State of Michigan
Department of Health and Human Services

CPS Fatality Reviews: 1/1/16 -12/31/16
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. The Office of Family Advocate (OFA) is a centralized unit at Michigan Department of Health and Human Services (MDHHS) that oversees the CPS Fatality Review Process.

OFA REVIEW PROCESS OF CHILD FATALITY CASES

The OFA uses a consistent set of criteria to determine when to review a child fatality. The OFA will review the complete case if:

- The child death occurred during an active CPS investigation or open CPS case.
- The child death occurred in a family that has three 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 three to four months).

OFA staff complete all reviews and carefully examine all relevant information including all the CPS complaints, prior CPS services cases (if any), MDHHS policy, and Michigan Child Protection Laws. Each review contains a summary of case facts, identified practice strengths, and findings with corresponding recommendations to practices, when applicable. After completing a review, OFA staff send it to the county for their response which may include the steps taken to improve practice and/or corrective action when necessary.

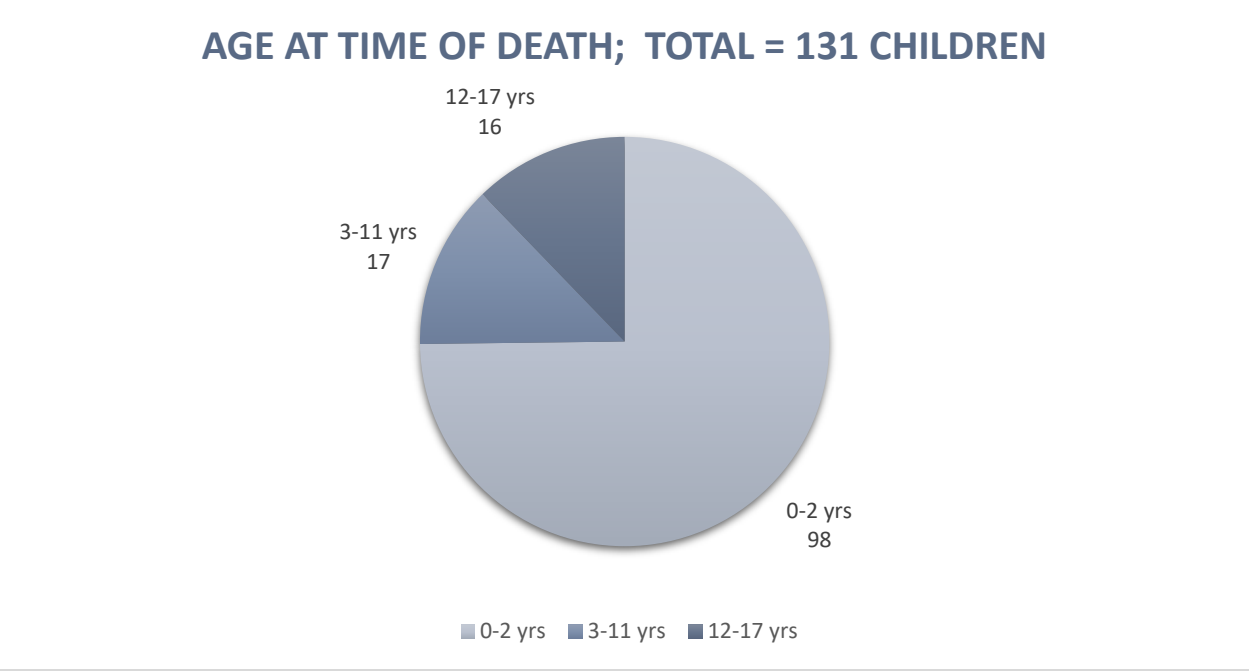
DEMOGRAPHICS AND STATISTICS

During the 2016 calendar year, 131 child fatalities met the previously discussed criteria in order for the OFA to complete a CPS Fatality Review.

