annual report

FY 2014

# OFFICE OF CHILDREN'S OMBUDSMAN

Dedicated to Serving Michigan's Children

# Mission Statement

The mission of the OCO is to assure the safety and well-being of Michigan's children in need of protective services, foster care, adoption services, and juvenile justice and to promote public confidence in the child welfare system.

This will be accomplished through independently investigating complaints, advocating for children, and recommending changes to improve law, policy and practice for the benefit of current and future generations.

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
OFFICE OF CHILDREN'S OMBUDSMAN
LANSING

ORLENE HAWKS
DIRECTOR

September 2015

The Honorable Rick Snyder, Governor

Honorable Members of the Michigan Legislature

Mr. Nick Lyon, Director, Michigan Department of Health and Human Services

In accordance with my statutory responsibility as the Director of the Office of Children's Ombudsman, I respectfully submit the Office of Children's Ombudsman FY 2014 Annual Report.

This report provides an overview of the activities of the Office of Children's Ombudsman from October 1, 2013 to September 30, 2014 and our role in Michigan's child welfare system. This report includes information about the complaints received and an analysis of our investigations. This year's report also contains recommendations derived from case investigations regarding non-parent adults and relative foster care placements.

We remain committed to our mission and vision that focus on changes in the child welfare system to improve outcomes for children and their families.

The staff of the Office of Children's Ombudsman appreciates the support of Governor Rick Snyder, the Department of Health and Human Services and the Michigan Legislature. Thank you for the opportunity and privilege to serve the children of Michigan.

Respectfully,

Orlene Hawks, Director and Children's Ombudsman

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# MESSAGE FROM THE OMBUDSMAN

This report marks the twentieth annual report produced by the Office of Children's Ombudsman (OCO). We have made many changes in the OCO and believe that we have made great strides in accomplishing our mission.

We have hired three new investigators, an intake analyst and a Deputy Director. We have created a new position, that of Chief Investigator.

As a team, the office researched and adopted a new procedural model that will reduce the time required to investigate a case by an estimated 33%. After using our own internal database for 20 years, we embarked on the development of a CRM case management system which will further increase our efficiency and allow our investigations to be more standardized and transparent.

We gained unfettered access to the Department of Health and Human Services MiSACWIS data system, which means that investigators no longer have to wait for files from DHHS to begin investigations. We are an active participant in the DHHS Innovation Delegation team and have recommended changes to the MiSACWIS system.

These innovations have had an effect. We have been able to reduce our backlog of cases by 75%. Office operations are more efficient, and at the end of the year, the office had a budgetary surplus available for potential training, programming and IT updating.
The Ombudsman logo and brochure have been redesigned as well. The website is undergoing substantial revision and will be completed soon. There are new scorecard metrics unique to the office that will allow for accurate reporting and transparency. Most recently, we secured new less costly office space, which will provide a more efficient and healthy working environment for our team.

What follows in this report is 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 that we feel are necessary. We are, of course, ever mindful of the hard work that all the participants in the child welfare system do ensuring the safety and well-being of the children in our state. We are committed to partnerning with the various state and private agencies in achieving that goal.

*Orlene Hawks*

*Director and Children's Ombudsman*

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# Executive Summary

## Authority

The Office of Children's Ombudsman (OCO) was established by the Children's Ombudsman Act, 1994 Public Act 204, Michigan Compiled Laws (MCL) 722.921, et seq. in 1994. The legislative purpose in creating the office was to provide the citizens of the state an impartial office to examine the operation of the various child welfare agencies to assure that they were in compliance with existing laws and policies and effect changes in the way the child welfare laws are executed. Since then the law has been amended to allow the office to examine some actions of the circuit courts in child welfare cases and agency compliance with the Foster Parent Bill of Rights Law. In 2014, the statute was amended to allow the Ombudsman to receive and investigate child death alerts.

## Administration and Staff

The Governor is empowered to appoint the Ombudsman. The Ombudsman in turn has the authority to appoint a staff sufficient to efficiently execute the statutory mandate. Presently the staff consists of a Deputy Director who supervises a multi-disciplinary team with diverse professional backgrounds and a broad range of experience in child welfare, including protective services, foster care supervision and licensing, legal practice, and family support services; seven investigators, five located in Lansing and two in Detroit; an Intake Analyst and support staff consisting of a Senior Executive Management Assistant and a Departmental Technician.

## Operating Budget

The appropriation for fiscal year 2014-2015 was $1,771,800. The principal expenditures were for personnel, office facilities and upgrading technology.

## Other Improvements

We have adopted a new set of metrics to more accurately evaluate the time needed to conduct an investigation from beginning to end. We have adopted a new logo and pamphlet. Soon we will be utilizing a greatly updated website. In accordance with the duty of the office to educate the public, that site will provide the public with answers to some basic questions concerning the operation and purpose of the Ombudsman's office. It will feature a monthly informative essay about some phase of child welfare in the state.

## Complaints and Contacts

During the period from October 1, 2013 through September 30, 2014, the OCO responded to 1,364 complaints and contacts. The OCO received 156 requests for general information about the child welfare system, referred 587 individuals to other agencies for assistance and opened 132 complaints for investigation.

The top three complaint sources were birth parents (42%), relatives of the child (23%) and the Ombudsman (21%).

## Complaints by County

In FY 2014, 46% of the 1,364 complaints and contacts received were from six counties: Wayne, Kent, Genesee, Oakland, Kalamazoo and Macomb. Wayne, the most populous of Michigan's counties, accounted for the largest number of complaints (273). Fifty-one counties reported fewer than ten complaints each, with the remaining 19 counties reporting between 11 and 49 complaints. Seven counties had no complaints during 2014.

### Quick Facts

- 1,872 children were assisted by the OCO in FY 2014.
- The average age of a child who was the subject of a complaint was 7.5 years.
- 68% of child deaths investigated by the OCO in 2014 involved a child under the age of one year.
- Unsafe sleep practices were involved in the death of 18 children in FY 2014 OCO investigations.

## Complainant Investigations

The OCO may investigate a complaint from an individual who alleges that DHHS and/or a private child placing agency violated law or policy or made decisions harmful to a child's health or safety.

**Of the 160 investigations completed this fiscal year, the majority (75%) focused exclusively on CPS concerns; 11% involved more than one program type (combination); and 14% addressed only foster care concerns.**

## Child Death Investigations

In addition, upon receipt of a child death alert from DHHS, 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

In these cases, the focus of the OCO investigation is to determine whether interventions by DHHS and/or a private child placing agency were handled in accordance with policy and law.

In FY 2014, the OCO received 262 child death alerts from DHHS resulting in the opening of 58 child death investigations. Fig. 1 shows statistics from those cases.

