State of Michigan

Office of Children's Ombudsman

Annual Report 2006-2007

Mission Statement

The mission of the Office of Children's Ombudsman is to assure the safety and well-being of Michigan's children in need of foster care, adoption and protective services 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.

Investigate complaints

Advocate for abused and neglected children

Recommend changes in law, policy, and practice

Improve the child welfare system

Children featured on the cover are available for adoption and photolisted in MARE. For more information regarding these children, or other children also available, please contact MARE at www.mare.org.

May 2008

The Honorable Jennifer Granholm, Governor
Honorable Members of the Michigan Legislature
Mr. Ismael Ahmed, Director, Michigan Department of Human Services

In accordance with my statutory responsibility as the Children's Ombudsman, I respectfully submit the 2006/07 Annual Report.

This report provides an overview of the activities of the Office of Children's Ombudsman from October 1, 2006 to September 30, 2007, and an analysis of the complaints received and investigated. In addition to the analysis are recommendations for positive change in the child welfare system to improve outcomes for children. This year, a new section has been added specifically focusing on child deaths. The Office of Children's Ombudsman has taken great effort to identify and investigate those cases in which a child has died due to alleged abuse or neglect. An analysis of child death investigation findings for the two previous fiscal years is included. The cover of this report is also new and features children listed in the Michigan Adoption Resource Exchange (MARE).

The Office of Children's Ombudsman appreciates the leadership and support of Governor Granholm, the Michigan Legislature and the Department of Human Services. Thank you for the opportunity to serve the children of Michigan.

Respectfully,

Verlie M. Ruffin
Children's Ombudsman

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The Role and Conduct of the OCO

The Michigan Legislature established the Office of Children's Ombudsman (OCO) in 1994 following several high-profile child abuse cases and growing public concern that more needed to be done to bring greater accountability to Michigan's child welfare system.

In creating the ombudsman's office, the Legislature sought to provide citizens with a way to obtain an independent and impartial review of the Department of Human Services' (DHS) decisions and actions in child protective services (CPS), foster care, and adoption cases.

The Office of Children's Ombudsman was established to investigate complaints about children under DHS supervision.

The OCO is responsible for monitoring and ensuring that DHS and private child-placing agencies are in compliance with law, rules and policies pertaining to children's protective services, foster care, adoption, and juvenile justice.

The OCO was also established to educate the public, take action on behalf of a child, improve the delivery of care to children in foster care and adoptive homes, and make recommendations to improve Michigan's child welfare system.

Independence

The OCO operates autonomously within the Department of Management and Budget. The ombudsman is appointed by the Governor with the advice and consent of the Senate. OCO investigators conduct their work objectively and independent of influence from the Governor's office and DHS.

Authority

The ombudsman cannot make, change, or set aside a law, policy, agency practice, or decision. However, the office can release its investigative findings and recommendations regarding needed improvements in laws, policies, and agency practices in reports to the department, private agencies, the Legislature, and our complainants. Furthermore, the ombudsman is authorized to hold informal hearings, take legal action on behalf of a child, refer a case to DHS for a CPS investigation, request a court subpoena compelling the production of a record or report, and pursue legislative advocacy on behalf of children.

The Children's Ombudsman Act (1994 PA 204) gives the ombudsman access to confidential DHS records and the department's computerized case management system, while protecting the confidentiality of the ombudsman's records and identities of the individuals who contact the office. State law authorizes the ombudsman to obtain information from other agencies and service providers, including records in the possession of public and private child-placing agencies and medical and mental health providers. OCO records are not subject to court subpoena, not discoverable in a legal proceeding, and are exempt from disclosure under the Freedom of Information Act.

Budget and Expenditures

The OCO was appropriated $1,364,100 for fiscal year 2006/07, which was allocated entirely from the state General Fund. Eighty percent was for personnel, with most of the remainder devoted to office facilities, technology, and supplies. The OCO has 11 full-time employees: the ombudsman, eight investigators, and two administrative staff. The ombudsman maintains offices in Lansing and Detroit.

Multidisciplinary Investigations

The OCO uses a multidisciplinary team approach to investigations. Investigators have diverse professional and educational backgrounds with a broad range of experience relevant to child welfare. OCO staff receives ongoing training and routinely consults with professionals outside the office on issues related to child welfare. Each investigation is assigned to a primary investigator, who is responsible for gathering evidence, conducting interviews, analyzing compliance, and developing preliminary findings and recommendations. Prior to completion of all investigations, investigative team members participate in the analysis of case facts, findings, and conclusions. Recommendations made in individual cases are the result of extensive input and discussion by the OCO investigative team.

Collaboration and Outreach

Throughout the year, OCO staff meets regularly with the DHS Office of Family Advocate and DHS central office policy and administrative staff to discuss individual cases, policy, and practice. DHS included OCO staff on proposed changes to CPS, foster care, and adoption policy.

This year, OCO recommendations and advocacy contributed to improvements in DHS policy governing: out-of-home placement decisions, the use of psychotropic medications prescribed to children in foster care, assessing the credibility of a child's statements during CPS investigations, and reaching accurate dispositions when the alleged perpetrator is a licensed foster parent.