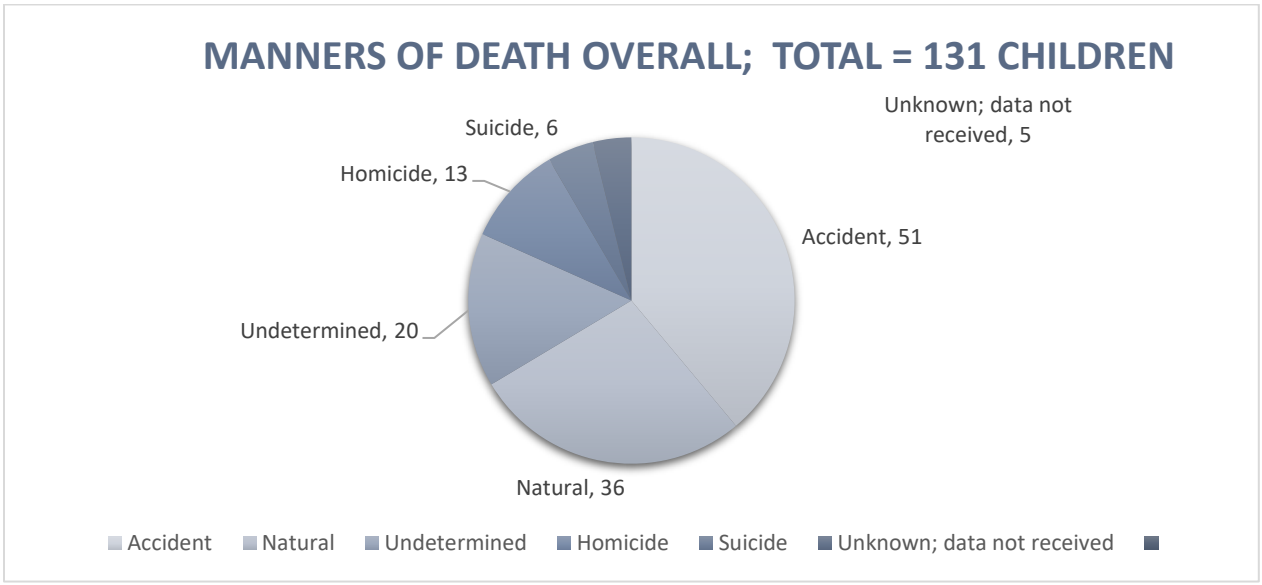
Counties Where Reviewed Fatalities Occurred

County	Number of Reviews
Wayne	36 (27%)
Ingham	9 (7%)
Kent	8 (6%)
Genesee	8 (6%)
Washtenaw	7 (5%)
Oakland	5 (4%)
Saginaw	5 (4%)
Jackson	4 (3%)
Kalamazoo	4 (3%)
33 other Michigan counties	3 or less

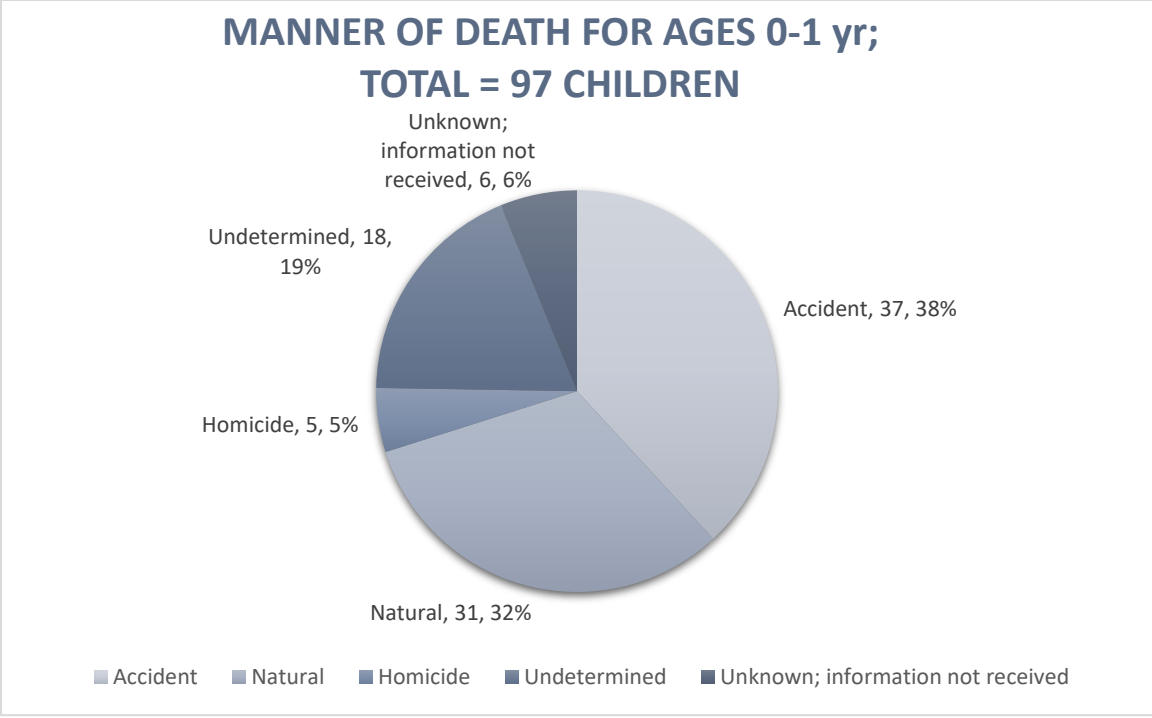
- The 33 other counties: Calhoun, Isabella, Berrien, St. Clair, Newaygo, Ionia, Lenawee, Missaukee, Macomb, Cass, Iron, Otsego, Schoolcraft, Manistee, Muskegon, Wexford, Mackinac, Iosco, Marquette, Tuscola, Shiawassee, Allegan, Isabella, Delta, Osceola, Emmet, Benzie, Clinton, Ottawa, Ogemaw, Hillsdale, Grand Traverse, and Chippewa