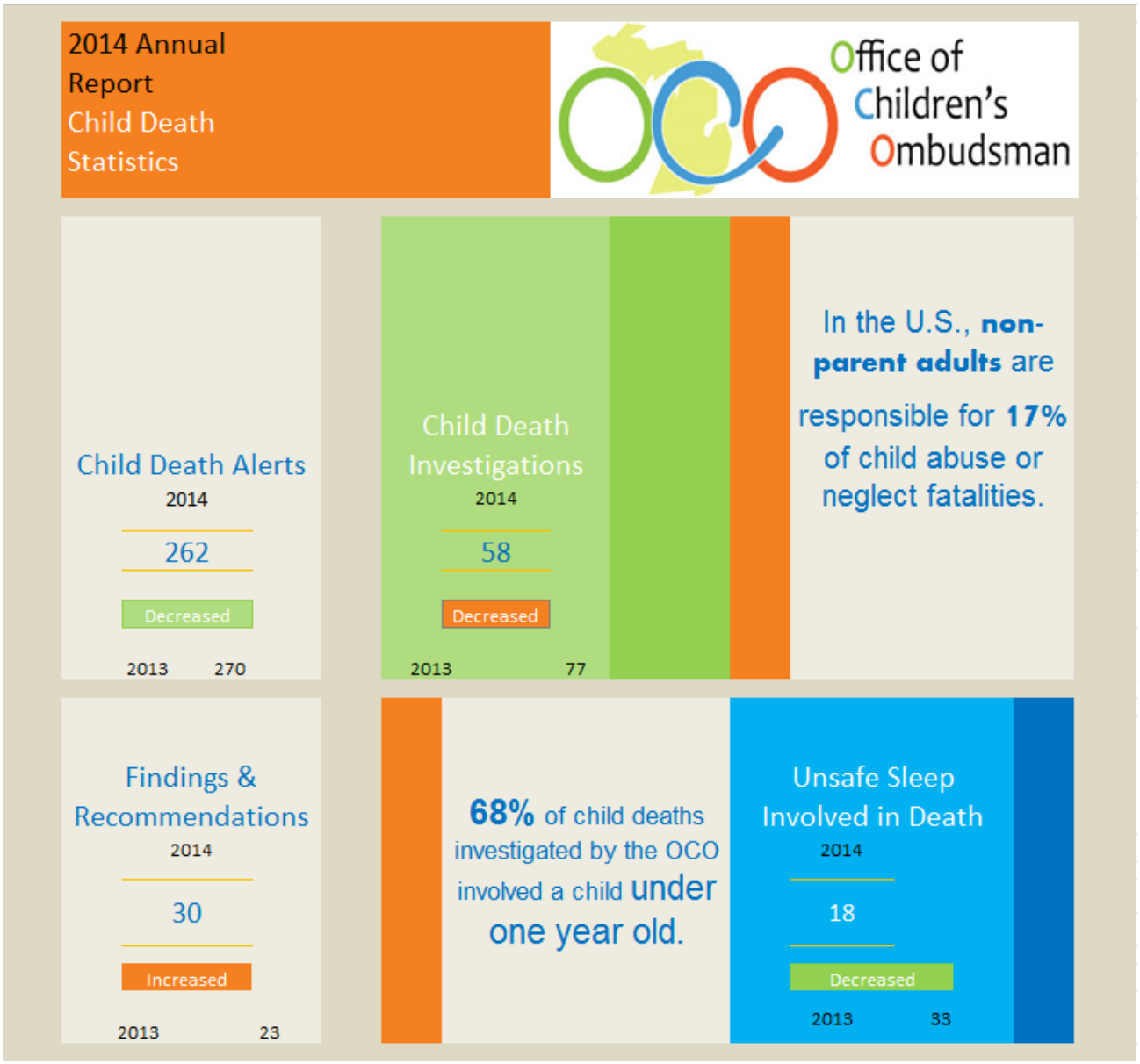


**Figure 1: Child Death Statistics – Fiscal Year 2014**

# Authority


The Office of Children's Ombudsman (OCO) is an independent state agency created by Public Act 204 of 1994 (the Children's Ombudsman Act). The Children's Ombudsman is appointed by the Governor with the advice and consent of the Michigan Senate.

The OCO

- ⇒ **Reviews** complaints about children who are involved with protective services, foster care, adoption services, and juvenile justice;
- ⇒ **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.

# Complaints and Contacts


Figure 2: Number of Complaints and Contacts per Fiscal Year

In FY 2014 the OCO responded to 1,364 complaints and contacts. Of those, 156 calls were requests for general information about the child welfare system and 587 calls were referred to other agencies for assistance.

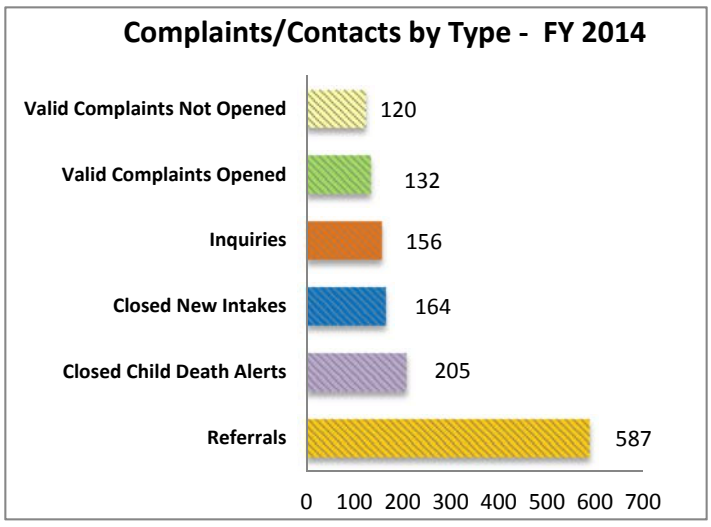


Figure 3: Complaints/Contacts by Type Fiscal Year 2014

A valid complaint is a concern about a child involved in Michigan's child welfare system where DHHS or a private child placing agency may have violated state or federal laws, state rules, and/or DHHS policies; or an alleged decision or action by DHHS or a private child placing agency was harmful to a child's safety, health or well-being.

The Ombudsman will open an investigation of a valid complaint when the complainant has exhausted other administrative remedies to resolve the complaint without success, and when an OCO investigation may positively impact the child's situation or children in future cases.

## Source of Complaints and Contacts

While anyone may file a complaint with the OCO, Section 5 of the Children's Ombudsman Act lists those individuals who may receive both findings and recommendations. Those individuals are:

(a) A child who is able to articulate a complaint.
(b) A biological parent of the child.
(c) A foster parent of the child.
(d) An adoptive parent or a prospective adoptive parent of the child.
(e) A legally appointed guardian of the child.
(f) A guardian ad litem of the child.
(g) An adult who is related to the child within the fifth degree by marriage, blood, or adoption, as defined in section 22 of the adoption code, MCL 710.22.
(h) A Michigan legislator.
(i) An individual required to report child abuse or child neglect under section 3 of the child protection law, 1975 PA 238, MCL 722.623.
(j) An attorney for any of the above.

The Ombudsman has the discretionary authority to investigate a complaint made by any individual not listed above. However, if the individual is not listed above, he or she may only receive recommendations made by the OCO. The Ombudsman may also open an investigation upon her initiative.

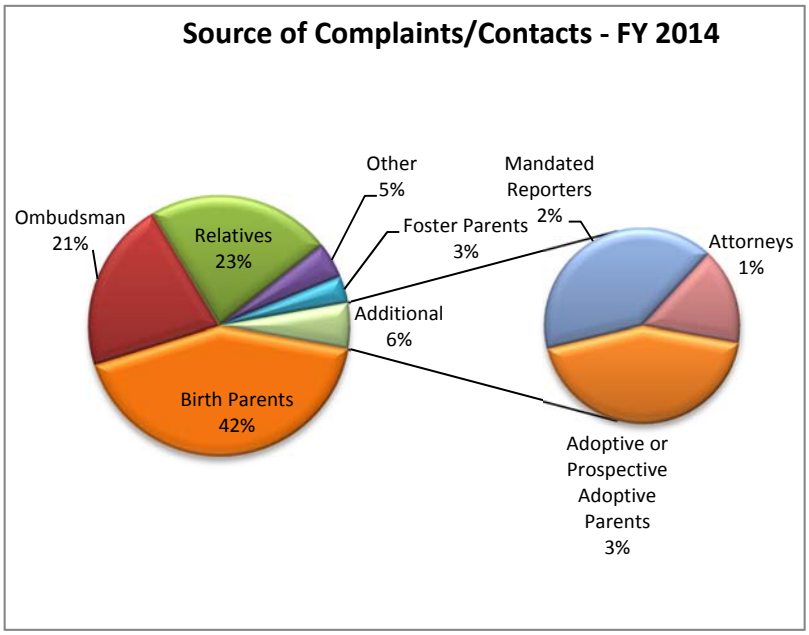


Figure 4: Source of Complaints –FY 2014

The 1,364 complaints and contacts received this FY involved 1,872 children in 76 counties.

The top three complaint sources were birth parents (42%), relatives of the child (23%) and the Ombudsman (21%).

## Complaints by County

The OCO tracks the number of complaints received by each county in the state. Figure 5 illustrates the complaint activity in each of the 83 counties for the 2014 fiscal year.

Forty-nine counties reported ten or fewer complaints; eight counties reported between 11 and 20 complaints; seven counties reported between 21 and 30 complaints; six counties reported 31 to 49 complaints; 58 complaints were reported from Kalamazoo County, 59 from Macomb County, 71 from Oakland County, 82 from Genesee County, 84 from Kent County and 267 from Wayne County.

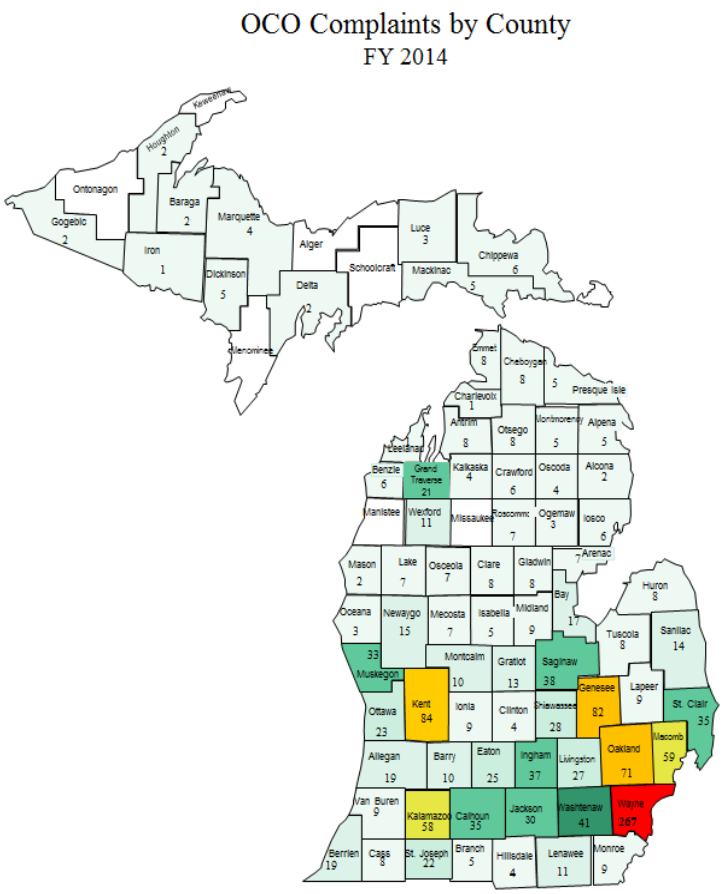


**Figure 5: OCO Complaints by County**

## Child Death Alerts

When DHHS is notified that a Michigan child has died, its'Office of Family Advocate (OFA)notifies the OCO by email. This Children's Protective Services Child Death Report is also known as a "child death alert." Information in the death alert can determine whether or not the OCO opens an investigation. In FY 2014, the OCO received 262 child death alerts from DHHS resulting in the opening of 58 child death investigations.

