Annual Report

FY 2016

Office of Children's Ombudsman

Message from the Ombudsman:

The Office of Children's Ombudsman (OCO) continues to focus our collective energy towards enhancing the foundation of the successes that we have enjoyed over the last year. Our team has worked diligently to implement the goals as identified in our strategic plan. We continue to advocate for children by developing potential statutory amendments based upon our findings. The OCO continuously looks for opportunities to strengthen our internal data collection and related reporting mechanisms. We continue to be committed to identifying and engaging external partners in the development of future systemic changes. We've added to our team to ensure the success of our strategic initiatives and to further our efforts of continuous process improvement.

In this report, you will find a description of the work we do, a report of the number and types of contacts and complaints we have processed, and our recommendations for changes in the child welfare system.

Moving forward, The Ombudsman staff will remain strongly committed in our goal of ensuring the safety and wellbeing of children in care.

Orlene Hawks

Director and Children's Ombudsman

The OCO

☐ Reviews complaints about children who are involved with protective services, foster care, adoption services, and juvenile justice; Figure 1 shows the number of complaints by program type.

☐ Determines whether the Department of Health and Human Services (DHHS), foster care agencies, and adoption agencies followed laws, policies and rules;

☐ Takes all necessary actions, including legal action, to protect the rights and welfare of Michigan's children.

☐ Reviews and investigates child death cases that may involve abuse or neglect;

☐ Recommends to the Governor, the Legislature, and the DHHS Director ways to improve the child welfare system; and

☐ Educates the public about laws and policies that affect the welfare of Michigan's children.