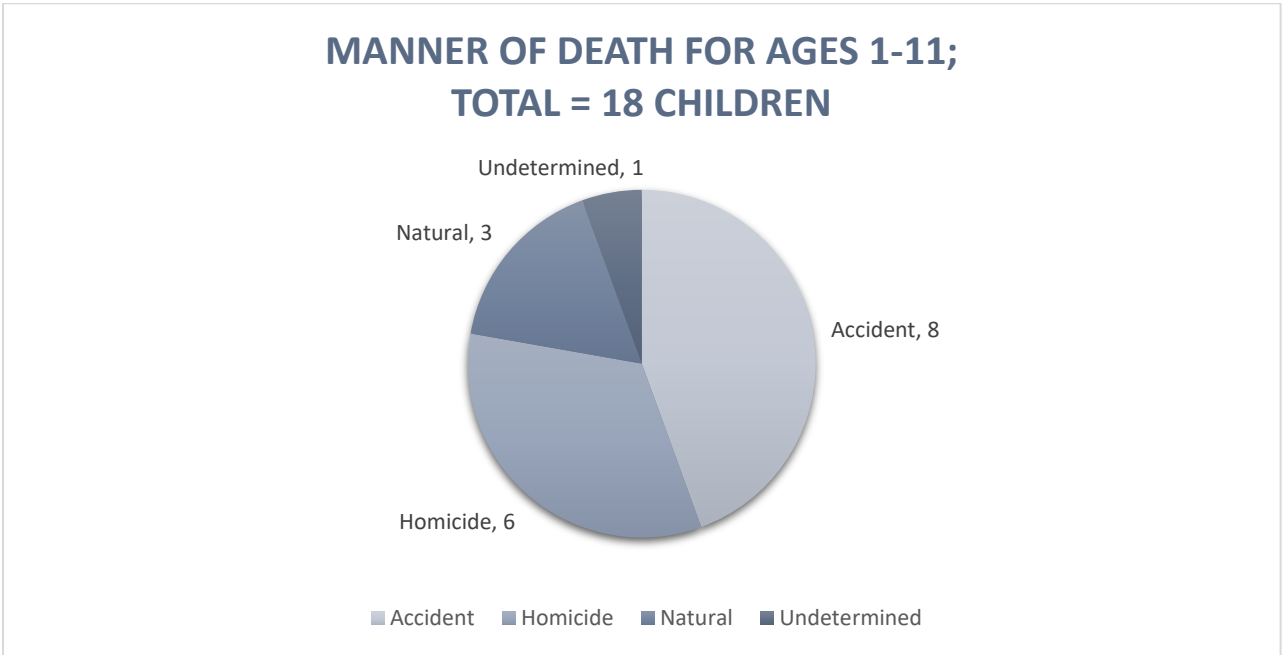
- Children 0-2 years of age represent 75% of the total number of fatalities. Their number is nearly three times that of both the other age groups combined.
- Children 3-11 years of age represented 13% of the total numbers of fatalities.
- Children 12-17 years of age represent 12% of the total numbers of fatalities.



- The manner of death most often identified is "accident" (39%) which includes deaths resulting from placing an infant in a compromised sleeping position (unsafe sleep). "Natural" deaths followed (27%), which include deaths related to pre-existing medical issues.