The Children's Ombudsman Act lists specific criteria to determine whether the OCO must open a child death investigation. The focus of an OCO investigation is to determine whether interventions by DHHS and/or a private placing agency prior to a child's death complied with policy and law. 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.

**The OCO received 262 child death alerts in FY 2014.**

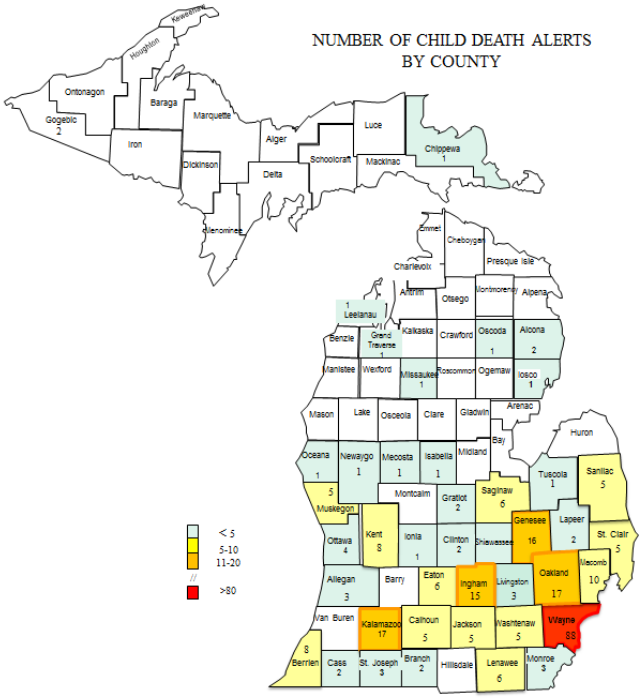


Figure 6: Number of Child Death Alerts by County

## Child Death Alerts by County

With 88 child death alerts, Wayne County reported the greatest number of child deaths in FY 2014. Oakland and Kalamazoo Counties each reported 17, Genesee County reported 16 and Ingham County reported 15. See Figure 6.

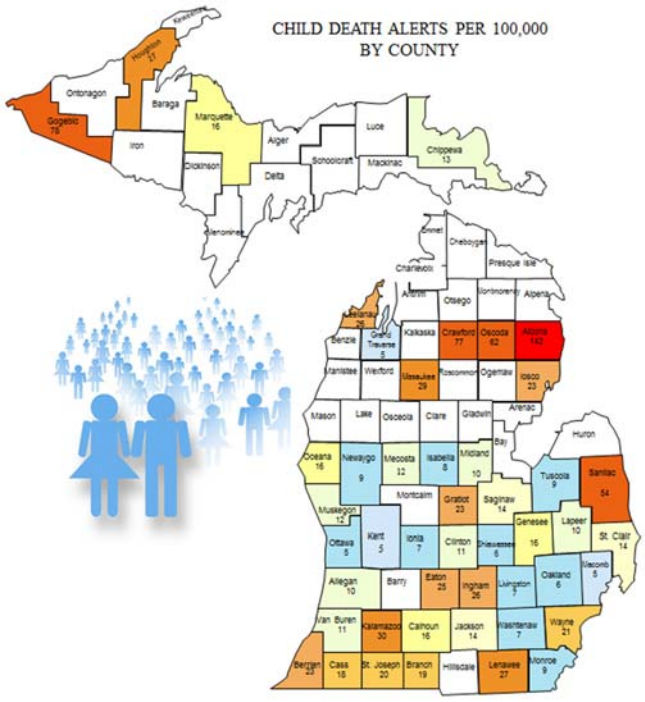


Figure 7: Number of Child Death Alerts per 100,000 Children by County

Figure 7 shows the number of child death alerts per 100,000 children in each county. The counties with the highest number of child death alerts per capita are Alcona, Gogebic, Crawford and Sanilac Counties.

# Complainant Investigations

The OCO may investigate a complaint from an individual who alleges that DHHS and/or a child placing agency violated law or policy or made decisions harmful to a child's health or safety.

An OCO investigator reviews case file records and interviews agency staff and other sources as needed. Documents reviewed from DHHS and/or private agencies include, but are not limited to, agency-generated records and reports, court documents, service provider reports, personal or confidential documents and other information deemed relevant by the OCO. Records and information are assessed according to DHHS policy, procedure, and applicable laws to determine whether the actions and decisions by the agency were in compliance. Cases sometimes involve more than one DHHS county office or private child placing agency investigations primarily focus on resolving concerns identified by the complainant. If other issues are identified during the OCO's investigation, those may be included as part of the OCO's investigation. These additional issues may be addressed with the involved agency.

Of the 160 investigations completed this FY, the majority (75%) focused exclusively on CPS concerns; 11% involved more than one program type; and 14% addressed only foster care concerns.

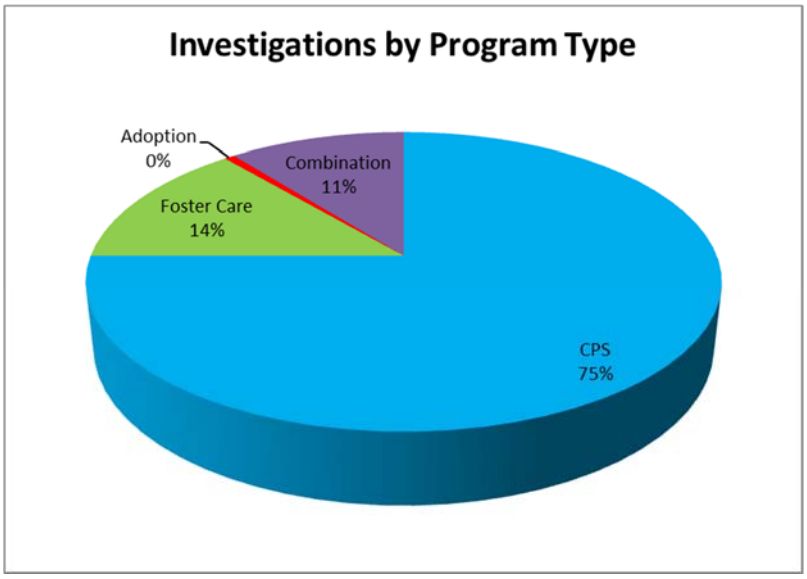


Figure 8: Investigations by Program Type

75% of investigations focused exclusively on Children's Protective Services concerns.

## Investigatory Interventions

If, based upon a complaint or information discovered at any other time during the course of an investigation, the OCO determines that immediate action is needed to protect a child or to ensure the well-being of a child, the OCO may issue one of the following to DHHS:

Request for Action

A Request for Action (RFA) is a request that DHHS address a concern that has come to the attention of the OCO that requires immediate attention. Because the concern may be time-sensitive or a child may be at risk, the OCO may not verify the information which forms the basis of the request. The RFA may be issued to the DHHS based solely on information obtained from a complainant at intake.

A Request for Action is issued to DHHS under one or more of the following circumstances:

- ⇒ Immediate risk to a child
- ⇒ Inappropriate placement of a child leaving the child at risk.

These requests are submitted to the DHHS Office of Family Advocate, and the involved agency responds in writing within five business days. An RFA may involve more than one concern about a child.

Although the OCO did not issue any Requests for Action this fiscal year, the following are examples drawn from prior year's activities.

A RFA issued in a previous year involved concerns about delayed mental health services for siblings. One of the siblings had mental health issues that the OCO believed required immediate attention. DHHS confirmed there was a delay in commencing the mental health services and after receiving the Request for Action took immediate steps to rectify the situation.

Another instance of an RFA issue involved asking DHHS to file a petition requesting termination of parental rights of both parents as required by section 18 of the Child Protection Law. DHHS filed the legally mandated petition after the prosecuting attorney refused to include both parents on the petition.

Request for Administrative Response

If the OCO determines that immediate review of an agency action or decision is necessary to protect a child or address a delay in permanency for a child, the OCO may issue a Request for Administrative Response (RFAR) to DHHS and/or a private child placing agency. This request for response may be made to the agency following intake (based solely on information verbally reported to the OCO) or during an OCO investigation. In these elevated response situations, the involved agency, responds within 10 business days.

