

**State of Michigan
Department of Human Services**

**Child Fatality Reviews: 4/1/08 - 3/31/09
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 for children in DHS care; and to give children in DHS care 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.

A settlement agreement was signed July 3, 2008 and a final consent decree was entered on October 28, 2008. Since then, DHS has made significant strides to improve the quality of service 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, and developing extensive 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.

The Child Welfare Quality Assurance (QA) Unit is responsible for analyzing results and incorporating the findings and recommendations from the reviews into relevant QA activities. The QA Unit has been established as a division of the Child Welfare Improvement Bureau in the Children's Services Administration to ensure the provision of service 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.

This report is a summary of the completed fatality reviews concerning 28 children: 19 children who died between 4/1/08 and 3/31/09 and 9 deaths which occurred prior to 4/1/08 and not included in the previous report.

Process

The QA Unit's source material included child fatality reports completed by the Office of Family Advocate (OFA), the Michigan Public Health Institute - Citizen Review Panel (MPHI-CRP) and the Office of Children's Ombudsman (OCO). The OFA, MPHI-CRP and the OCO reviewers wrote an individual report for each child fatality.

The fatality review process was overseen by the OFA, whose director facilitated the reviews and ensured that a qualified reviewer conducted each review. The reviewers examined relevant information, including the child's foster care and adoption file, Children's Protective Services (CPS) complaints involving the child's foster care home(s), if any, the foster parents' licensing file, police reports, medical, educational, and mental health documents, the child's legal file, placement history, and all other information related to the child death.

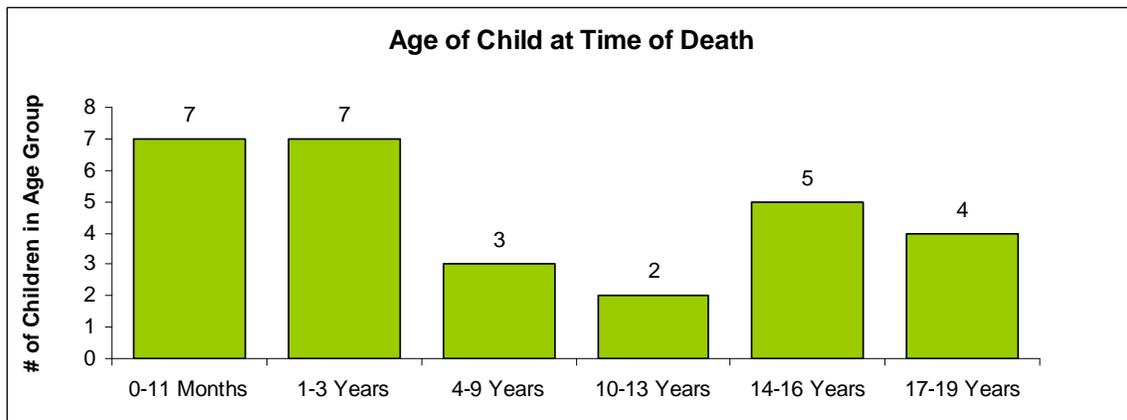
The Office of Family Advocate sent completed summaries to the QA Unit. The QA Unit reviewed the individual reports for each of the 28 child fatalities. Information from these reports was compiled and used for analysis. The QA Unit used the Services Worker Support System (SWSS) to expand the information from the fatality review summaries. Specific demographic data, such as the child's age, race, gender, and living arrangement, was derived from SWSS data.

Results

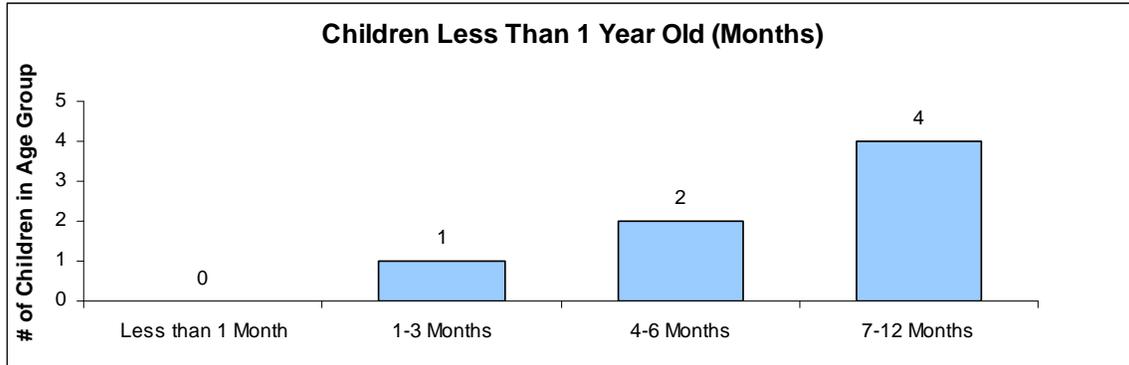
Child welfare stakeholders completed 28 fatality reviews for this review period. The OCO reviewed one of these cases. The MPHI-CRP reviewed one of these cases. The OFA oversaw the review of the remaining 26 cases.