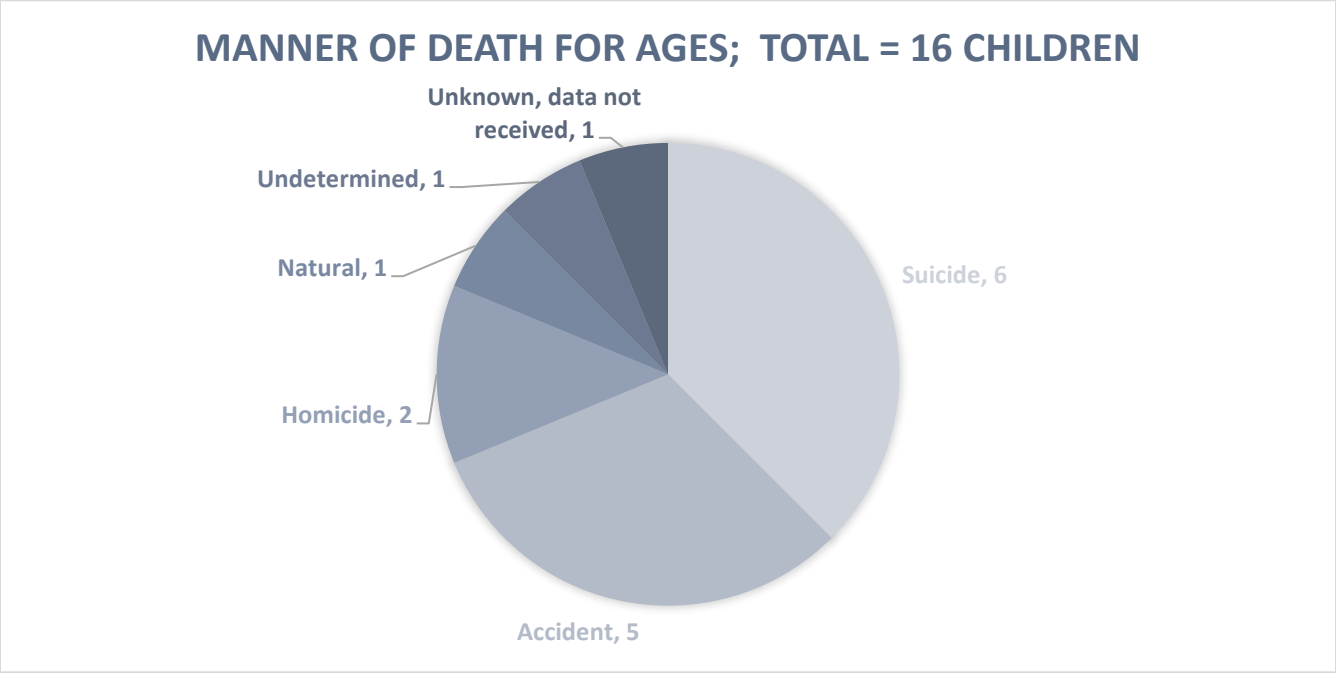
- For children under the age of 0-1, the most common manner of death was "accident" (38%). Of the 37 accidental deaths, 34 (88%) involved unsafe sleep of a newborn.
- Many of the children that died of natural causes between the age of 0-1 did so within the first few months of life due to medical conditions.



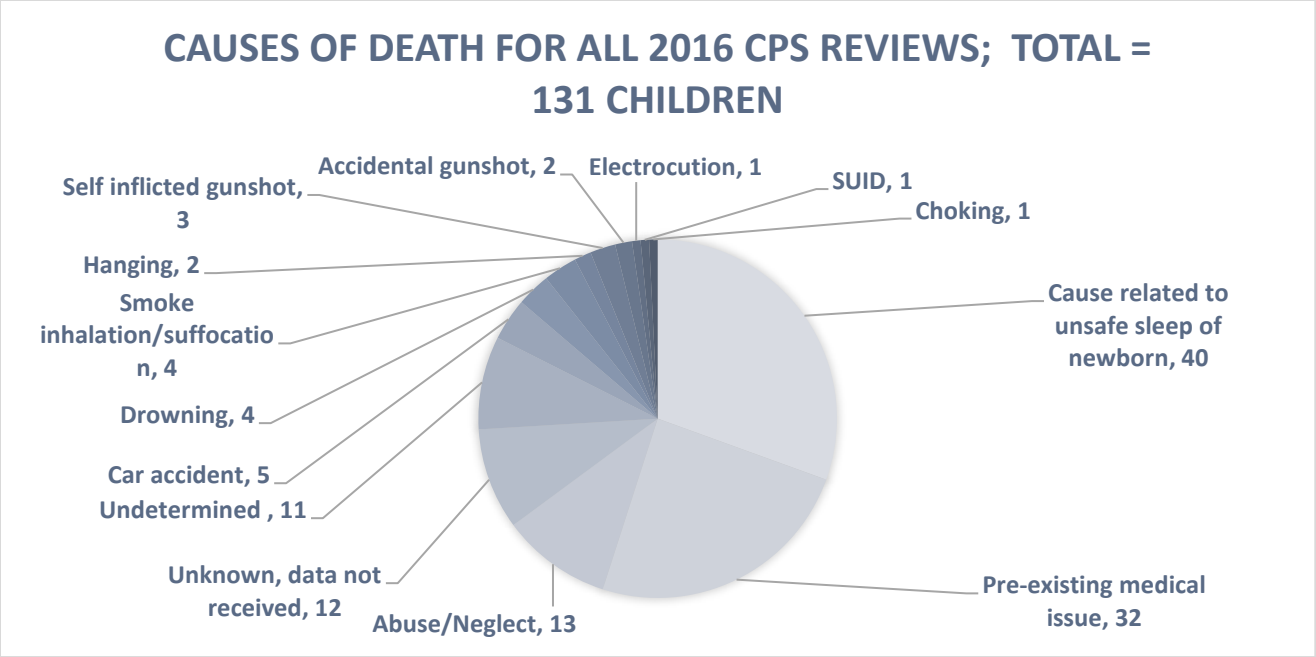
- For children age 1-11, the most common manner of death was also "accident". The causes include three children who died by drowning, two by smoke inhalation, two by