The following is a summary of three RFARs and the DHHS responses for this fiscal year:

The first example presents an issue referred to as "relative placement." In this case, there were two children:

*The OCO requested that DHHS comply with MCL 722.954a and FOM 722-03B regarding relative placement by completing the Initial Relative Safety Screen, conducting a home study, giving "special consideration and preference" to placement of both children with a relative, and consider "proximity to the family,"and "continuity of relationships." Further, the OCO requested that the agency record on form DHS-31 that it considered these factors when making its placement decision, and distribute that document to the entitled parties.*

In response to OCO's request, DHHS completed an Initial Relative Safety Screen. The screen revealed that the relative being

considered for placement did not meet current DHHS standards because of a felony conviction, past and current drug use, and uncooperative contacts with DHHS requiring law enforcement intervention. DHHS declined to make that placement, completed form DHS-31, distributed it to the required parties, and gave consideration to placement with relatives, proximity to family, placement with siblings and continuity of relationships.

The second case resolved conflicting recommendations from two agencies concerning adoption planning involving a child's grandparents.

The OCO requested that DHHS resolve the stalemate regarding adoption planning for the child with her paternal grandparents. Conflicting recommendations regarding adoption planning with the grandparents left her without permanency and allowed continued placement with foster parents who did not wish to adopt her. While the adoption agency recommended the grandparents for adoption, and the MCI superintendent recommended that supervised visits begin with the grandparents so that this additional information could be used in his consent decision, the family court ordered that visits not take place between the child and the grandparents.

DHHS's response to the RFAR: *Although the adoption agency recommended that the grandparents be granted consent to adopt, it is the MCI superintendent and DHHS that ultimately present the final consent decision and recommendation to the court regarding who should adopt the child. After a careful review of this case, the MCI superintendent could not wholly recommend the paternal grandparents for placement. To assist in his decision making, he requested that the court grant visitation to the grandparents but the court denied the request. A meeting between DHHS, the agency, Lawyer the Guardian ad Litem to discuss whether it is in the child's best interest to request that the court reconsider the order against visitation was scheduled. In the meantime, the agency continued its effort to recruit a suitable adoptive placement and the child was placed on the Michigan Adoption Resource Exchange.*

A third RFAR involved a caseworker leaving children at a hospital overnight after removal from their homes while an appropriate placement was found.
The OCO requested that DHHS review the legality and appropriateness of the decision to request that a hospital house children overnight while seeking placements for them.

The OCO also requested that DHHS ensure the appropriateness and safety of one child's current placement.

The OCO requested that DHHS and Centralized Intake determine whether a CPS worker or other local-office DHHS employee is a "person responsible" for the health and welfare of a child in the worker or employee's physical custody pursuant to court order, and whether leaving a child at a hospital without agency supervision constitutes "child neglect."

DHHS' response: *DHHS Central Office and county administration reviewed the appropriateness of the decision to leave the children at the hospital pending their placement. As a result, the County DHHS director sent a communication to all children's services staff regarding the need for appropriate placements of all foster children, including children who require hospital treatment and/or stays. CPS Program Office agreed to provide a communication to the field through the monthly supervisory teleconference to ensure that children's services staff in general have a better understanding of their roles in these situations.*

DHHS reported that the child was placed with his biological father and that DHHS

determined the placement to be appropriate and the father was receiving the necessary services.

DHHS Children's Legal Services, for its part, was to make a request to the Michigan Attorney General to determine whether a local office DHHS employee should be considered as a "person responsible" based on their employment status.

## Case Resolutions

The OCO completed 160 investigations in FY 2014.[1]
Investigations are resolved in three different ways:

Affirmation

The OCO found no violations of law, policy, or procedure.

**The OCO affirmed DHHS and/or a child-placing agency 68 times following investigations.**

Administrative Close
Cases are resolved in this manner when they cannot be affirmed; however, a Report of Findings and Recommendations is not warranted. The OCO closes its investigation administratively when:

- ⇒ The agency is currently addressing the complainant's concerns.
- ⇒ The OCO investigation revealed that further OCO involvement will not affect the outcome of the case.
- ⇒ The agency addressed law, policy, or practice violations at the OCO's request.

**The OCO concluded 79 investigations as administrative closings this fiscal year.**

Preliminary Investigations
A case is opened for a preliminary investigation to determine whether a full investigation is warranted, or if it is determined at intake that the complainant's specific concern may be quickly resolved.

**The OCO concluded 34 preliminary investigations this fiscal year.**

Findings and Recommendations
A Findings and Recommendations (F&R) is issued by the OCO to DHHS and/or private child placing agency for major violations of laws, rules, and/or policies, or agency actions and decisions were not consistent with the case facts or the child's best interests. The F&R contains specific findings describing the violations and corresponding recommendations that certain actions be taken.

**In 49 Reports of Findings and Recommendations, the OCO issued 198 findings and 169 recommendations this fiscal year.**

## Release of Results to Complainants

When an investigation is completed, the OCO notifies the complainant in writing of the outcome of the investigation and any action taken by the involved agencies to address the complaint issues. The relationship a complainant has to the child, as described in the Children's Ombudsman Act, governs the information that can legally be provided to the complainant. In addition, the OCO adheres to state and federal laws governing confidentiality; therefore, there may be information that cannot legally be provided to a complainant about the results of the OCO's investigation.

The Children's Ombudsman Act also prohibits the OCO from sending written

[1] Because an investigation may involve more than one agency, and the investigation may involve a different resolution for each agency, the number of resolution cited here is greater than 160.

results to a complainant if there is an ongoing CPS or law enforcement investigation at the time the OCO investigation is completed.

In these cases, the OCO sends the complainant a letter stating that he or she will receive the OCO results once the CPS and/or law enforcement investigations are closed.

## Analysis of Findings Regarding Complainant Cases (Violations)

The most prevalent findings this Fiscal Year were in the CPS program area. The Child Protection Law and DHHS/CPS policy require numerous actions and decisions by caseworkers for every CPS investigation. There are more than 50 CPS policies that guide caseworkers through the investigation process and describe what must be documented.

The OCO produced **49** F&Rs regarding CPS, encompassing **198** findings and **169** recommendations. As in previous years, the majority of the findings for this fiscal year focused on noncompliance with existing law or policy.

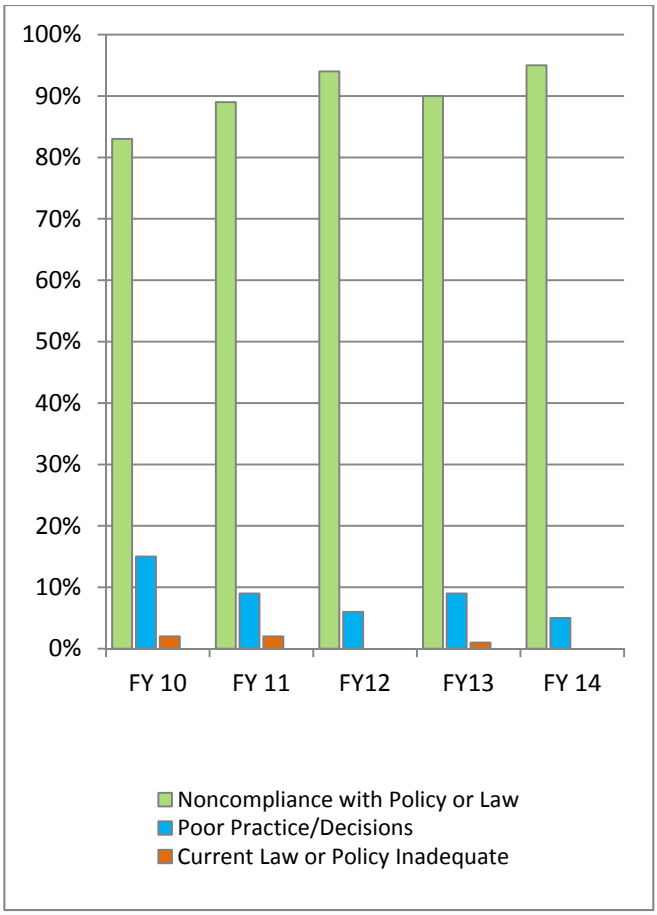


Figure 9: **OCO Findings**

A brief description of the most frequently violated CPS policies and a few of the non-compliance issues the OCO found include:

PSM 713-1 CPS Investigation – General Instructions and Checklist. This policy describes the actions CPS must take for every investigation. Common areas of non-compliance with this policy included:

- Failure to contact mandated reporters
- Failure to view and record an infant's sleep environment
- Failure to interview the alleged perpetrator and collateral contacts
- Failure to interview all children and nonparent adults who reside in the home
- Identifying unsafe sleep practices, by themselves, as child abuse or neglect

PSM 713-3 Face-to-Face Contact. This policy defines who caseworkers are required to have face-to-face contact with during an investigation. In many instances the OCO found that DHHS:

- Failed to comply with policies concerning interviewing children at school
- Failed to make face-to-face contact with non-custodial parents

PSM 713-04 Medical Examination and Assessment. This policy describes the purpose of a medical exam, when a medical exam is required, communication with medical practitioners, and the required contacts for medically fragile children. Non-compliance was found in this area in that there was:

- Failure to obtain a medical exam when required by policy
- Failure to communicate with medical practitioners when requesting a medical examination

PSM 713-08 Special Investigative Situations.
This policy, in part, defines threatened harm and describes the steps that CPS must document if an alleged perpetrator cannot be interviewed. The common areas of non-compliance with this policy included:

- Inappropriately finding a parent responsible for
- threatened harm without evidence of another form of child abuse or neglect
- Failure to document efforts made in an attempt to secure an alleged perpetrator's cooperation with the investigation

Child Protection Law and the Juvenile Code. Violations of these laws included:

- Failure to file mandatory petitions
- Inaccurate findings of child abuse and neglect
- Failure to request immediate protective custody
- Failure to refer complaints to the prosecuting attorney/law enforcement

In addition to findings regarding specific policy and law violations, the OCO also identified as prevalent concerns issues about poor practices and poor decisions.