Of the 28 cases reviewed, 17 (60.7%) of the cases were under the direct supervision of DHS and 11 (39.3%) were under the direct supervision of private child placing agencies (CPA). Eighteen of the 28 children (64.3%) were male and 10 (35.7%) were female.

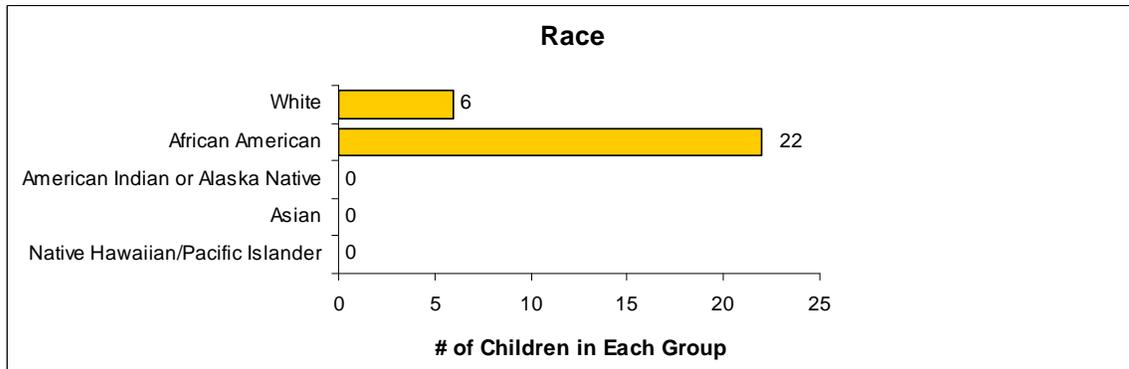
The average age of the children was 7.6 years at the time of death. Fourteen (50%) of the children were three years old or younger when they died. The graph below illustrates the age of the children.



Of the children who died during this period, seven (25%) were under the age of one. The graph below shows the age of these children in months.



Twenty-two of the children (78.6%) were African American and six (21.4%) were white. The graph below shows the number of children in each racial group.

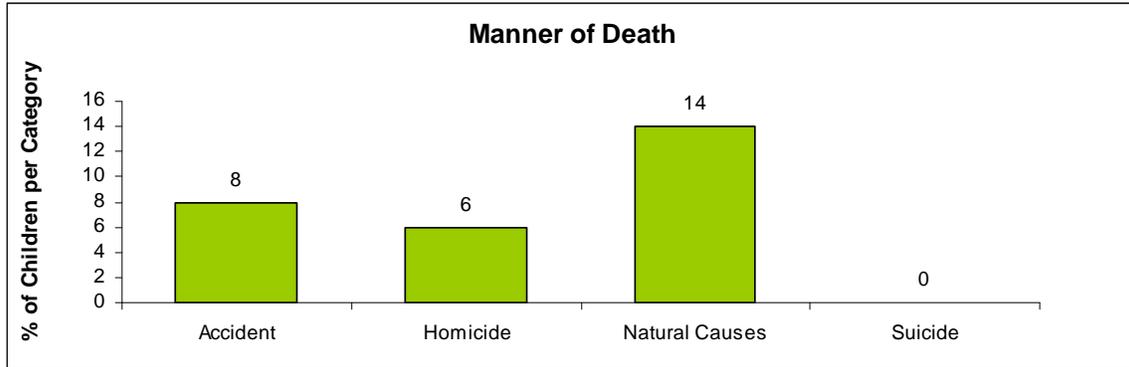


Half of the children, 14, died of natural causes. Eight of the fatalities (28.6%) were accidental and six (21.4%) were homicides. None of the cases reviewed involved suicide.