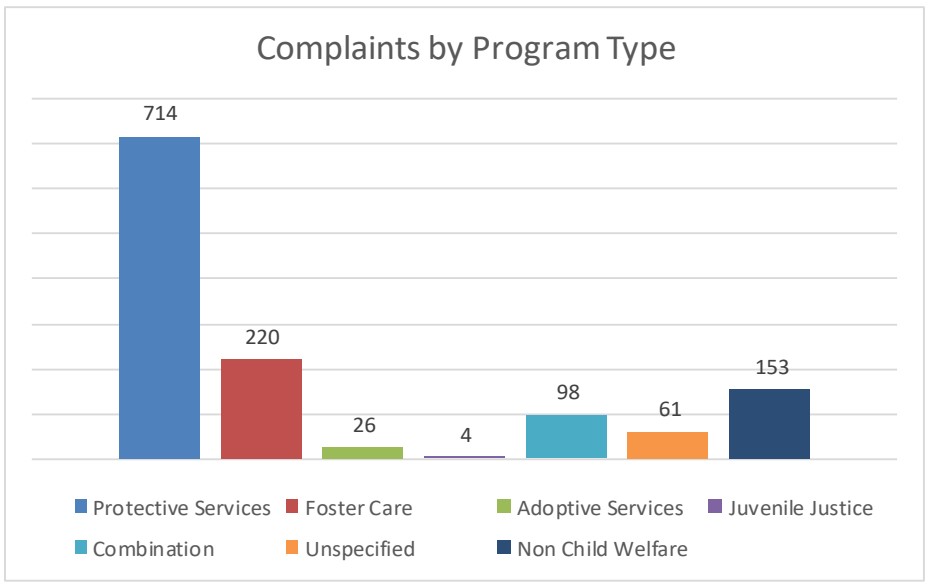

Figure 1

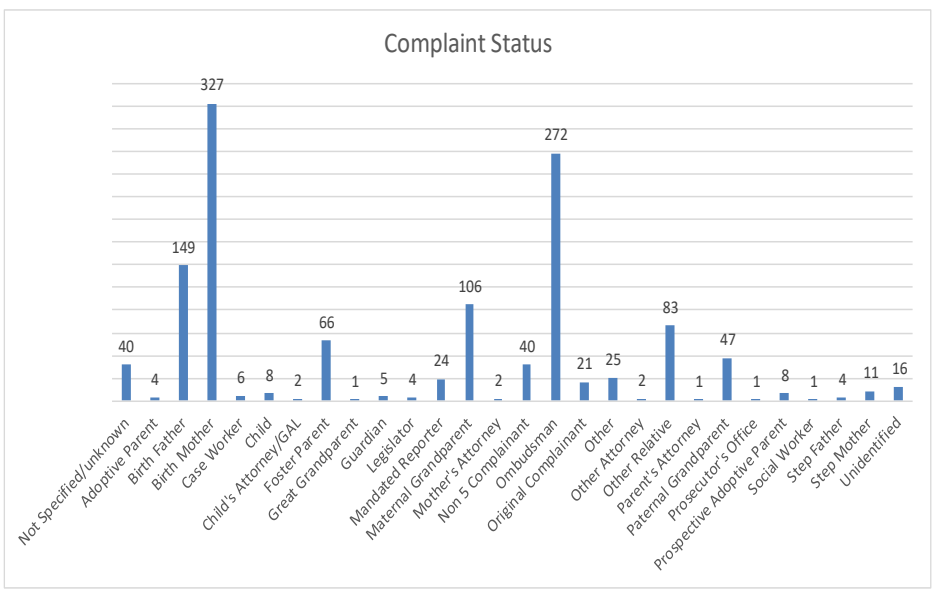

Figure 2

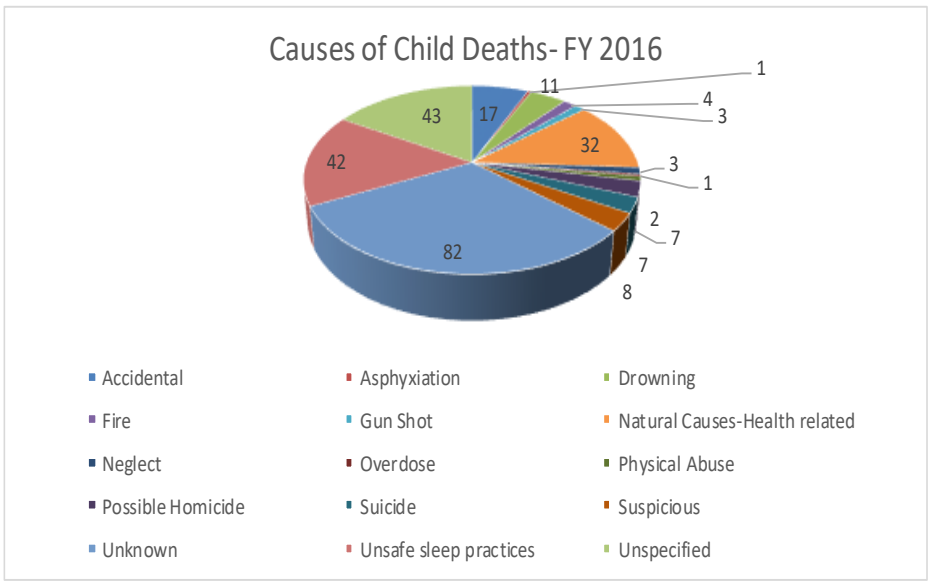

Figure 3

Figure3 shows the causes of child deaths in FY 16 per the Child Death Alerts received. In FY 16, the OCO received 263 Child Death Alerts. Of those 263 received, 144 were opened for investigation.

The OCO investigates two types of cases, Complainant Investigations and Child Death Investigations.

The OCO may investigate a complaint from an individual who alleges that DHHS and/or a private agency violated law or policy or made decisions harmful to a child's health and/or safety. Figure 2 shows complaints received broken up by complainant source.

Child Death Investigations focus on determining whether interventions made by DHHS and/or a private agency were handled in accordance with law and policy. The OCO also determines whether a correlation existed between previous agency involvement with the family and the circumstances that led to the child's death. When DHHS is made aware of a Child Death, the Office of Family Advocate (OFA) notifies the OCO via a Child Death Alert. Information in the Child Death Alert is used to determine if the OCO will open up an investigation. The OCO must investigate a child's death when:

- A child died during an active CPS investigation or open services case, or there was an assigned or rejected CPS complaint within the previous 24 months.
- A child died while in foster care, unless the death resulted from natural causes and there were no prior CPS or licensing complaints concerning the foster home.
- A child was returned home from foster care and there is an active foster care case.
- The foster care case involving the deceased child or sibling was closed within the previous 24 months.

The OCO can be contacted by calling 1-800-642-4326 or 517-373-3077; by fax 517-335-4471; by email childombud@michigan.gov; by mail at P.O Box 30026 Lansing, MI 48909 or online at www.michigan.gov/OCO

Please provide your name, telephone number, children's names, dates of births, the agency involved (County DHHS or private), a description of your concern and what you would like the OCO to do.

