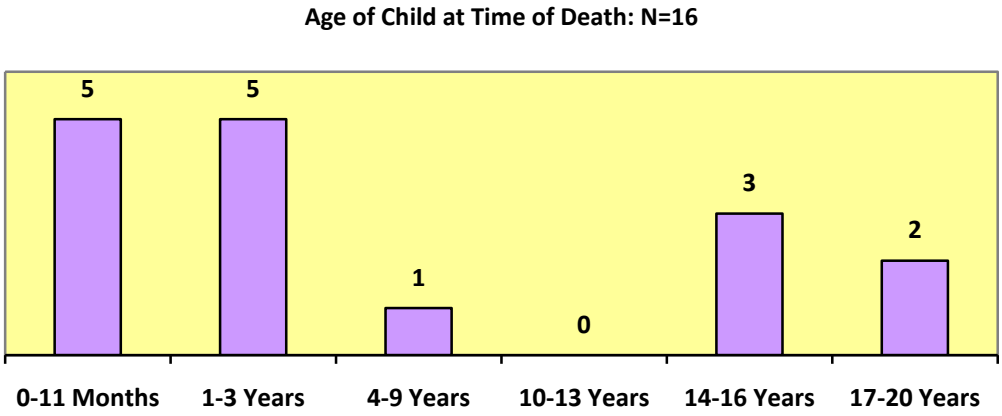
The reviewers examined relevant information, including the child's foster care and adoption file, all Children's Protective Services (CPS) complaints involving the child's foster care home(s), the foster parents' licensing file, police reports, medical, educational, and mental health documents, the child's 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. In some cases, OFA staff traveled to the county and met with all workers involved with the case to give feedback about strengths and findings noted from the review.

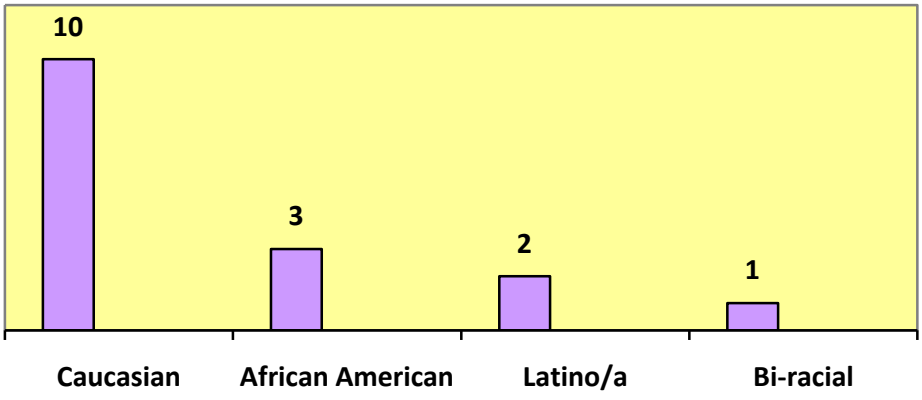
Demographics

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 19 years old. Four of the 16 children (25%) were less than six months old at the time of death. Five of the 16 children (31%) were over the age of 13 at the time of their death.