sustaining injuries in car accidents, and one by shooting himself while playing with a gun.

- The second most common manner of death was "homicide", where a child died as a result of injuries suffered from abuse or neglect.



- The most common manner of death for children age 11-17 was suicide (38%). In 2015, 20% of the children age 11-17 died by suicide.
- Four of the children who died by suicide were males, two were female. Five of the six children who died by suicide were 15 years old, the other child was 14 years old. Four of the children hung themselves, two died from self-inflicted gunshot wounds.
- The second most common manner of death was accident. Types of accidents included two children that died from injuries sustained in a car accident, one teen died after accidentally shooting himself while playing with a gun, one teen died of smoke inhalation, and one teen died by electrocution after coming into contact with a downed power wire.



- 24% of the children who died had a pre-existing medical condition; in many cases the child's death was expected.
- 31% of the children who died were infants who were put in a compromised sleeping position (unsafe sleep). In 2015, 50% of the overall deaths reviewed by the OFA involved unsafe sleep.

Summary of 2016 CPS Fatality Reviews

OVERALL STRENGTHS IN 2016 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 2016, the OFA cited 295 individual strengths within the 131 cases it reviewed with the following most noted:

- 35% of the CPS Fatality Reviews cited staff who engaged parents with safe sleep education.
- 29% of the CPS Fatality Reviews cited staff who contacted and collaborated with law enforcement.
- 26% of the CPS Fatality Reviews cited staff who obtained medical records or an exam.
- 18% of the CPS Fatality Reviews cited staff who located and engaged with collateral contacts to gather evidence.
- 15% of the CPS Fatality Reviews cited staff who engaged the family in comprehensive safety planning.
- 14% of the CPS Fatality Reviews cited staff who engaged and supported the family through their time of grief.
- 12% of the CPS Fatality Reviews cited staff who made referrals and connected the family with local community services including grief therapy.

- 10% of the CPS Fatality Reviews cited staff who kept overall excellent documentation.
- Additional identified strengths include making multiple attempts to contact a parent, good communication with medical providers, calling CPS Centralized Intake timely with a new complaint, excellent communication between MDHHS departments, documented monthly supervision, and using the DHHS-2096, CPS fatality investigation checklist, to assist in completing an investigation.

OVERALL FINDINGS IN 2016 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 is 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. In 2016, the OFA made 209 findings within the 131 cases it reviewed with the following most noted:

- 78 reviews (60%) had findings related to CPS not completing a required face to face interview during one or more investigation, most often with the non-custodial father.
- 22 reviews (17%) had findings related to CPS not adequately assessing or developing a comprehensive safety plan with the family.
- 19 reviews (15%) had findings related to CPS not completing a mandated medical exam of a child.
- 15 reviews (11%) had findings related to standards of promptness regarding the timely completion of reports and other documentation.
- 15 reviews (11%) had findings related to finding incomplete documentation within MiSACWIS.
- 11 reviews (8%) had findings related to CPS making an incorrect disposition regarding an investigation.
- 6 reviews (5%) had findings related to CPS not making a timely complaint to CPS Centralized Intake after a child died during an active investigation.
- 5 reviews (4%) had findings related to CPS missing steps during an investigation.
- 5 reviews (4%) had findings related to CPS not seeing a child timely.
- Additional findings include inconsistent documentation of monthly case conference with a supervisor, not verifying medication, not adequately reviewing the tenets of safe sleep with a parent, and not documenting diligent efforts made to locate an absent parent.