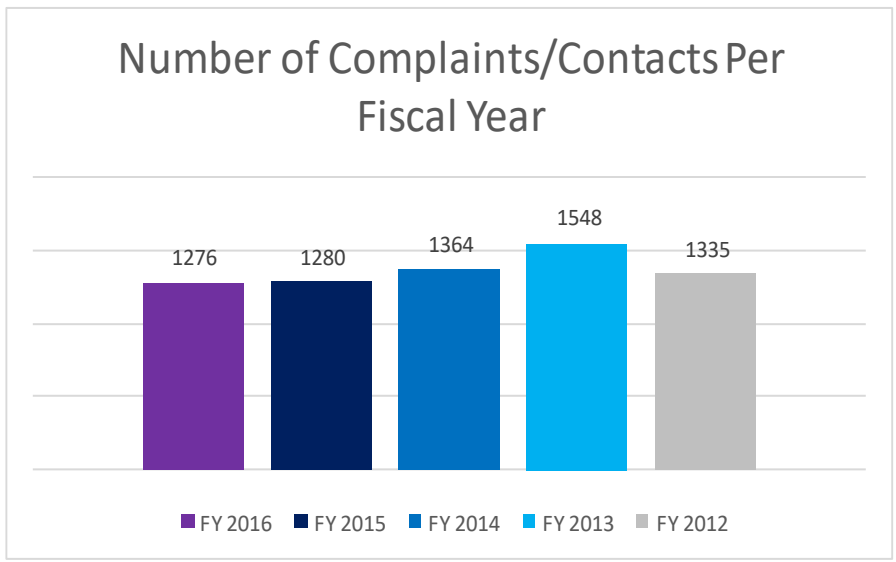

Figure 4 shows the number of Complaints and Contacts for FY 16. Of those 1276 complaints and contacts received, the OCO opened 173 for investigation.

Figure 4

RECOMMENDATION 1

The OCO recommends the Michigan Legislature amend the Children's Ombudsman Act (COA) to permit the OCO to publish any departmental response to a Report of Findings and Recommendations containing the department's interpretation of a law or policy. The recommended statutory amendment would not alter the OCO's responsibility to safeguard confidential information.

The COA established the OCO as a means of investigating the actions of the Michigan Department of Health and Human Services (MDHHS) and child placing agencies to ensure their compliance with relevant statutes, rules and policies pertaining to children and families receiving child welfare services in Michigan.

Although an agency's interpretation of a statute is entitled to deference and MDHHS is entitled to promulgate children's services policy, the OCO has received several responses to its Reports of Findings and Recommendations from MDHHS that the OCO believes are inconsistent with statutes, policies and actual best practices in the field.

MDHHS Response to OCO Comment:

MDHHS is the state agency responsible for interpreting and implementing applicable law, rule, and policy. In many instances, MDHHS was involved in helping to draft, analyze, and shape the law prior to final passage and enactment. The development of policy and practice standards is a lengthy process that often includes consultation with legal experts, the federal government, and advisory workgroups; analysis of available social science research; and feedback from internal and external stakeholders. MDHHS takes seriously, and thoroughly reviews, any allegation of noncompliance with the law up to and including consultation with the Attorney General's office if determined necessary, to assure accurate interpretation.

Examples of such responses include:

- MDHHS stated that the attorney-client privilege applied to conversations between county MDHHS staff and MDHHS Central Office staff when they consulted on a case. No attorney for MDHHS was present during the conversations in question.

  MDHHS Response to OCO Comment:

  The above statement is factually untrue. The consultation referenced included a MDHHS Bureau of Legal Affairs staff attorney who was present during the conversation and provided legal advice to MDHHS. The federal courts have recognized the attorney-client privilege extends to government attorneys.

- MDHHS indicated that Children's Protective Services (CPS) workers are not mandated to report new allegations of suspected child abuse or neglect to Centralized Intake on an active investigation. MDHHS stated that as long as the worker thoroughly investigates those new allegations during the active investigation and documents the findings, that is adequate, even though a report to Centralized Intake is mandatory per MCL 722.623(1) (a) – (b) and various sections of MDHHS' own policy (PSM 712-1 and 718-8).

  MDHHS Response to OCO Comment:

  The OCO has mischaracterized MDHHS statements. CPS must investigate each allegation of suspected child abuse or neglect that meets the legal and policy criteria for investigation, including allegations of abuse or neglect that the CPS investigator learns while conducting an investigation. MDHHS policy addresses these situations and clearly requires investigation and disposition of each allegation. There is no cogent or lucid purpose for CPS to contact the hotline number to report a complaint about which the CPS investigator is already aware and investigating. Such a process would be ineffectual and inefficient, there by constituting a waste of the taxpayers' money and state resources.