Investigative staff was involved in a comprehensive redrafting of DHS adoption services policy, developing a protocol to improve collaboration between CPS and local Friend of the Court offices, and making improvements to the statewide Absent Parent Protocol.

OCO staff served on numerous advisory boards, workgroups, and committees including: DHS Adoption Policy Advisory, CPS and Friend of the Court Coordinated Protocol, Michigan Court Improvement Program, Michigan Association for Family Court Administration, Statewide Adoption Oversight, Safe Delivery, Kids Count, Foster Care Review Board, and Domestic Violence Coalition. OCO staff also participated in federally mandated Citizen Review Panels including Child Death Review and the Panel for Prevention.

During this fiscal year, the OCO co-sponsored a multidisciplinary training for professionals involved in child welfare entitled "Paving the Road to Recovery and Reunification: Courts, Child Welfare, and Treatment Partners."

Each year, the ombudsman receives requests to provide presentations to interest groups, child advocates, and various child welfare stakeholders throughout Michigan. This year, ombudsman staff made eleven presentations to interest groups on topics related to child welfare. In addition, the ombudsman or staff testified at several state legislative hearings on pending bills or the work of the office.

Priorities

Consistent with the Children's Ombudsman Act and office mission, the OCO used the majority of its resources to perform the following duties:

- ***Respond to citizen complaints.*** The office received more complaints this year than in any previous year. Whenever possible, citizens are provided with meaningful and effective strategies for resolving their concerns. When the OCO investigates the department or private child-placing agency's handling of a child's case, we inform the complainant of the actions taken by the OCO to investigate the complaint and the actions taken by the respective agency in response.

- ***Advocate on behalf of children.*** When contacted about a child, the ombudsman takes action whenever it determines the child may be unsafe, an administrative action may be harmful to the child, or to prompt action by the department to promote well-being and permanency for the child. For instance, the ombudsman may send a written request to DHS to conduct a CPS investigation or safety assessment of a child believed to be in danger. After careful investigation of case facts, the ombudsman may request that a child-placing agency change the permanency plan for a child, file a termination petition, provide mental health or medical services to a child, conduct a thorough home study, or consider a replacement of a child. The ombudsman may request that a licensing investigation be conducted of a child-placing agency or foster home, or may refer a criminal matter to a county prosecutor, attorney general, or law enforcement agency.

- ***Improve the child welfare system.*** One of the OCO's primary roles is to identify problems and make recommendations to improve the child welfare system. Through case analysis and investigative findings this year, the office issued over 200 individual recommendations to DHS for system-wide improvement or to correct problematic decisions that affected individual children. DHS agreed with and took steps to implement the majority of those recommendations.

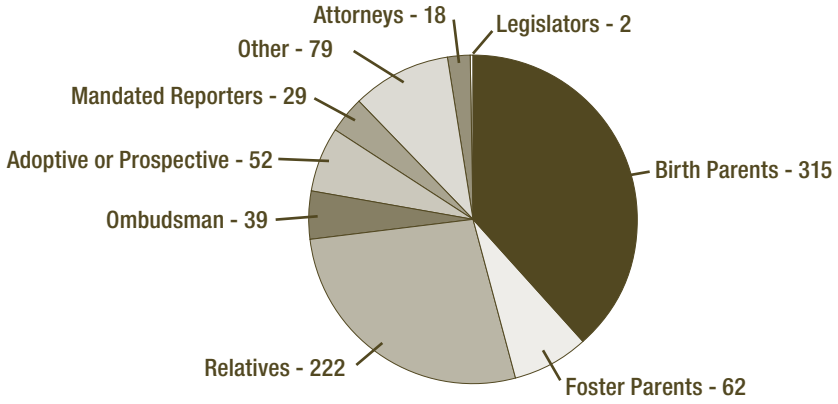
Complaints

A primary function of the ombudsman's office is to respond to complaints about children involved in Michigan's child welfare system. Anyone concerned about the safety or well-being of a child may make a complaint to the OCO. Complaints can be made by telephone, mail, fax, email, or by submitting an electronic complaint form accessible at the OCO website: www.michigan.gov/oco.

The OCO is required by law to keep the identity of complainants confidential unless the complainant gives the ombudsman permission to disclose his or her identity. Within the limits of federal and state confidentiality laws, the ombudsman may provide a complainant with information that the OCO obtained during its investigation of the complaint. Following an investigation, the OCO may provide information to the complainant regarding DHS' and/or the private child-placing agency's handling of the case.

Source of Complaints

In fiscal year 2006/07, the OCO received 969 complaints concerning 1371 children in 68 of Michigan's 83 counties. Birth parents made up the greatest share of complainants (39%) followed by relatives of the child (27%).



The identity of the complaint source was not obtained in 151 of the 969 complaints made for a variety of reasons including some complainants wished to remain anonymous, some refused to complete the intake process, and some were inquiries or referrals and therefore did not complete the formal intake process.