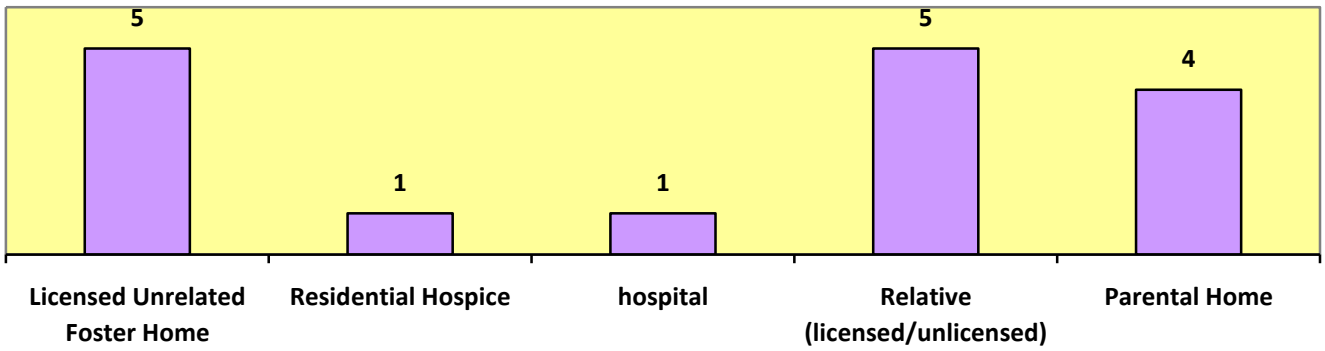
- 2 of the 4 children that were in an unsafe sleeping position (50%) were Caucasian. 1 of the 4 children (25%) was African American and 1 of the 4 children (25%) was Latino.

Counties where ward deaths occurred

County	Number of 2013 Ward Deaths
Genesee	3
Wayne	2
Oakland	2
St. Clair	2
Eaton	1
Calhoun	1
Lenawee	1
Tuscola	1
Livingston	1
Ogemaw	1
Ingham	1

- The OFA reviewed 16 ward fatalities that occurred in 11 different counties. 8 of the 16 deaths (50%) occurred in one of the six DHS urban counties (Wayne, Oakland, Genesee, Kent, Macomb, or Ingham).

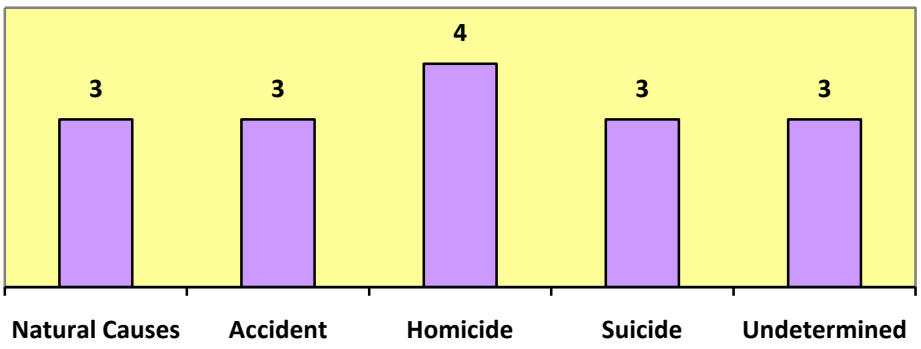
Living Arrangement at Time of Death: N=16



- Five of the 16 children (31%) died while living in an unrelated foster home. Five of the 16 children (31%) died while living with a relative, either licensed or unlicensed. Four of the 16 children (25%) died while living with a biological parent. Two of the 16 children (13%) resided in a medical setting, whether a hospital or residential hospice.

- Two of the five teens (40%) resided in an unrelated foster home at the time of death, one of the five teens (20%) lived in the biological home, one of the five teens (20%) lived in a residential hospice, and one of the five teens (20%) lived in an unlicensed relative home.