Specific examples of findings in these areas included:

- Failure to provide services to a parent or other caregiver
- Providing services without an identified and/or justified need
- Making a safety plan that required a child to take responsibility for his own safety.
- Failure to contact an alleged victim or perpetrator timely.
- Requesting an ex-parte order without substantial, imminent or immediate risk of harm.

CASE EXAMPLE #1

In its 2013 annual report, the OCO recommended that MDHHS improve compliance with MCL 722.637 and 722.638, which requires the department to file court petitions in certain circumstances. MDHHS agreed to explore policy and practice changes to improve agency compliance with these laws.

In 2014, the OCO investigated a complaint concerning a mother whose parental rights had been terminated in another state in 1999 for severe physical abuse of two children. In 2013, a county DHHS office conducted a CPS investigation, found her responsible for abusing one of her current children, but failed to file a petition requesting termination of her parental rights to that child as required by MCL 722.638. The OCO found that the county agency violated this statute, and the agency agreed. The OCO recommended that DHHS Central Office implement changes to MiSACWIS that will prevent a CPS worker or supervisor from proceeding further with case documentation without completing and submitting a petition when required by MCL 722.638. MDHHS CPS Program Office agreed to work with MiSACWIS staff to implement a change to the system that will notify workers and supervisors when a mandatory petition is required.

## Investigation Results by Agency in Complainant Cases

The 160 investigations completed in FY 2014 involved 45 DHHS county offices and 16 private child placing agencies. Some cases involved investigations of multiple agencies.

One hundred forty-one investigations (88%) involved only DHHS (one or more county agencies), seven (4%) involved both DHHS and one or more private child placing agencies, and 12 (8%) involved only a private child placing agency. The investigations resulted in 34 preliminary closings, 68 affirmations, 49 with findings and recommendations, and 79 administrative closings.

The following charts list the outcome(s) by DHHS county office and private child placing agency for OCO investigations completed in FY 2014.

**INVESTIGATIONS 2014 – OUTCOMES BY AGENCY [PCPAs]**

| Private Child-Placing Agency (PCPAs) | Number of Investigations | Case Closure Type (Outcome) Distribution | | | |
|---|---|---|---|---|---|
| 16 PCPAs | | Affirmation | Findings & Recommendations | Administrative | Preliminary |
| Alternatives for Children | 1 | 1 | | | |
| Bethany Christian Services | 2 | 1 | | 1 | |
| Catholic Charities | 2 | | | 1 | 1 |
| DA Blodgett Services for Children & Families | 1 | | | | 1 |
| Ennis Center for Children | 1 | | | 1 | |
| Family & Children's Services of Midland | 1 | | | | 1 |
| Families Counseling & Children's Services | 1 | | | | 1 |
| Guiding Harbor Girlstown | 1 | | | | 1 |
| Judson Center | 1 | | | 1 | |
| Lutheran Social Services | 2 | 1 | | 1 | |
| Oakland Family Services | 2 | | 1 | | 1 |
| Orchards Children's Services | 1 | | | 1 | |
| Spectrum Human Services | 1 | | 1 | | |
| Wellspring Lutheran Services | 1 | | 1 | | |
| Wolverine Human Services | 1 | | | 1 | |
| Youth Guidance Foster Care | 1 | | | | 1 |
| Totals PCPAs | 20 | 3 | 3 | 7 | 7 |

| OCO INVESTIGATIONS 2014 – OUTCOMES BY AGENCY | | | | | |
|---|---|---|---|---|---|
| **DHHS** | **Number of Investigations** | **Case Closure Type (Outcome) Distribution** | | | |
| 45 County Offices | | Affirm | Findings & Recommendation | Administrative | Preliminary |
| Alcona | 1 | 1 | | | |
| Allegan | 2 | | | | 2 |
| Antrim | 1 | 1 | | | |
| Benzie | 1 | | | | 1 |
| Berrien | 1 | | 1 | | |
| Calhoun | 1 | | | 1 | |
| Cass | 1 | | | | 1 |
| Chippewa | 1 | | | 1 | |
| Clare | 1 | | 1 | | |
| Clinton | 1 | | | 1 | |
| Crawford | 2 | 1 | 1 | | |
| Centralized Intake | 5 | 1 | 2 | | 2 |
| Dickinson | 1 | | | 1 | |
| Eaton | 4 | 1 | | 3 | |
| Emmet | 1 | | 1 | | |
| Genesee | 14 | 8 | 2 | 3 | 1 |
| Gratiot | 2 | | | 2 | |
| Huron | 2 | | 1 | | 1 |
| Ingham | 9 | 1 | 1 | 6 | 1 |
| Jackson | 6 | 2 | 1 | 3 | |
| Kalamazoo | 14 | 1 | 2 | 10 | 1 |
| Kent | 7 | | 3 | 3 | 1 |
| Lapeer | 1 | | 1 | | |
| Lenawee | 4 | | 1 | 2 | 1 |
| Livingston | 4 | 1 | 1 | 1 | 1 |
| Macomb | 11 | 2 | 6 | 2 | 1 |
| Mason | 1 | 1 | | | |
| Mecosta | 1 | | 1 | | |
| Midland | 1 | 1 | | | |
| Monroe | 1 | | 1 | | |
| Muskegon | 4 | | 1 | 2 | 1 |
| Newaygo | 1 | | | | 1 |
| Oakland | 13 | | 2 | 11 | |
| Osceola | 1 | | 1 | | |
| Otsego | 1 | | | | 1 |
| Ottawa | 2 | | 1 | 1 | |
| Presque Isle | 1 | | | | 1 |
| Saginaw | 6 | 1 | 3 | 2 | |
| Sanilac | 1 | | | | 1 |
| Shiawassee | 1 | | | | 1 |
| St. Clair | 8 | 2 | | 3 | 3 |
| St. Joseph | 1 | | 1 | | |
| Tuscola | 1 | 1 | | | |
| Washtenaw | 5 | | 2 | 1 | 2 |
| Wayne | 28 | 5 | 8 | 13 | 2 |
| Totals DHHS | 176 | 31 | 46 | 72 | 27 |

**Table 1: OCO INVESTIGATIONS OUTCOMES BY– DHHS**

## Child Death Investigations

The Children's Ombudsman Act lists specific criteria to determine whether the OCO must open a child death case for investigation. The focus of an OCO investigation is to determine whether interventions by DHHS and/or a private child-placing agency prior to a child's death complied with policy and law. 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.

An OCO investigation must be conducted when a child's death allegedly resulted from abuse or neglect and at least one of the following criteria is met:

- 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 reviews agency case files and may request records of a court, attorney general, prosecuting attorney, private attorney retained by DHHS, and a county child fatality review team

The OCO opened 58 new death investigations in FY 2014.

"It's hard to imagine anything as devastating as the loss of a child, especially a loss that is 100 percent preventable." [2]

Sue Snyder, 2014

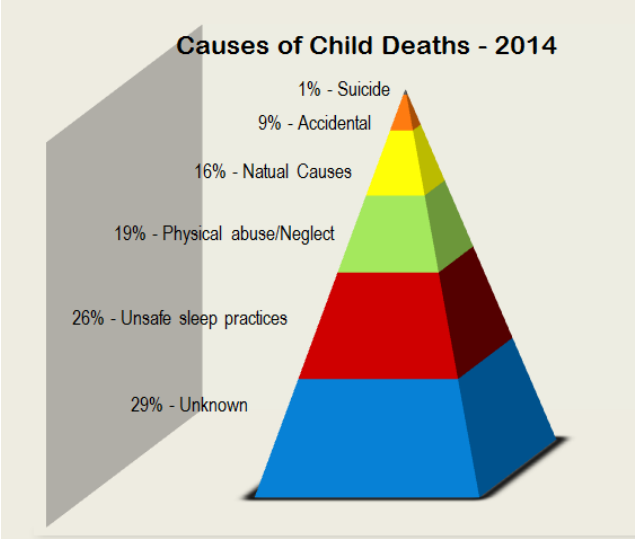


Figure 10: Causes of Child Deaths Fiscal Year 2014

## Analysis of Findings

The most prevalent findings pertaining to CPS involvement with a family prior to a child's death and during the CPS investigation of the child's death were:

- ⇒ CPS workers failed to comply with policies requiring medical examinations or consultations in cases involving physical abuse, child death, or "medically fragile" children.
- ⇒ CPS workers failed to contact or interview a child; a parent, guardian, or other caretaker; a mandated reporter; or key witnesses.
- ⇒ CPS workers failed to reach the correct disposition of a complaint based on evidence gathered during the investigation.
- ⇒ CPS workers failed to accurately document a family's child welfare history.
- ⇒ CPS workers failed to comply with policies governing "threatened harm" and domestic violence.