FOLLOW-UP OF PAST FINDINGS AND RECOMMENDATIONS

In its previous annual report, *CPS Fatality Reviews: 1/1/15 – 12/31/15 Office of Family Advocate Report*, the OFA made recommendations to MDHHS based on its overall findings from the Fatality Reviews conducted in that year. Since that issuance of that report, MDHHS has taken the following steps to improve practices.

- The OFA challenged MDHHS in its previous annual report to examine what additional methods and/or programs could be incorporated into current policy and practice that would enable workers to encourage and motivate sustained behavior change in an effort to reduce the number of SUID deaths that occur due to a parent putting a child in an unsafe sleeping position. The OFA suggested using strategies such as collaboration between MDHHS Central Office and local counties, utilizing known predictive factors to identify at-risk parents/children earlier, continued training of safety planning, introducing

CPS staff to motivational interviewing techniques, training staff to develop comprehensive safe sleep plans with parents, providing concrete items when needed, such as cribs, and creating a support network for the parent in an effort to elicit sustained behavior change.

Since making the recommendation, 30 frontline child welfare workers attended the 2017 Infant Safe Sleep Conference to receive advanced education on safe sleep and engagement with parents around the subject. Additionally, the MDHHS Safe Sleep program presented a new child welfare safe sleep training utilizing the risk reduction model to the CPS Advisory board for feedback and to allow them to begin guiding and educating their staff on the risk reduction model for practical use with clients

Local county offices continue to collaborate with community agencies to obtain Pack n Plays, cribs, or bassinets and CPS program office continues to participate with the Infant Safe Sleep Advisory Committee for policy guidance around safe sleep and to be able to share and encourage use of successful cutting edge community-based initiatives surrounding safe sleep with child welfare staff.

OFA Unit Recommendations

safeTALK

In 2016, the percentage of OFA reviews concerning teens who died by suicide nearly doubled from the previous year. In the past few years, MDHHS has attempted to expand the resources and training available for Michigan child welfare staff concerning suicide awareness and prevention. In 2016, MDHHS hosted the second "Suicide Prevention conference" for child welfare staff statewide where nearly 280 staff received safeTALK, a nationally recognized suicide-awareness training. More recently, MDHHS sponsored nine child welfare staff to become certified to train safeTALK. The OFA recommends MDHHS sponsor an additional 10 child welfare staff in the upcoming year to be certified in safeTALK as it continues to provide additional resources and training for staff around suicide and suicide prevention.

Medical Exam Policy Modification

Though the requirement to complete required medical exams during CPS fatality investigations is located in PSM 713-04, Medical Exam Policy, nearly 15% of the cases reviewed by the OFA did not have a mandated medical exam completed. The OFA recommends CPS Program Office add the requirement to PSM 713-08 Special Investigative Situations under the Child Death header, and PSM 713-01, investigation guidelines, to increase the likelihood of policy compliance.

Safe Sleep

Though the percentage of cases reviewed by the Office of Family Advocate involving unsafe sleep dropped in 2016, the overall number of deaths due to unsafe sleep statewide remained constant. As such, the OFA again challenges MDHHS to explore what additional methods and/or programs could be incorporated into current policy and practice that would enable workers to encourage and motivate sustained behavior change in an effort to reduce the number of SUID deaths that occur due to a parent putting a child in an unsafe sleeping position. The OFA suggests using strategies such as collaboration between MDHHS Central Office and local

counties, utilizing known predictive factors to identify at-risk parents/children earlier, continued training of safety planning, introducing CPS staff to motivational interviewing techniques, training staff to develop comprehensive safe sleep plans with parents, providing concrete items when needed, such as cribs, and creating a support network for the parent in an effort to elicit sustained behavior change.

Policy Change for Face-to-face in Critical Cases

Through consultation with local counties after completing a Fatality Review, the OFA learned that many counties require additional oversight requirements for critical cases. As such, the OFA recommends CPS Program Office consider requiring mandatory second line approval and/or supervisors accompanying investigators on initial face to face visits with the family for all critical cases, including those involving a fatality.