- Based on a case decided under the Child Custody Act, MDHHS asserted that a child's relationship to his or her siblings is severed once the child is adopted. Based on this, MDHHS stated that a foster care agency has no legal obligation to make efforts to place such siblings together. This is contrary to MDHHS' own policies (FOM 722-03 and 72206I), Michigan law (MCL 712A.13a(1)(l) and 722.952(l)) and federal law (42 USC 675(12)), which all specify that efforts should be made to place siblings in foster care together in all cases.

  MDHHS Response to OCO Comment:

  The OCO has mischaracterized MDHHS statements. What MDHHS asserted in its original response to the OCO was that once a child is adopted, the "legal" relationship between the siblings is severed and no longer recognized. However, the department does not mistake the severance of a legal relationship as an invalidation of the social and emotional relationship between siblings. Department policy and the MiTEAM case practice model that is used by MDHHS demonstrate the strong priority MDHHS places on maintaining sibling relationships. For example, Department policy requires that siblings be placed together whenever possible and when siblings cannot be placed together, a detailed visitation plan must be developed to ensure they maintain regular contact. Furthermore, even when legal relationships have been severed by the court, MDHHS will still make attempts to place children together and maintain their relationship when possible and if the adoptive parent is willing.

- MDHHS refused to provide a child's CPS records to his adoptive parents, as required per MCL 722.627(2)(e), MCL722.622(u) and SRM 131, on the grounds that all of that child's CPS records were now a part of his adoption record, per MCL 710.67, and were therefore confidential to even the child's adoptive parents.

  MDHHS Response to OCO Comment:

  MDHHS will thoroughly consider the OCO's concerns and review its application of law.

  MDHHS Response to Recommendation 1:

  A venue currently exists for the OCO to bring any opposing view or potentially inconsistent policy or practice to the attention of MDHHS for consideration. As an example, the OCO Annual Report allows the OCO to publicly highlight its findings and recommendations and provides a platform for MDHHS to publicly respond.

RECOMMENDATION 2

To lessen the variability among county MDHHS offices, the OCO recommends that MDHHS revise PSM 713-01 to provide better guidance on when CPS may find a caretaker responsible for an "unsafe sleep" death. The amended policy should:

Require CPS workers to request that an alleged perpetrator submit to a timely drug and alcohol screen.

Provide specific guidance on how a CPS worker should assess the behavior or judgment of an alleged perpetrator who used alcohol or drugs at the time of the infant's death.

Specify what is considered "reasonable frequency" in checking on an infant according to their age and developmental and medical needs.

Define the phrase "adversely affected the safety of the infant" to provide guidance on the required connection between a hazardous or unsanitary home environment and an infant's death.

PSM 713-01 pp. 3-4 state:

The parent/caregiver's knowledge of the tenets of infant safe sleep and lack of following them does not, in and of itself, constitute child abuse or neglect. When a child death occurs in an "unsafe sleep" environment, evidence of the following should be considered and may affect the case disposition:

Substance abuse. The parent/caregiver was under the influence of alcohol or drugs, and there was evidence that his/her behavior or judgment was impaired and/or adversely affected his/her ability to safely care for the infant.

Supervision. The parent/caretaker did not check on the infant at a reasonable frequency consistent with the infant's age and medical or developmental needs, or the parent left the infant with a person he/she knew or should have known was incapable of safely caring for the infant.

Hazardous environment. The environmental conditions in the home were hazardous or unsanitary and adversely affected the safety of the infant.

MDHHS Response to Recommendation 2:

When CPS responds to a complaint involving the sudden and unexpected death of an infant, the focus of the investigation is to determine whether child abuse or neglect occurred prior to the death. While the investigation will include collection of evidence related to how and where the infant was placed to sleep, it is not the role of CPS to determine the cause or manner of death; and CPS does not solely base its disposition of parental abuse or neglect on how and where the infant was placed to sleep.

Because each investigation is unique, the type of evidence pursued and collected during a CPS investigation must be driven by the individual facts and circumstances of each case. MDHHS agrees further guidance is needed for investigators responding to sudden and unexpected infant deaths. However, a drug and/or alcohol screen is not categorically warranted in each investigation and existing CPS policy provides guidance to investigators on when a drug and/or alcohol screen should be pursued. MDHHS will implement policy amendments in 2018 and share them publicly.

The following are examples showing variability of practice among counties:

Substance abuse:

A mother finds her one-month-old infant unresponsive around 6 a.m. in her bed along with herself and two older children. The infant does have a crib and the children do have their own beds; however, these were not utilized. The mother tested positive for marijuana the day of her infant's death. CPS found no preponderance of evidence of improper supervision and placed the complaint in category IV.