[2] Helen DeVos Children's Hospital. (2014). The Importance of safe sleep practices, Sue Snyder. [Press release]. Retrieved from http://www.michigan.gov/dhs/0,4562,7-124--340085--sm,00.html

## Child Death Statistics

FIG. 11 shows that 54 (68%) of the children in the 79 death investigations completed in 2014 were under age one at the time of death, and 89% were three years old or younger.

Six death investigations (8%) involved children aged twelve through seventeen years.

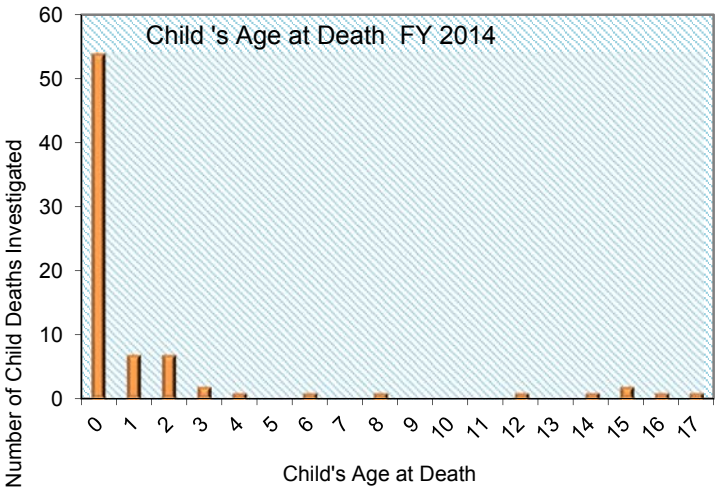


Figure 11: Child's Age at Death FY 2014

FIG. 12 shows the location of child deaths that were investigated in FY 2014. Of the 29 counties where a child death occurred, the highest numbers of investigations per county were from Wayne (17), Kalamazoo (11), Oakland (8), Genesee (7), Saginaw (5) and Ingham (5).

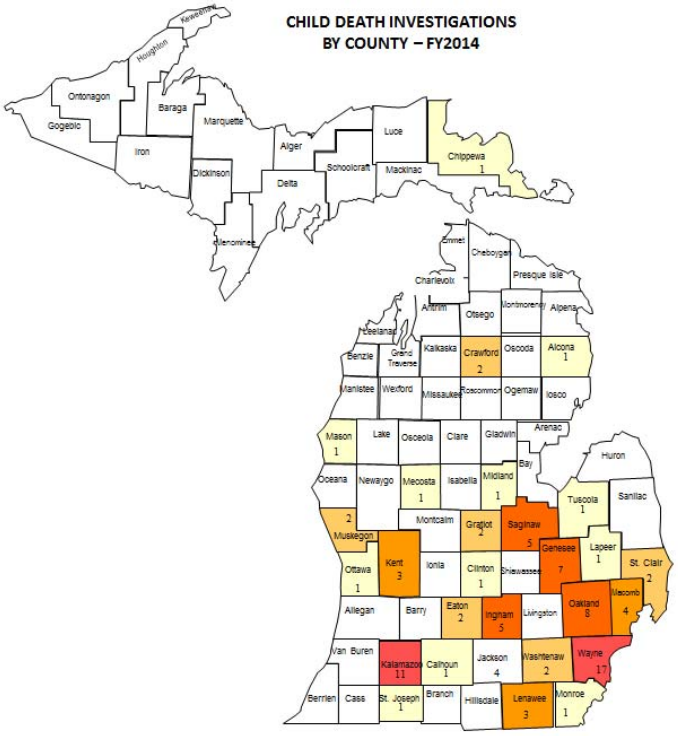


Figure 12: Child Death Investigations by County

CASE EXAMPLE #2

In 2013, the OCO reviewed a highly publicized child death case from Wayne County. As a result of its investigation, the OCO issued a lengthy report of Findings and Recommendations, most with which DHHS agreed with. In March 2015, the OCO requested information regarding actions that were to be taken as a result of the 2013 child death investigation.
The following are examples of changes and improvements made to Michigan's Child Welfare system following the OCO investigation:

- ⇒ CPS Program Office and the Office of Family Advocate (OFA) developed a training specific to evaluating threatened harm and safety. This training was presented to all Wayne County staff in 2013. All child welfare staff statewide is expected to attend the training by the end of 2015.
- ⇒ The Assistant Attorney General's (AAG) office provided training to all Wayne County child welfare workers, supervisors, and managers regarding the circumstances that require a petition be filed and now provides ongoing refresher training in Wayne County on a variety of topics including court preparation, petition writing, and court testimony.
- ⇒ CPS policy is to be modified to reflect the legal requirement that a petition must be filed during an open CPS case with high or intensive risk if the perpetrator refuses to voluntarily participate in services.
- ⇒ Medical personnel from local hospitals attended a Wayne County CPS supervisors' meeting to clarify the role of medical personnel and the importance of communicating with CPS prior to a child being examined in an emergency room at the request of CPS.
- ⇒ A Mandated Reporter Initiative Work Group was formed in 2013. This group has developed a resource website for DHHS staff and mandated reporters in Michigan.
- ⇒ CPS policy regarding face-to-face contact during open CPS cases was enhanced (effective 7/1/15).
- ⇒ A 4-day domestic violence training will be required for all child welfare caseworkers and supervisors beginning in the Fall 2015.
- ⇒ The Wayne County protocol on child abuse has been updated.
- ⇒ Representatives from Wayne County Children's Services Administration, the Detroit Police Department's Child Abuse Unit, the Family Court, the AAG, and the Wayne County Prosecutor formed a group and agreed to meet quarterly to address system issues and identify strategies to enhance collaboration efforts.
- ⇒ Multiple Management Directive Letters (MDL) were issued (or reissued) in Wayne County that provided guidance to child welfare staff on a variety of topics that included:
    - o "Protocol for Investigating CPS Complaints Concerning Medical Neglect"
    - o "Compelling Parental Compliance for Assessments and Services on Protective Services Cases"
    - o "Expectations when Filing Petitions"

# Child Death Investigations – Results by Agency

The OCO completed 79 child death investigations[3] in FY 2014. These included cases pending from FY2013 and cases opened in FY2014, and involved **29** DHHS county offices and **2** private child-placing agencies. The numbers in the chart below reflect investigations involving multiple agencies.

| Agency | # of Child Death Investigations | Case Closure Type (Outcome) Distribution | | |
|---|---|---|---|---|
| DHHS | | **Affirm** | **F&R** | **Administrative** |
| Alcona | 1 | 1 | | |
| Calhoun | 1 | | | 1 |
| Chippewa | 1 | | | 1 |
| Clinton | 1 | | | 1 |
| Crawford | 2 | 1 | 1 | |
| Centralized Intake | 3 | 1 | 2 | |
| Eaton | 2 | 1 | | 1 |
| Genesee | 7 | 5 | 2 | |
| Gratiot | 2 | | | 2 |
| Ingham | 5 | 1 | | 4 |
| Jackson | 4 | 1 | 1 | 2 |
| Kalamazoo | 11 | 1 | 2 | 8 |
| Kent | 3 | | 1 | 2 |
| Lapeer | 1 | | 1 | |
| Lenawee | 3 | | 1 | 2 |
| Macomb | 4 | 1 | 3 | |
| Mason | 1 | 1 | | |
| Mecosta | 1 | | 1 | |
| Midland | 1 | 1 | | |
| Monroe | 1 | | 1 | |
| Muskegon | 2 | | 1 | 1 |
| Oakland | 8 | | 1 | 7 |
| Ottawa | 1 | | 1 | |
| Saginaw | 5 | 1 | 3 | 1 |
| St. Clair | 2 | 1 | | 1 |
| St. Joseph | 1 | | 1 | |
| Tuscola | 1 | 1 | | |
| Washtenaw | 2 | | 2 | |
| Wayne | 17 | 3 | 5 | 9 |
| **Totals** | **94** | **21** | **30** | **43** |
| Orchard Children's Services | 1 | | | 1 |
| Wolverine Human Services | 1 | | | 1 |
| **Grand Totals** | **96** | **21** | **30** | **45** |

**Figure 13: Child Death Investigation – Results by Agency**

[3] Several of the investigations involved more than one agency and resulted in 96 separate outcomes.