The deaths classified as accidental included: two from automobile accidents, two that were a result of house fires, and one each due to drowning, overdose, asthma attack, and being hit by a moving vehicle. Of the six children classified as homicides, five died from gunshot wounds. All of the children who died from gunshot wounds were between the ages of 14 and 18 years. One child under the age of three died from injuries related to shaken baby syndrome. While the child's death occurred in a foster care placement, the injuries were sustained prior to the placement. None of the deaths reviewed were a direct result of caretaker abuse/neglect.

Nine children were born with significant medical issues. Of these, six died prior to their first birthday. All nine of these children died as a result of their specific medical condition.

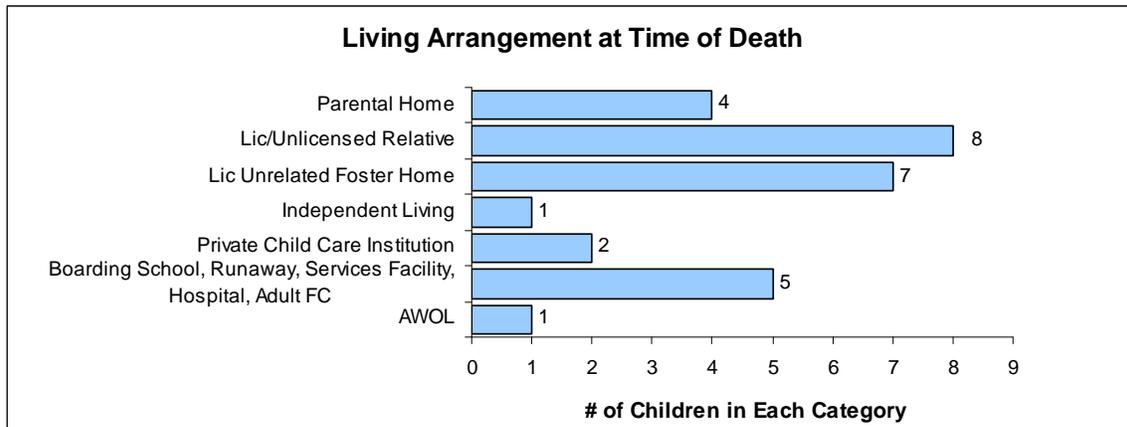
The manner of death for the 28 fatalities is illustrated in the graph below.



The deaths occurred in nine of Michigan's 83 counties. The table below shows the number of fatalities that occurred per county, the number of active foster care cases on March 31, 2009. The totals for children in care in the state are at the bottom of the table.

County Name	Children in Foster Care	
	# of Fatalities	# of Active FC Cases (3/31/09)
Cass	1	123
Genesee	3	1,298
Gladwin	1	12
Gratiot	1	57
Jackson	1	289
Kent	1	954
Ottawa	1	139
Saginaw	1	328
Wayne	18	5,238
Total for State	28	17,570

Eight (28.6%) of the children were living with a relative when they died. Seven (25%) were in a licensed unrelated foster home. Five (17.9%) had a living arrangement of boarding school, runaway, services facility, hospital, or adult foster care. Four (14.3%) were living in a parental home. Two (7.1%) resided in private care institutions. One child was in independent living and one was absent without legal permission. The graph below illustrates the living arrangement of these children.



Reviewer Findings

The Office of Family Advocate, the Office of Children’s Ombudsman and the Michigan Public Health Institute – Citizen Review Panel studied 28 fatalities and made findings of non-compliance with specific policies, laws or best practices. Twenty-seven of the reviewed cases detailed an instance in which the supervising agency did not follow existing policy properly.

Specific reviewer comments regarding policy violations:

Services Worker Face-to-Face Contacts (FOM 722-6 and PSM 713-3)

- No documented face-to-face contact by the foster care worker with the child in four years while the child was in residential care.
- No documented face-to-face contact by the foster care worker for the eight weeks preceding a child’s death.
- Three updated service plans, two consecutive, with no documented contacts by the foster care worker with any service provider.
- Fifteen missing contacts in one initial service plan and two updated service plans.
- No documentation in residential updated service plans of any face-to-face contact with the foster care worker in over three years.
- No face-to-face contact in 16 weeks.
- No face-to-face contact in initial service plan, none attempted with parents or hospital personnel.