A mother finds her five-month-old infant unresponsive around 6 a.m. in between the mattress and the adjacent wall. The infant had a crib; however, it was not being utilized. This mother was not tested for drugs on the day of her infant's death but admitted to consuming beer and liquor the night before. CPS found a preponderance of evidence of improper supervision of the infant by the mother and threatened harm of her two older children. The complaint was concluded as a category I, a permanent custody petition was filed, and her two older children were placed in foster care.

Supervision:

A mother places her four-month-old infant on her bed, on their side, on a pillow, under covers, and leaves the room to take a shower. When she returns 10-15 minutes later, she finds the infant face down on the pillow and unresponsive. CPS found a preponderance of evidence of improper supervision by the mother and utilized a mandatory override to conclude the complaint as a category I with an intensive risk level.

A mother places her one-year-old infant in their pack and play for a nap with a pillow and a blanket around 12:00 p.m. Around 6:00 p.m., the mother finds the infant unresponsive. It was determined that the mother hadn't checked on the infant for an extended period of time because rigor mortis had set in when found. The medical examiner found that the cause of death was positional asphyxia and the manner of death was accidental. No preponderance of evidence of improper supervision was found and the complaint was concluded as a category IV.

Hazardous environment:

A mother places her three-month-old infant in her bed with her, along with her seven- and nineyear-old children. The three-month-old was later found unresponsive. First responders described the home as cluttered, with mice running through it. The mother stated that she slept with her children because she did not want the mice or roaches to get to the children. The cause of death was probable asphyxia by suffocation and the manner of death was accidental. No preponderance of evidence was found and the case was concluded as a Category IV.

A mother places her ten-month-old infant to sleep on her queen-size bed on top of some blankets. When she woke up in the morning around 8:00 AM, she found the infant unresponsive. The condition of the home was said to be deplorable. CPS found a preponderance of evidence of physical neglect and improper supervision regarding the infant's unexplained death and the deplorable conditions of the home. Both parents were placed on central registry and a permanent custody petition was filed.

RECOMMENDATION 3

The OCO recommends that MDHHS publish statistics demonstrating the effectiveness of the category III open/close procedure, including a comparison of the recidivism rate of families subject to monitoring and families whose cases were immediately closed, and the number of families who voluntarily seek out and receive services following case closure.

In 1998, the Michigan Legislature added MCL 722.628d to the Child Protection Law, which established categories for dispositions of CPS complaints based on future risk to the involved children. MCL 722.628d(1)(c) states:

> *Category III - community services needed. The department determines that there is a preponderance of evidence of child abuse or child neglect, and the structured decision-making tool indicates a low or moderate risk of future harm to the child. The department shall assist the child's family in receiving community-based services commensurate with the risk to the child. If the family does not voluntarily*
> *participate in services, or the family voluntarily participates in services, but does not progress toward alleviating the child's risk level, the department shall consider reclassifying the case as category II.*

Shortly after the statute was added, MDHHS amended CPS policy to allow CPS workers to provide a referral or a list of community resources to a parent or caregiver, then immediately close the category III case (the "open/close procedure"). A CPS worker may also choose to monitor a category III case for 90 days or more. See PSM 714-1.

It should be noted that the use of the "open/close procedure" makes it impossible for CPS to comply with the last sentence of the statute. The "open/close procedure" prevents a CPS worker from determining if the needs of the family have been addressed and the risk of harm has been alleviated, or if the case should be reclassified as category II.

The OCO has reviewed numerous cases which were disposed of using the "open/close procedure," including several involving families with numerous "open/close" cases. Of particular concern are the number of child-death cases involving multiple children from a single family who were born with the active ingredient of marijuana in their bodies, where several of the complaints involving the drug-positive newborns were disposed of using the "open/close procedure."

MDHHS response to OCO Recommendation 3:

As required by MCL 722.628d(c), when the Department confirms child abuse or neglect and the structured decision-making tool indicates a low to moderate risk of future harm to the child, *"[t]he department shall assist the child's family in receiving community-based services commensurate with risk to the child."* MDHHS is presently obtaining and reviewing recurrence of maltreatment data reports for all CPS categories, including IIs and IIIs, to identify the factors that correlate with risk recurrence including child age, type of complaint, and family history. This data will inform policy and programs needed to effectively mitigate recurrence and will be shared as soon as it's available.