# Recommendations

## Recommendation 1: Non-Parent Adults

In 2014, CPS workers confirmed abuse or neglect in 21,049 investigations. Of those cases, 1510 perpetrators were unrelated to the child victim. Nationwide, non-parents are responsible for 17% of child abuse or neglect fatalities.[4]

In its annual reports between 1995 and 1998, the OCO recommended several legal and policy changes to address the increasing presence of a parent's "living-together partner" (typically a "boyfriend") in the home. In response to the OCO's recommendations, the Michigan Legislature enacted new law, which:

- ⇒ Defined "non-parent adult" as a person who has substantial and regular contact with a child, a close personal relationship with the child's parent or other caretaker, and is not related to the child.
- ⇒ Permitted CPS to place a non-parent adult on its central registry if it determined that the non-parent adult abused or neglected a child.
- ⇒ Permitted courts to take jurisdiction over a child based on a non-parent adult's conduct and issue orders to the non-parent adult (most importantly, orders restricting the non-parent adult's contact with the child).
- ⇒ Permitted courts to terminate a parent's parental rights based on the non-parent adult's conduct.

Although existing law and policy allow CPS and courts to address non-parent adult conduct, they only address the issue after something bad has happened to a child—i.e., after a child has been abused or neglected, a non-parent adult has been substantiated, or a petition has been filed in court.

[4] The FY 2014 statistic is derived from a DHHS boilerplate report required under 2014 PA 252, Article X, Section 514. Michigan does not separately report the number of non-parent adult perpetrators to the Michigan Legislature or the federal government. See *Child Maltreatment 2013*, Table 5-5, Perpetrators by Relationship to Their Victims, 2013, p. 76. The national fatality statistic is from *Child Maltreatment 2013*, Table 4-4, Child Fatalities by Relationship to Their Perpetrators, p. 61.

Law and policy changes are needed to require CPS workers to evaluate the safety of a child in a non-parent adult's care during an investigation and to allow a court to better address non-parent adult conduct after a court case has closed.

The OCO recommends the following:

**DHHS should add language to the CPS safety assessment requiring workers to address a non-parent adult's legal relationship with his own children, if any.** CPS workers should obtain relevant court records, document reasons why a non-parent adult does not have custody of his children, and assess why a parent without custody of his own children can safely parent another parent's child. If the non-parent adult does not have children, the CPS worker should assess the non-parent adult's capacity to safely supervise the parent's children by evaluating such factors as the non-parent adult's age, previous experience (if any) supervising children, the child's age, and the child's vulnerability.[5]

**The Michigan Legislature should amend section 7 of the Child Protection Law, MCL 722.627, to allow a CPS worker to disclose a non-parent adult's CPS history to a parent.** Currently, CPS workers investigating a "known perpetrator complaint" (for example, a boyfriend with CPS history has moved in with a new family) are prohibited by law from disclosing the boyfriend's CPS history to the parent. However, CPS workers must still warn the parent that the parent will be held responsible if the boyfriend harms the parent's child. Permitting disclosure to the parent would allow the parent to make a fully informed decision.

In lieu of the proposed statutory amendment outlined above, DHHS should amend policy to require CPS workers to ask a non-parent adult to sign a release of information to allow the worker to immediately communicate the non-parent adult's CPS history to the parent.

**The Michigan Legislature should amend section 2 of the Child Protection Law, MCL 722.622, to expand the definition of "threatened harm" to include risks associated with a non-parent adult who is being investigated by law enforcement for a crime against a child, who has current charges against him for a crime against a child, or who has lost custody of his own children or has had contact with his own children restricted in some way (e.g., supervised parenting time).** Current law requires threatened harm to be based upon a caretaker's criminal conviction, formal CPS finding of child abuse or neglect, or prior termination of parental rights.

**The Michigan Legislature should amend sections 6a and 13b of the Juvenile Code, MCL 712A.6b and MCL 712A.13a, to clarify that an order permanently prohibiting the non-parent adult from entering a child's home or having contact with a child survives the court's termination of jurisdiction over the child. It is unclear whether such orders end by operation of law when the court that issued the order terminates its jurisdiction of the case in which the order was entered.**

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[5] Concerns could be addressed in safety assessment item 7, "Caretaker makes inadequate/inappropriate child care arrangements or plans very poorly for child's care."

**MDHHS Response to Recommendation 1:**
Current law and policies related to non-parent adults provide sufficient tools needed for CPS staff to thoroughly assess child safety and take necessary action to protect children. However, further guidance to the field regarding practice application will be provided in 2015 and 2016 to increase consistency and thoroughness when assessing child safety, when investigating these cases, and when filing petitions based on threatened harm. The Department will provide a statewide training conference for child welfare staff in December 2015 which will focus on assessing child safety with an emphasis on threatened harm, including situations involving non-parent adults.

## Recommendation 2: Relative Placement

Under current law, within 30 days of a child's removal from parental custody, CPS and foster care workers must identify, locate, and consult with relatives to attempt to place the child in a fit and willing relative's care as an alternative to placement in an unrelated foster parent's home. In fact, current law establishes a preference for placement of children with relatives during the 90 days following removal. Within this 90 day period, foster care agencies must document a final placement decision and distribute that decision to the parties to the case and any relative interested in placement of the child. DHHS policy requires caseworkers to use the form DHHS-31 to meet this legal requirement.

The OCO continues to receive numerous complaints from relatives who allege that they expressed interest in taking placement of their relative-child, were denied placement, but never received a formal decision from the foster care agency as required by Michigan law.[6]

**To improve practice in this area, the OCO recommends that the Michigan Legislature amend section 4a of the Foster Care and Adoption Services Act, MCL 722.954a, to require foster care agencies to:**

- ⇒ **Identify by name each relative interested in taking placement on the DHHS-31.**
- ⇒ **Document on the DHHS-31 case-specific reasons for denying an interested relative placement of a child. Currently, agencies may simply check a box on the DHHS-31 form indicating that "available relatives do not meet current DHHS standards for placement." A relative who has expressed interest in taking placement of a child should receive in writing specific reasons for the agency's refusal to place the child with him or her.[7]**
- ⇒ **File a copy of the DHHS-31 with the court. This would help strongly encourage agency compliance with the statute and allow courts to ensure that interested relatives received meaningful placement consideration before dispositional hearings, after which a child's placement is formalized and expected to remain stable.**

[6] See OCO Annual Report, 2011-2012, Recommendation 1 ("Improving Documentation of Placement Decisions") and Recommendation 3 ("Placement with Relatives"). The OCO also made recommendations regarding relative placement in our annual reports issued between 1995 and 2005.

[7] This proposed amendment would align the relative-placement statute with laws requiring agencies to state in writing their reasons for denying foster home licensure. See Child Placing Agency Rule 400.12325(5)(b) (when recommending to the Bureau of Children and Adult Licensing (BCAL) that a foster home license application be denied, a child placing agency must provide the applicant with a written statement of facts supporting the recommendation) and MCL 722.121(2) (BCAL must provide a license applicant with ". . . notice in writing of the grounds of the proposed . . . denial . . .").

**MDHHS Response to Recommendation 2:**
Current law and applicable policies strongly encourage and support relative placement, when appropriate. MDHHS will explore ways to enhance practice to ensure relatives are properly notified of placement decisions, including a reinforcement of policy requirements during the October Statewide Supervisory Conference Call and the issuance of an informational memorandum (CSA-CI) as a written follow-up to the conference call.

Foster care policy requires the caseworker assess all relatives who express an interest in placement using the DHS-3130A, the Relative Placement Home Study. Notification to prospective relative caregivers regarding the results of their home evaluation and placement recommendation occurs via the DHS-3130A. If the child's immediate family and all interested relatives can determine together, such as at a facilitated Family Team Meeting, which relative is best suited to care for the child(ren), the worker need only assess the agreed upon relative using the DHS-3130A. If the family cannot come to a consensus and multiple relatives continue to request placement the worker must complete a DHS-3130A for each potential relative provider. Current MDHHS policy requires that each relative receive a copy of their own completed home study, ensuring their confidentiality, and that the court receive a copy of all the completed reports.

Michigan Law and MDHHS policy require the caseworker to send the DHS-31 once "within ninety calendar days after the child's removal from his or her home" to all relatives identified as appropriate by the parent(s). Including personal specific information about the relative's denial would constitute a breach of confidentiality as the form is widely distributed to a number of parties including the parents, the prosecutor, the child's attorney, court, and all other relatives who have expressed an interest in placement. Additionally, relatives who express an interest in placement after the caseworker sends out the DHS-31 do not receive this notification.

## Office of Children's Ombudsman Future Initiatives

This report shows that we have accomplished a lot in the last year, but we look forward to doing more in the next. Because we have been able to improve our day to day operation and become more efficient, we can now be more proactive regarding our mission to educate the public by meeting with concerned community groups and organizations.

