STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR
OFFICE OF CHILDREN'S OMBUDSMAN
LANSING
SUZANNA SHKRELI
DIRECTOR

Findings and Recommendations
Regarding the Michigan Department of Health and Human Services involvement with
[redacted] DOD: 10/30/2020

Under state law a record of the Office of Children's Ombudsman's is confidential, shall only be used for purposes set forth in this act, is not subject to court subpoena, and is not discoverable in a legal proceeding. Additionally, a record of the Office of Children's Ombudsman's is exempt from disclosure under the Freedom of Information Act.

Date of report: May 11, 2021

Case No.: 2020-0343

Summary:

[redacted] died on October 30, 2020. Pursuant to MCL 722.627k, the Michigan Department of Health and Human Services (MDHHS) notified the Office of Children's Ombudsman (OCO) of the child fatality. On November 4, 2020, the OCO opened an investigation into the handling of this matter by Wayne County Department of Health and Human Services (DHHS) - North Central, pursuant to its statutory responsibilities.

The OCO reviewed confidential records and information in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), which includes but is not limited to service reports, medical records, and social work contacts; conducted searches in the Judicial Data Warehouse and central registry; and reviewed MDHHS child death notifications received by the OCO between June 2020 and April 2021 involving children who died from gunshot wounds. The OCO also spoke with [redacted] involved in three investigations concerning [redacted] family, completed in 2020, and interviewed the detective in charge of the homicide investigation.

The objective of this review was to identify areas for improvement in the child welfare system. By looking at how this family's case was handled by Wayne County DHHS - North Central, and the involvement of staff, court personnel, physicians and law enforcement, this review reinforces the principle that the safety and well-being of a child is the shared responsibility of the family, community, and both law enforcement and medical personnel

aiding children and families. It is not intended to place blame, but to highlight areas of concern regarding the handling of this case and advocate for changes in the child welfare system on behalf of similarly situated children.

Family History:

[redacted] is the mother of [redacted], [redacted], [redacted], and [redacted]. [redacted] is [redacted] father; [redacted] is [redacted] father; [redacted] is [redacted] father; and [redacted] is [redacted] father. At the time of [redacted] death, Ms. [redacted] and her four children resided together with Mr. [redacted]. Mr. [redacted] and Mr. [redacted] had sporadic contact with [redacted] and [redacted]. Mr. [redacted] was incarcerated in Arizona during the 2020 investigations under review.

Ms. [redacted] was the subject of eight CPS investigations prior to [redacted] death. Five of those investigations were placed in category IV, including a complaint alleging that [redacted] was born positive for Tetrahydrocannabinol (THC, an active ingredient of marijuana) and morphine on September 28, 2020. Three investigations were placed in category III: a 2017 case involving domestic violence, a 2017 case involving a THC-positive newborn ([redacted]), and a 2020 case involving improper supervision for leaving the children home alone.

[redacted] was the subject of two prior investigations. A 2014 complaint involved domestic violence against a living-together-partner. According to case file documents, during this investigation, it was determined that [redacted] hid firearms inside the home, which were discovered by a 12-year-old boy who resided in the home. This complaint was placed in category IV. A 2011 complaint alleged the unsafe sleep death of Mr. [redacted] son, [redacted], which was placed in category III.

Relevant Violations Reviewed:

The OCO found that there were no relevant policy violations.

Tobin Miller
Chief Investigator, Office of Children's Ombudsman
111 S Capitol Ave
Lansing, MI 48933

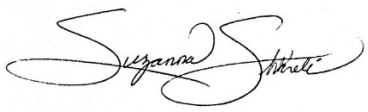
Finding(s):

Primary Agency of Focus:	None
Secondary Agency(ies):	None
The OCO finds that between June 2020 and April 2021, the OCO received 11 child death notifications from MDHHS that a child had died as a result of a gunshot from an unsecured firearm within a home.	

Recommendation(s):

Primary Agency of Focus:	Children's Services Administration
The OCO recommends that MDHHS develop a plan to provide free resources or for the department to purchase resources to help families secure firearms. For example, an MDHHS plan could task local DHHS offices with identifying sources of free trigger locks and lock boxes in their communities so that CPS clients may be referred to those sources. The OCO also recommends that MDHHS make funds available to local offices for purchase and distribution of such safety devices to CPS clients. The OCO also recommends MDHHS utilize its partners to develop the safest and most effective way MDHHS can determine which families are in need of gun-safety devices.	

Primary Agency of Focus:	Children's Services Administration
The OCO recommends that MDHHS develop a flyer or pamphlet addressing gun safety that CPS workers may distribute to clients as part of the community resource materials for category III and IV complaints. The flyer or pamphlet may be based on that distributed by Mott's Children's Hospital, available at https://healthblog.uofmhealth.org/childrens-health/keeping-kids-safe-from-gun-accidents-6-strategies-for-families. The flyer should identify free sources of trigger locks and gun safes, if available, and instruct clients on how to request funds for purchase of such safety devices.	