- Sibling not interviewed for 18 days.
- Lack of interviews with alleged victims and perpetrators.
- CPS did not meet standard of promptness for face-to-face contact.

Relative Caregiver / Guardian Home Study Outline (FOM 722-3)

- Home study was not completed as required.
- There was no documentation of a Law Enforcement Information Network (LEIN) request.

Medical Record Maintenance / Medical Passports (FOM 722-6)

- During and after a child's hospitalization, no documentation in DHS or private child placing agency case records of any direct contact with the treating physician, hospital discharge instructions or medical treatment records.
- Updated service plan indicating child had been taken off her apnea monitor without any corresponding documentation of any doctor's order. The parent agency treatment plan for the same period directed the foster parents to use the monitor whenever the child "is not within direct eyesight."
- No documentation of parental consent for psychotropic medications.
- The child's physician was changed without documenting either of the exceptions: The child is in a managed care plan or it presents an unreasonable burden for the new caregiver.
- Multiple medical appointments, services and medications which were apparently never reported by the private child placing agency to the DHS foster care worker.
- Child was rushed to the hospital after pulling out her tracheotomy tube but no documentation was in the case record or any safety plan to prevent the child from pulling the tracheotomy tube out in the future or regarding changing the level of supervision necessary for the child.
- Medical information was included in the court report, but no medical records for these incidents were found in the case record.

Obligation to Report Suspected Abuse and Neglect (FOM 722)

- Mandated reporters failed to make a timely report to CPS as directed by the Child Protection Law.

Child Death Reporting Requirements (FOM 722-2)

- Improper procedures for reporting child death.

CPS Risk Assessment (PSM 713-11)

- CPS investigation documented a mother's admission of the use of marijuana during her pregnancy and that she tested positive at the child's birth, but did not find a preponderance of evidence of physical abuse.

- CPS investigation documented very poor home conditions, where CPS required the mother to voluntarily place the children until repairs could be made, but did not find a preponderance of evidence of environmental neglect.
- Failure to report to CPS that a foster mother was allowing her 29 year old son to have continued unsupervised contact with a 15 year old foster child, against the direction of the foster care worker, after allegations of sexual activity between them.
- Infant Safe Sleep practices were not used for a child under one year of age.
- No contact with the doctor regarding any potential concerns.
- Failure to substantiate physical abuse on a newborn who tested positive for cocaine.

Case Records (FOM 722-5)

- CPS investigative reports were missing.

CPS Decision to Reject (PSM 712-7)

- Notation that CPS complaint was rejected after preliminary investigation, but no documentation in the file of any preliminary investigation.

Updated Service Plan Content and Completion Requirements (FOM 722-9)

- Consecutive plans were both completed on the same date and were virtually unchanged.
- Plan was not completed until six months after child's death.

Parent Agency Treatment Plan and Service Agreement Requirements (FOM 722-8C)

- Were not signed by all parties.
- Contained noted inaccuracies and inconsistencies.
- Indicated it was developed with the help of the birth mother when case information indicated otherwise.
- No parent agency treatment plan was completed.

In addition to policy violations, reviewers noted concerns regarding the quality of services provided to children and families as well as questions about supervisory oversight. Comments included:

- The CPS investigation was not thorough in that it lacked verification and/or follow up of asserted case facts.
- CPS supervisory oversight of cases was inadequate to ensure child safety and support quality casework.
- Foster care missed opportunities to provide meaningful intervention.
- CPS did not accurately document family history, potentially leading to an improper assessment of family functioning.

Quality Assurance Assessment

Inadequate oversight / monitoring of the foster care case by both the DHS foster care worker and supervisor is an ongoing quality assurance concern. Untimely reports, lack of required case contacts, and failure to follow defined policy are issues that supervision is responsible for monitoring.

One child was involved in four investigations over four years; the reviewer noted no documented face-to-face contacts with any alleged perpetrator, victim, witness, or collateral contact in any of the four investigations. All of the reports had been approved by the involved supervisor. Additionally a foster parent was listed on the central registry as a perpetrator and the information was not documented or provided to Bureau of Children and Adult Licensing.

Recommendations

Recommendations are made by the QA Unit based on both specific responses from the case reviewers and overall trends observed as reports were compiled. The recommendations below involve five different administrative units. A general recommendation is for local offices to review policy to ensure consistent application by all service providers. Specific recommendations for the involved local office were made directly to the local office at the conclusion of each individual review. Notable recommendations were for DHS and private child placing agencies (CPA) to review specific procedures relevant to the files reviewed and for Bureau of Children and Adult Licensing and the Child Welfare Contract Compliance Unit to further review two different private CPAs to determine whether further actions, including restricting or eliminating current programs, should be taken.