We will also have a more visible presence and transparency. In doing so, we can communicate our mission and our methods to a larger audience.

Our goal is to reach out to the institutions we investigate with training and informative conferences addressing often recurring problems we see. These trainings and conferences will be planned to be delivered in locations throughout the state and focus on educating agencies how to take preventive measures before tragedies occur.

### VISION STATEMENT

The Office of Children's Ombudsman strives to be a part of the solution that fosters greater accountability and transparency for Michigan's child welfare system.

# Attachment A: Contact the OCO

There are several ways to contact the OCO.

Call: 1-800-642-4326

Fax: 517- 335-4471

Web: www.michigan.gov/OCO

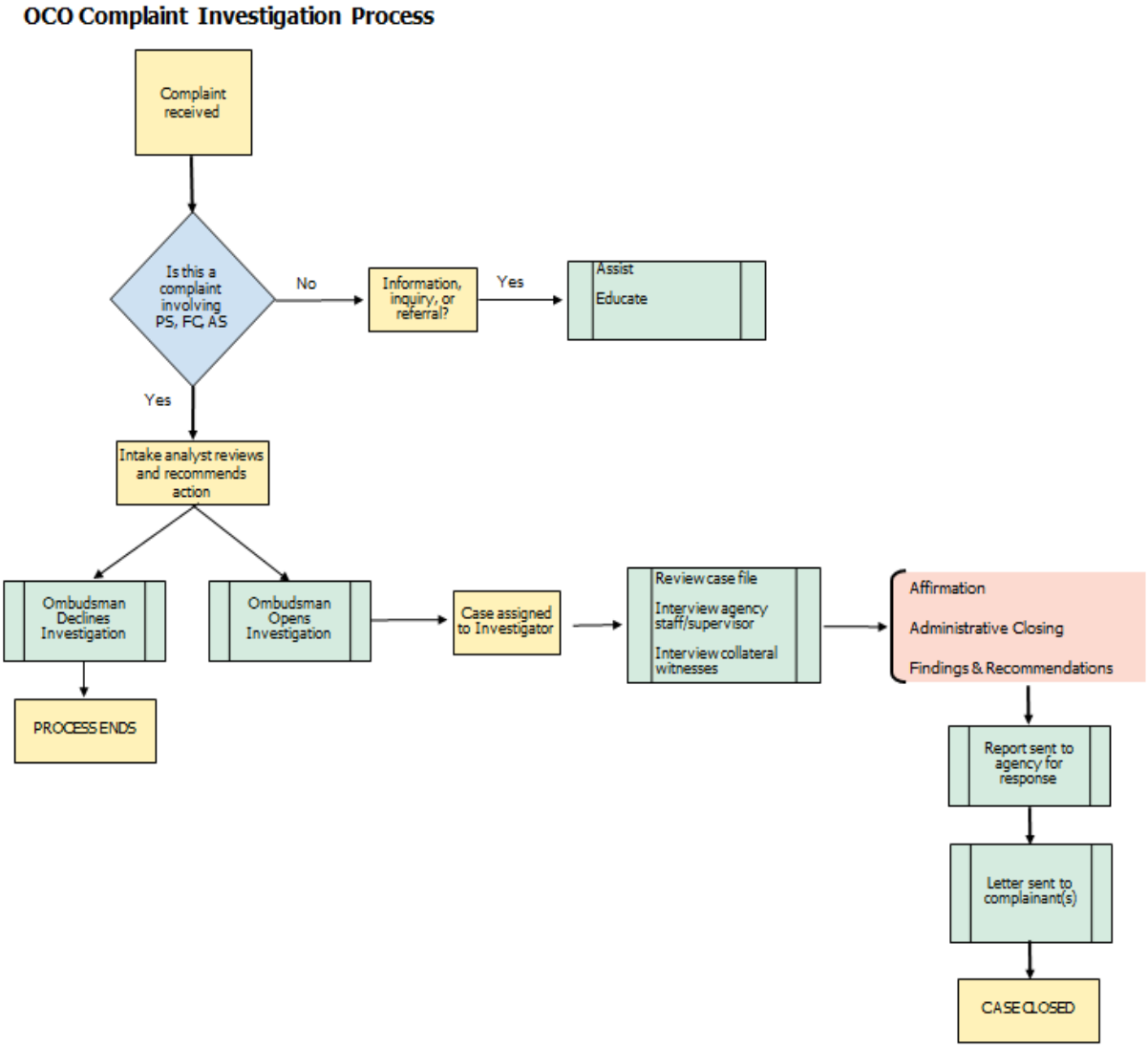
Email: childombud@michigan.gov

Mail: P.O. Box 30026
Lansing, MI 48909

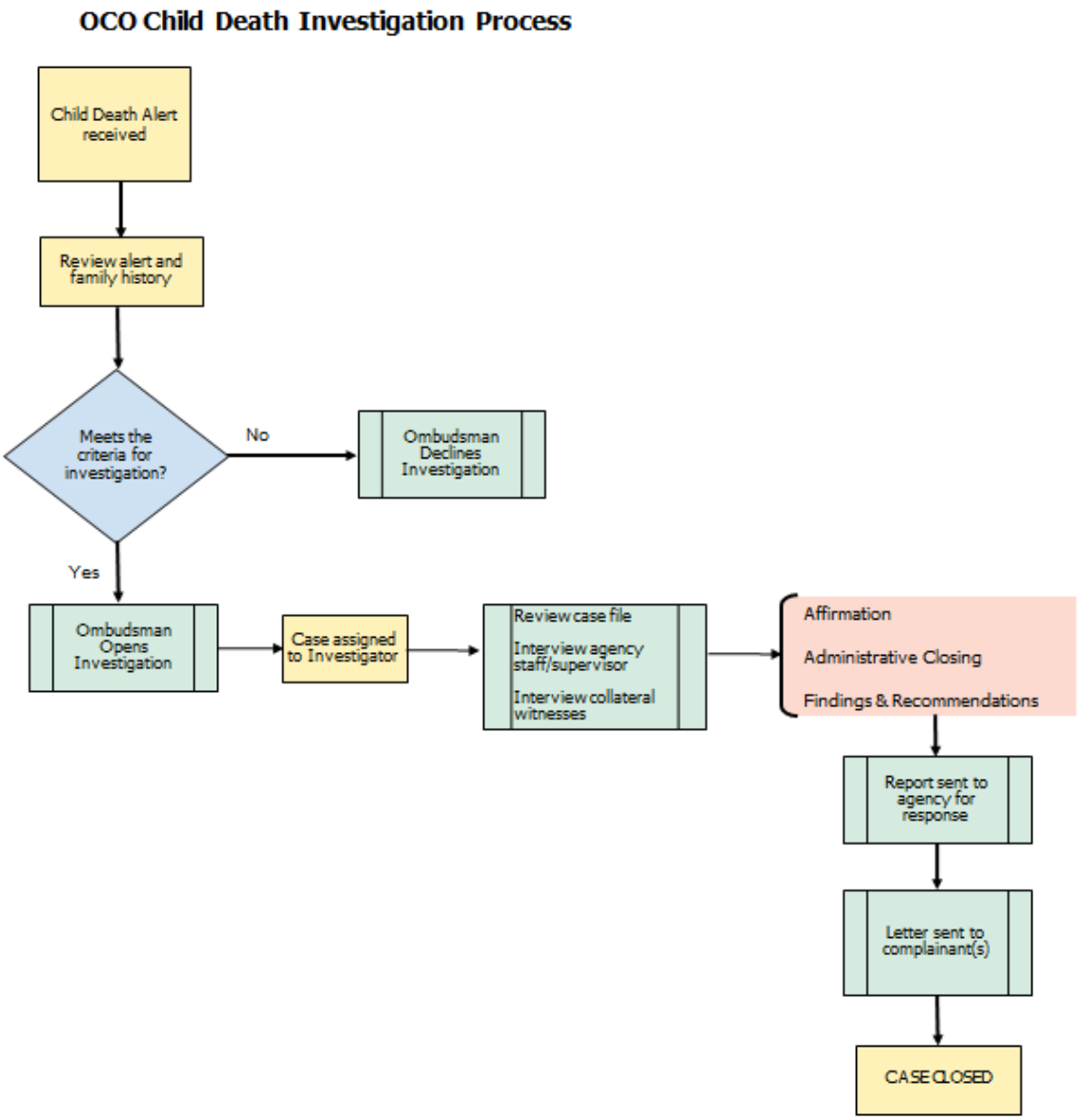
Please provide the following information:

- Your name and telephone number.
- Child(ren)'s name(s) and birthdate(s).
- Your DHHS county office or private agency (foster care or adoption agency).
- Describe your concern.
- What would you like the OCO to do?

# Attachment B: OCO Complaint Investigation Process



# Attachment C: OCO Child Death Investigation Process



# The Office of Children's Ombudsman

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