

OFFICE OF FAMILY ADVOCATE
MICHIGAN DEPARTMENT OF HUMAN SERVICES

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PROTECTING MICHIGAN'S CHILDREN

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WHO WE ARE

- ▶ A centralized unit within the MDHHS' Children's Services Agency Central Office.
- ▶ Report directly to the MDHHS CSA Executive Director.

Staff:
OFA director: Seth Persky
OFA specialist: Joel Brown (FC reviews)
OFA analyst: Jeremy Smith (CRT reviews)
OFA analyst: Mike Greening (CRT reviews)

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OFFICE OF FAMILY ADVOCATE

- ▶ Liaison office to the Office of Children's Ombudsman
- ▶ DHHS CPS and FC Fatality Reviews
- ▶ CPS Compliance Review (CRT)
- ▶ Constituent calls
- ▶ Policy-including SRM 131, Confidentiality

Child Fatality Registry
Every child death is a tragedy. It is our goal to raise public awareness about child deaths in Michigan and assist with identifying local resources and efforts for those in need. The data presented here details only a small percentage of children who die in Michigan because safety on child deaths where abuse and/or neglect may have been a factor. We have made great efforts to better understand each child's circumstance to their death and have attempted to learn and better practice from each one.

Child Fatalities in the state of Michigan

Year	Child Fatalities
2012	320
2013	342
2014	338
2015	301
2016	290

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Family Advocate Primary Duties: 1-MDHHS/PAFC liaison to OCO

The OFA was created in August 1995 as the DHHS and PAFC liaison to the Office of Children's Ombudsman, Legislature, and Governor's office for all matters concerning child welfare



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Office of Children's Ombudsman

An external monitor granted extraordinary powers to review and critique DHHS cases.

The OFA:
Processes OCO requests for records and information
Works to ensure compliance with PA 204
Respond to the OCO Annual Report Recommendations



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- ▶ The OFA coordinates responses to all types of OCO reports
 - ▶ Gather input from field offices/private agencies
 - ▶ Obtain input from policy/program office
 - ▶ Obtain input from Office of Legal Affairs
 - ▶ Obtain input from Central Office Management
 - ▶ Develop official MDHHS/private agency response

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SIMILARITIES BETWEEN OCO AND OFA

- ▶ Both offices serve as a monitoring mechanism for MDHHS's child welfare programs
- ▶ Both offices take referrals and complaints from the general public and child welfare professionals.
- ▶ Both publish annual reports.
- ▶ Both offices have access to confidential child welfare files and follow strict confidentiality guidelines.

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DIFFERENCES BETWEEN OCO AND OFA

- ▶ The OFA is internal to MDHHS, the OCO is an independent state within the Dept. of Technology, Management and Budget.
- ▶ The OCO can also make recommendations to the legislature for statutory changes to improve the child welfare system.
- ▶ The OCO has legal authority to file a petition on behalf of a child. OFA can't independently file court petitions.
- ▶ OFA can compel a local DHHS/private agency to take certain action, the OCO cannot.
- ▶ OCO's director is appointed by the governor and approved by the senate.
- ▶ OCO is statutorily obligated to submit written responses with investigation results to complainants. OFA is not required to do so and might respond in a variety of ways.

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2-FATALITY REVIEWS



- ▶ The OFA is charged with conducting in-depth reviews of cases where a child involved with the child welfare system has died.
- ▶ 325 fatality alerts in 2019

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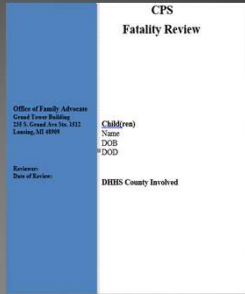
WHAT DOES THE OFA REVIEW IN A FATALITY CASE?

- ▶ When reviewing a Foster Care or CPS Fatality, the OFA will assess:
 - All CPS Reports
 - All Foster Care Reports
 - Family Preservation Reports
 - Medical Records
 - Petitions
 - Court Reports
 - Service Provider Records
 - Law Enforcement Reports
 - ▶ OFA Staff review the entire case history for every fatality.
 - ▶ Documentation confirming the cause and manner of death
- The final report is reviewed by the CSA Director, Children's Rights, agencies involved
- The focus of the reviews is to ensure staff are following all "applicable" policy and demonstrating best practices.