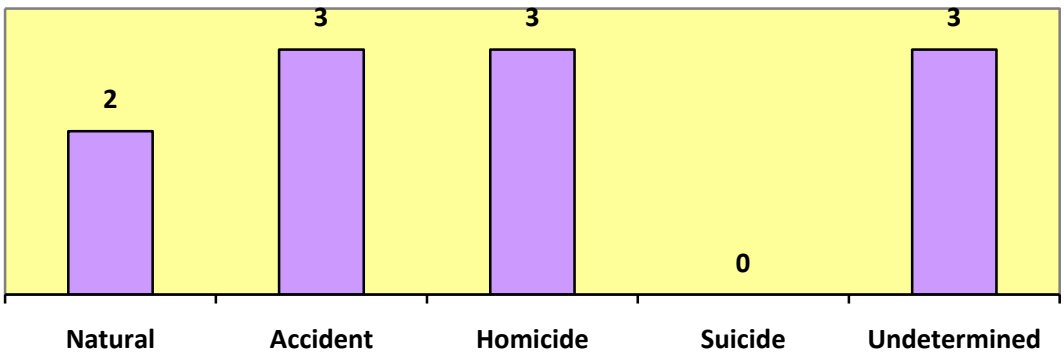
Manner of Death: N=16



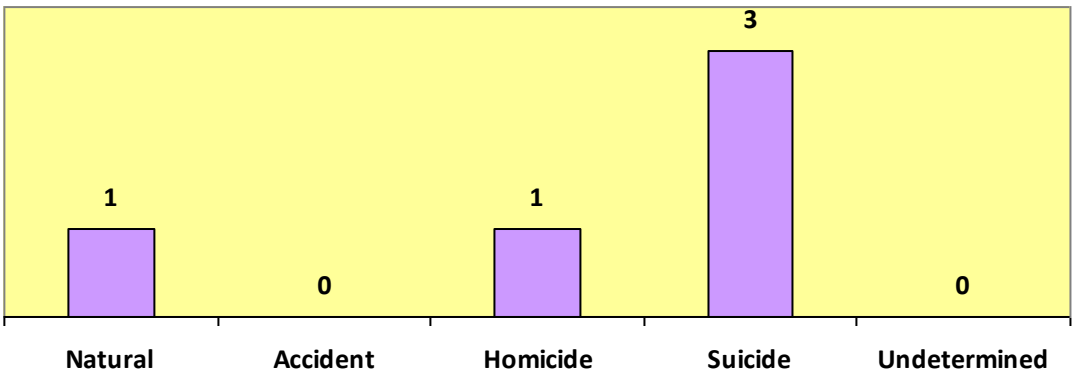
- Individual autopsies were used to determine the manners of death for all 16 children.

- The causes of death range from various medical issues unrelated to abuse or neglect in 4 cases, positional asphyxia in 2 cases, gunshot wounds in 2 cases, choking in 2 cases, hanging in 2 cases, drug overdose in1 case, blunt force trauma inflicted by the parent in 1 case, and sudden unexplained infant death in 2 cases.

Manner of death for children UNDER the age of 13 years: N=11



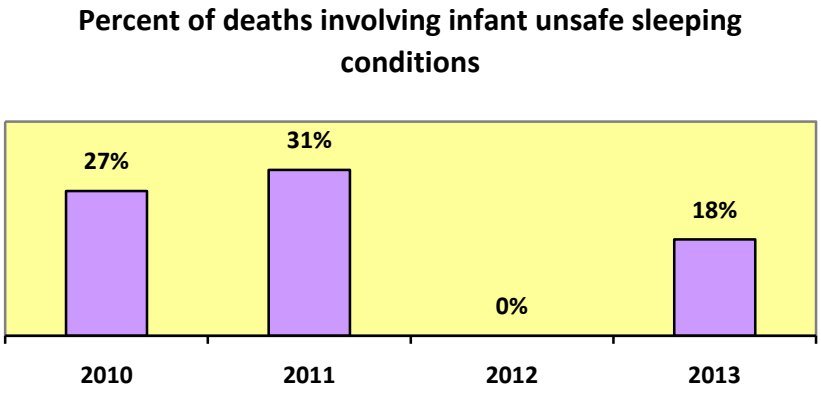
Manner of death for children OVER the age of 13 years: N=5



- Only 2 of the 11 children (18%) UNDER the age of 13 died from natural causes. 3 of the 11 children (27%) died from an accident, 3 of the 11 children (27%) died from homicide related to a previous caregiver, and 3 of the 11 children (27%) died of undetermined causes (2 of these cases involved the unsafe sleep of a newborn).

- 3 of the 5 children OVER the age of 13 (60%) died by suicide. 1 of the 5 children OVER the age of 13 (20%) died from natural causes and 1 of the 5 children (20%) OVER the age of 13 died from homicide.