Suzanna Shkreli
Director
Office of Children's Ombudsman
111 S Capitol Ave
Lansing, MI 48933

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

July 30, 2021

Suzanna Shkreli
Office of Children's Ombudsman
401 S Washington Sq Ste 103
Lansing, MI 48933

Dear Ms. Shkreli:

The following is the Michigan Department of Health and Human Services (MDHHS) response to the findings and recommendations from the Office of Children's Ombudsman (OCO) Report of Findings and Recommendations regarding [redacted].

This report contains confidential information from a Children's Protective Services file. The Michigan Child Protection Law [MCL 722.627, section 7(3)] prohibits the release of this information to any individual/entity not authorized under Section 7(2) of the law. Pursuant to Section 13(3), release of this confidential information to an unauthorized individual/entity may subject you to criminal and/or civil penalties.

Finding(s):

Primary Agency of Focus:	None
Secondary Agency(ies):	None
The OCO finds that between June 2020 and April 2021, the OCO received 10 child death notifications from MDHHS that a child had died as a result of a gunshot from an unsecured firearm within a home.	

Recommendation(s):

Primary Agency of Focus:	Children's Services Administration
The OCO recommends that MDHHS develop a plan to provide free resources or for the department to purchase resources to help families secure firearms. For example, an MDHHS plan could task local DHHS offices with identifying sources of free trigger locks and lock boxes in their communities so that CPS clients may be referred to those sources. The OCO also recommends that MDHHS make funds available to local offices for purchase and distribution of such safety devices to CPS clients. The OCO also recommends MDHHS utilize its partners to develop the safest and	

most effective way MDHHS can determine which families are in need of gun-safety devices.

MDHHS Response to Recommendation: MDHHS agrees that workers should have access to information related to firearm safety and resources when opportunities to discuss the topic arise or for families who request such information. MDHHS reviewed the 10 cases referred to by the OCO where a child died because of a gunshot from an unsecured firearm within a home. Five of the 10 cases involved a youth who was shot after playing with an unsecured firearm found in the home. Four of the 10 cases involved a teenager who used a firearm to complete a suicide. One of the 10 cases involved a youth who was shot in public by an unknown person.

As a result of this OCO recommendation and the review of the five cases which involved an unsecured firearm, MDHHS's Children's Services Agency (CSA) reached out to the MDHHS Department of Communications regarding the creation of a webpage workers and community members will have access to through the MDHHS website which will contain links to sites such as Mott's Children's Hospital and the University of Michigan's Firearm Safety Among Children and Teens (FACTS), information related to firearm safety, how to access free safety devices such as trigger locks in each local community, suicide prevention resources, and useful instructional aids. CSA will continue to consult with our stakeholders to assist in the development of the webpage which should be available within 90 days.

In 2019, CSA developed a robust plan to reduce child fatalities in the state of Michigan that result from abuse, neglect, or suicide and has worked with several internal and external stakeholders including the Injury and Violence Prevention Unit at MDHHS, the Michigan Public Health Institute, the Michigan Association for Suicide Prevention, and the Depression Center at the University of Michigan to enact the plan. Additionally, Michigan is in its third round of federal funding from the Garrett Lee Smith Memorial Act which provides seed money towards suicide prevention efforts and is one of five states that are participating members of Child Safe Forward, hosted by the Department of Justice and federal Office of Victims of Crime. Child Safe Forward is a national initiative to reduce child abuse and neglect fatalities and injuries through a collaborative, community-based approach.

Primary Agency of Focus:	Children's Services Administration

The OCO recommends that MDHHS develop a flyer or pamphlet addressing gun safety that CPS workers may distribute to clients as part of the community resource materials for category III and IV complaints. The flyer or pamphlet may be based on that distributed by Mott's Children's Hospital, available at https://healthblog.uofmhealth.org/childrens-

health/keeping-kids-safe-from-gun-accidents-6-strategies-for-families. The flyer should identify free sources of trigger locks and gun safes, if available, and instruct clients on how to request funds for purchase of such safety devices.

MDHHS Response to Recommendation: MDHHS agrees with this OCO recommendation and is working with the Depression Center at the University of Michigan to develop an informational pamphlet which will be made available to child welfare staff either through the aforementioned webpage and/or by assigning it a QR code. The pamphlet will outline strategies for firearm safety, resources families can access in their local communities, and should be available to staff within 90 days.

Thank you for the opportunity to respond to this Report of Findings and Recommendations. If you have questions or concerns, please feel free to contact me.

Sincerely,

Demetrius Starling
Executive Director
Children's Services Agency