Children's Protective Services Program Office:

- Amend policy requiring medical evaluations to include the requirement to obtain a medical evaluation of any alleged child victim who cannot communicate.
- It is recommended that a standardized mandated reporters training be developed. It is suggested that all DHS and CPA services workers be required to complete the training and that the training should be made available for all other mandated reporters.

Foster Care Program Office:

- Clarify policy regarding criminal record checks (FOM 722-6A or FOM 914) to outline the procedures for purchase of service providers to obtain and document the Law Enforcement Information Network (LEIN) and central registry check.
- Ensure that all policy timeframes are consistent for medical documentation (FOM 722-6 and FOM 913-1) and enhance policy

(FOM 722-5) to clearly delineate the case record content requirements for the private agency and DHS during purchase of service cases.

Child Welfare Contract Compliance Unit:

- Develop requirements for a CPA that is licensed to place special needs children to include specialized training for the foster care workers and foster parents responsible for the specialized care.
- Develop requirements that the Foster PRIDE (Parent Resources for Information, Development, and Education)/Adopt PRIDE training to include infant safe sleep practices as part of the curriculum for foster parents.

Bureau of Children and Adult Licensing:

- Develop a process to ensure that a child placing agency is not licensed to accept placement of special needs children without employees being trained in the specialized care required to meet the children's needs.
- Amend licensing rules to require all foster parents to receive training on infant safe sleep practices and require use of these practices for all children age one or under, unless a physician's written documentation grants an exception.
- Implement policy to address requirements for a foster home that has a family member or foster child who is unable to communicate.

Child Welfare Training Institute:

- Develop training curriculum in conjunction with the new DHS medical director for workers assigned to cases involving medically fragile children.
- Review existing training materials regarding medical documentation to ensure that they clearly address the policy and procedures for the specialists.
- Develop continuing education curriculum for specialists and supervisors in regards to documenting medical information.
- Include child death reporting process in new supervisor training.

Follow Up

DHS has continued to make strides to improve the quality of service to children and families in the child welfare system. The previous fatality report, *Child Fatality Reviews: 4/1/05-3/31/08, Quality Assurance Report*, identified recommendations for further improvement within the department. The following steps taken by DHS address some of these recommendations.

- CPS intake policy was amended on February 1, 2010 to expand required checks for licensing status of persons associated with the complaint. These inquiries are to be supported by SWSS clearances conducted by

- CPS intake to determine if a licensed provider is identified as a member of the CPS complaint.
- The medical passport policy was updated on December 1, 2009 to emphasize mandated requirements. Policy on required immunizations was added with verification and documentation process outlined. On March 10, 2010 a memorandum was distributed to all foster care staff regarding required medical and dental exam entries into SWSS-FAJ. This memorandum required that the initial and yearly medical and dental examinations back to October 1, 2007 be entered on all currently open cases.
 - The Children's Services Administration (CSA) introduced a new medical and mental health training series on January 6, 2010 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. The Child Welfare Training Institute, in collaboration with the CSA medical director, presented the ongoing training entitled Medical and Mental Health Training Series: Meeting the Needs of Children in the Child Welfare System.
 - DHS announced on March 10, 2010 that it will conduct training on child welfare caseworker visitation in the summer of 2010 for foster care, juvenile justice, CPS and adoption workers and supervisors in DHS and private child placing agencies. Training objectives include: recognizing the relationship between visits and child safety, placement stability and permanency; reviewing policy requirements and the use of structured decision making tools for assessing child safety and affecting permanency and well-being; planning visits; and documenting the quality of the visits in services plans and SWSS.

Conclusion

As in the previous child fatality report, fatalities are most prevalent among the youngest in the child welfare system. Half of the fatalities reviewed involved children three years of age or less. Of these, over three quarters died from natural causes. Only one child 14 years of age or older died of natural causes. For this group, just over half died from homicide and a third of the deaths were accidental.

Information from these reviews indicates a need for improved case management, training, supervisory oversight and policy revision. Many of the findings and recommendations involve multiple administrative units departments. The results of this analysis will be shared with the DHS Quality Council and Children's Cabinet and utilized in the CQI process.