- The child OVER the age of 13 that died of homicide died after receiving a gunshot wound by non-family members. The 3 children UNDER the age of 13 that died of homicide all died after succumbing to injuries inflicted by the biological parent.



- 3 of the 16 cases (25%) involved an infant under the age of 12 months that was put into a compromised sleeping position by the caretaker.

OFA Identified Strengths:

In 2013, the OFA began to identify strengths related to exceptional actions noted in the documentation. 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 all 16 fatality reviews; in total there were 40 strengths identified.

Identified Strengths:

Consideration as to out-of-home placements of children: 8 of 16 cases (50%) involved DHS staff taking exceptional actions in order to locate an out-of-home placement that would best suit the child.

Exceeding parenting time standards: 5 of the 16 cases (31%) involved DHS staff developing plans which enabled parents to have extraordinary amounts of parenting time with their children that exceeded policy expectations.

Exceptional documentation: 5 of the 16 cases (31%) involved DHS staff completing detailed documentation throughout a case, exceeding required standards.

Face to face visits with foster parents: 4 of the 16 cases (25%) involved a DHS worker exceeding the number of face to face visits required with the foster parent and child within the first 60 days of placement.

Providing safe sleep information: 4 of the 16 cases (25%) involved one or more workers supplying and documenting detailed safe sleep information shared with a client who has a child under the age of 12 months old.

Exceptional coordination with outside agencies: 3 of the 16 cases (19%) involved a DHS worker successfully coordinating efforts with an outside agency such as law enforcement or medical.

Reports completed and approved ahead of required timeframes: 2 of the 16 cases (13%) involved a local office completing and approving reports well ahead of required expectations.

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 or wellbeing at all stages of the child's involvement 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 16 completed fatality reviews, 7 cases resulted in no findings, meaning no areas of concern with compliance were noted. 9 of the 16 (56%) cases 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.

***Safety Findings*:**

For the 9 fatality reviews completed during 2013 in which findings and recommendations were identified, the OFA issued 21 findings related to areas affecting a child's safety and made 27 recommendations to the DHS local county and central offices.

***Summary of the OFA Findings Related to Safety*:**
Insufficient contacts: 5 of the 21 (23%) findings involved DHS or private contracted agency providers not making sufficient contacts with family members.

Safety Planning: 4 of the 21 (19%) findings involved a lack of a documented safety plan concerning a high risk situation. An effective safety plan identifies specific actions that the youth or caretaker can immediately take to prevent or respond to immediate risk factors related to factors such as substance dependency, family violence, homelessness, etc… prior to DHS making a referral or parents participating with services.

Incomplete investigations: 4 of the 21 (19%) findings involved CPS closing an investigation before completing all required activities.

Incorrect dispositions: 3 of the 21 (14%) findings involved CPS making an incorrect disposition following an investigation. In each case, the county corrected the disposition after review.

Delayed intervention: 2 of the 21 (9%) 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.

***Summary of the OFA Recommendations Related to Safety*:**
22 of the 27 recommendations dealt specifically with safety findings. 18 recommendations were directed toward the DHS local county offices, 2 were directed toward the private agencies involved, and 2 were directed towards CPS program office.

- 10 of the 22 (45%) recommendations required the local DHS or private agency to review a policy or practice with workers.
- 9 of the 22 (41%) recommendations required the local agency to comply and/or develop a plan to ensure future compliance with a specific policy.
- 2 of the 22 (9%) recommendations required Program Office to consider a new policy or practice.
- 1 of the 22 (5%) recommendations required a local DHS agency to conduct a random sample of case reviews.

***Wellbeing findings*:**

For the 9 fatality reviews completed during 2013 in which findings and recommendations were identified, the OFA issued 5 recommendations to the DHS local county and central offices as a result of 5 findings related to the well-being of children in care.