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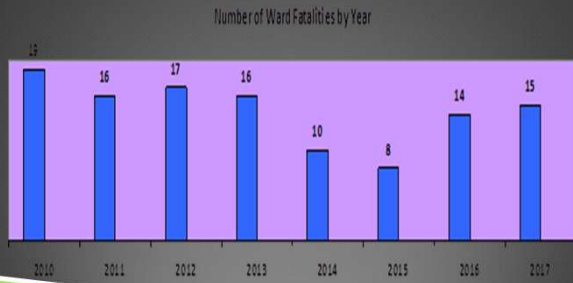
REVIEW COMPLETION

- ▶ Identify strengths, findings & recs (if any)
- ▶ Request a Face to Face follow up with county/PAFC staff
- ▶ Conduct a 6 month follow up



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NUMBER OF WARD DEATHS



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2018 FATALITY REVIEW STRENGTHS SUMMARY

- Safe sleep education
- Good engagement with other family and collateral sources to get evidence
- Excellent coordination with outside agencies
- Excellent effort to locate appropriate placements
- Over and above support to the family

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2018 FATALITY REVIEW FINDINGS SUMMARY

- Lack of comprehensive safety planning
- Missing required medical exam of a child
- Missing standards of promptness (i.e. late reports)
- Missing face to face visits (most notably with non-custodial parents)
- Insufficient contacts (most notably face to face visits with children in first 60 days of placement)
- Casefiles lacked required documentation

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WHAT TO EXPECT WITH A HIGH PROFILE OR FATALITY CASE

- Many of our recent high profile cases had a worker with 6-18 months experience.
- Anxiety, fear, trauma are common worker reactions when a case becomes high profile. Don't be afraid to ask questions!
- Best things to do:
 - Follow policy!
 - Make sure everything is updated in the system.
 - Do not talk to anyone you aren't sure is someone you can talk to about the case.
 - Find your supports, this may be very difficult for a few months.
 - Let the OFA know how we can be most helpful, we will keep you/your county/agency in the loop!!

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3-CPS COMPLIANCE REVIEW TEAM (CRT)

- ▶ Created in October 2018 in response to the Office of Auditor General CPS investigation report.
- ▶ Reviews random CPS investigations which were dispositioned in the previous month.
- ▶ Reviews are based solely on MiSACWIS documentation.
- ▶ Results of all case reviews are provided to the County director for dissemination.

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CRT REVIEW SCORING

Meets Expectations
Case would be documented in MiSACWIS to meet all policy and law requirements.


Reportable Finding
These cases would contain an OAG Reportable Condition or other minor documentation deficiencies however, would not have an OAG Material Condition or known critical safety issue.

Material Finding
These cases would contain an OAG Material Condition, however, would not have a known safety issue or missed petition.

Critical Safety Alert
These cases have a missed critical safety issue and/or missed petition requirement.

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4-CONSTITUENT COMPLAINTS



- ▶ Your clients call Lansing with complaints; 600+ in 2017
- ▶ Mostly, we educate and advocate for the field and inform the public about policies and procedures
- ▶ Occasionally we contact the field for more information, or to provide a "heads up".

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GOVERNOR'S OFFICE, LEGISLATORS, AND STAKEHOLDERS

- ▶ Review complaints
- ▶ Bound by confidentiality laws
- ▶ We will let you know when they call and their concerns
- ▶ Feel free to ask questions!!



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SPECIAL CASE REVIEWS

- ▶ The OFA may review cases either at the request of the MDHHS and/or CSA Director, the BSC, or the local county.
- ▶ These cases may be high profile or involve questions of policy, child maltreatment while in care, or a variety of other issues.



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5-WHAT ELSE?



- ▶ SRM 131; Confidentiality
- ▶ Review draft policy and protocol
- ▶ Ensure initiation of corrective action where needed
- ▶ Review proposed legislation specific to the Child Protection Law

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REPRESENT MDHHS



- ▶ Serve on Child Death Advisory Team, CPS and Adoption Advisory Teams, Citizen Review Panels, Governor's Task Force, State Foster Care Review Board Advisory, etc.
- ▶ Process all requests for release of confidential information made under Section 7c of the Child Protection Law

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