***Summary of the OFA Findings Related to Well-Being*:**
Foster Care visitation: In 3 of the 5 (60%) findings, the foster care agency worker did not complete the required face-to-face contacts with the foster child after placement.

Missing contacts: In 1 of the 5 (20%) findings, the worker did not complete required collateral contacts.

Standards of Practice: In 1 of the 5 (20%) findings, the worker did not turn in paperwork timely.

***Summary of the OFA Recommendations Related to Well-Being*:**
5 recommendations were directed toward the DHS local and private agencies.

- 5 of the 5 (100%) recommendations required the local DHS or private agency to review a policy or practice with workers and/or develop a plan to ensure future compliance with that policy.

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 current policy or practice, none of the 16 fatalities occurred as a result of actions or omissions on the part of DHS or private agency workers. The findings and recommendations 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. 7 of the 16 cases (43%) reviewed by the OFA in 2013 documented the child died as a result of medical issues not related to the services provided by the DHS. Medical examiners could not determine the manner or cause of death for 1 of the 16 children (6%) and labeled the death as Sudden Unexplained Infant Death.

Though DHS often provides numerous services to children and family, some children die from tragic events that DHS could not have prevented. 1 of the 16 cases (6%) involved a child dying after choking on a sandwich. 1 of the 16 cases (6%) involved a fatal shooting of a teenager by his peers. 3 of the 16 cases (18%) involved teenagers committing suicide despite DHS providing numerous services to them.

In 2013, 3 of the 16 (18%) were related to issues involving infants put in compromised sleeping conditions. 1 of the children died while placed in a foster home, 1 died while placed in the biological parent's home, and 1 child died while placed with an unlicensed relative.

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

Business Service Centers:
A recommendation was made to 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 and Family Preservation Office:
A recommendation was made to continue to consider the development of a suicide prevention/depression education initiative for foster parents and case managers working with high-risk adolescent wards.

Staff from the Office of Family Advocate, along with representatives from DHS Program Office, Department for Continuous Quality Improvement, and Office of Workplace Development and Training, have partnered with the Department of Community Health and the Michigan Association for Suicide Prevention to begin a comprehensive suicide prevention/depression management initiative. The initiative has two major goals, the first is to hold the first statewide suicide prevention conference sponsored by the three agencies, with a target date of April 2015. The second is to work with suicide prevention experts to assess and evaluate if DHS has sufficient services and support for older youth in care.

Child Welfare Training Institute:
A recommendation was made to 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.

DHS's Child Welfare Training Institute continued to work with the Office of Family Advocate and CPS Program Office to track and provide training for all DHS child welfare staff concerning safety assessment and planning. In the past year, staff from both offices conducted 17 trainings in as many counties across all five Business Service Center districts. CWTI developed an on-line version of the training and has begun to develop resources which will allow for additional trainers statewide. Response to the training has been overwhelmingly positive.

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

This past year, DHS's Office of Workplace Development and Training reviewed the PRIDE training material and determined that more information could be added regarding suicide prevention and depression management. To that end, DHS has partnered with the Department of Community Health in seeking a grant that would provide Safetalk, a suicide prevention training, to foster/adoptive/kinship parents and caseworkers statewide, both public and private, over the next five years. The Department will continue to explore depression management learning opportunities for caregivers and workers.

OFA Unit Recommendations:

Children Services Administration:

- Determine what, if any, barriers exist at the local level which may prevent or deter workers from consistently making required home visits and develop a comprehensive statewide plan of action to address those barriers.

Child Welfare Training Institute, Children's Services Administration, Office of Family Advocate:

- Continue efforts to provide on-line and classroom training for all DHS child welfare staff regarding the consistent development of behaviorally based safety plans which address immediate risk and structuring for safety between home visits.

Office of Family Advocate, Children's Services Administration:

- Continue efforts to develop a suicide prevention/depression management initiative concerning adolescents in foster care by assisting in planning the statewide conference slated for 2015 and examining data concerning these cases in an effort to determine what, if any, additional efforts DHS should be making with this high risk population.