Complaint Analysis

Complainants who contact the OCO have varying degrees of understanding about the child welfare system. The intake investigator will assist complainants by providing them with detailed information about applicable laws and policies. Educating the public about how the child welfare system works in Michigan is a statutory duty of the office and an essential component of system accountability. When citizens are informed about the relevant laws and policies that govern practice, they are better able to navigate the system, advocate knowledgably and effectively for themselves and the child, and resolve their complaint.

If information provided by the complaint source is insufficient to determine whether an investigation is needed, the OCO may conduct a preliminary case review. A preliminary review may consist of reading specific documents or interviewing people knowledgeable about the child's situation. This year, the OCO conducted 30 preliminary case reviews and opened 8 of those for investigation.

The ombudsman uses the following **criteria to evaluate each complaint** and decide whether to investigate:

- The complaint concerns a child involved with CPS, foster care, adoption, or juvenile justice.
- The complaint alleges that an action or inaction by DHS or a private child-placing agency may have violated law, rule, or DHS policy.
- An alleged decision or action by DHS or a private child-placing agency was harmful to a child's safety, health or well-being.
- The complainant has exhausted other administrative remedies without success.
- It is likely that an investigation by the OCO will positively impact the child's situation or children in future cases.
- The complaint concerns a child who has died due to alleged abuse or neglect and the family had prior involvement with CPS.

Complaint Categories

Not all complaints are appropriate for investigation by the OCO. To most effectively manage and respond to citizen complaints, the ombudsman classifies complaints into one of the following four categories:

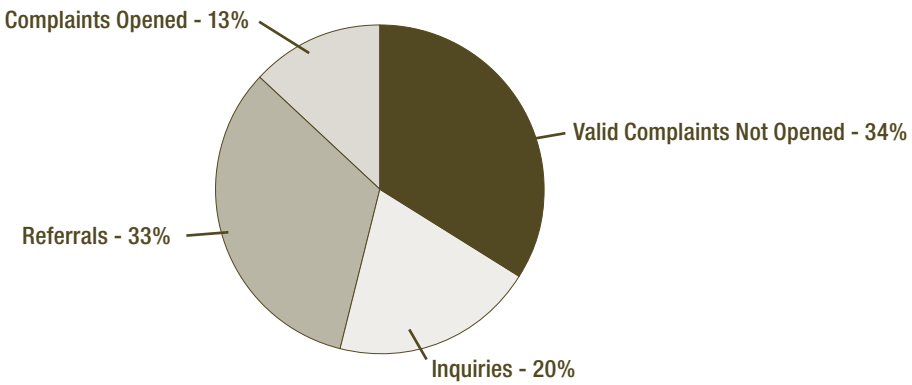
Inquiries - requests for information, general concerns about the child welfare system, or specific complaints involving areas that the ombudsman does not have jurisdiction to investigate, such as Friend of the Court, child custody matters, or educational issues.

Referrals – complaints that concern a child involved with CPS, foster care, adoption, or a juvenile justice program, but that involve actions of an agency or person the OCO is not authorized to investigate, such as the court, law enforcement, or an attorney.

Valid Complaints Not Opened – complaints that are within the OCO's jurisdiction to investigate, but the ombudsman determines that an investigation will either not resolve the complaint issue or the complaint would be more effectively resolved through other action. A complainant may allege that the court should not have terminated parental rights or request an investigation of an administrative act that occurred many years ago. A person may disagree with an agency's decision or action, but there is no indication that the action or decision was contrary to law or policy.

Valid Complaints Opened – complaints that involve CPS, foster care, adoption services, or juvenile justice and include allegations of law or policy violation or poor practice that impacted a child's safety or well-being. The ombudsman determines that the complaint satisfies complaint analysis criteria and opens an investigation.

Of the 969 complaints received this year, the majority (34%) were classified as valid complaints not opened, followed by referrals (33%), inquiries (20%), and complaints opened for investigation (13%).

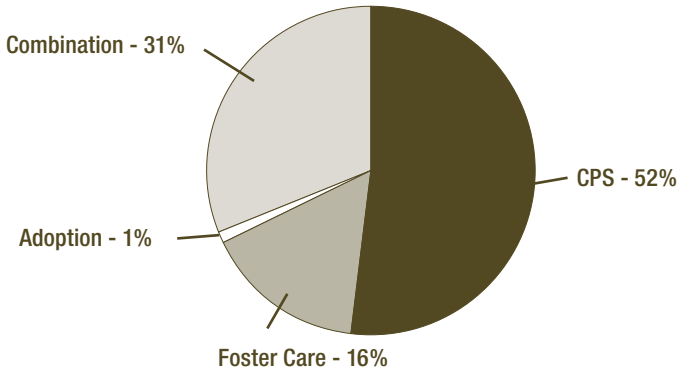


Investigations

The OCO completed 134 investigations this year. On average, investigations took 4.63 months to complete and included a comprehensive review of pertinent case file material obtained from DHS and/or a private child-placing agency. When applicable, the OCO conducted interviews with DHS and private agency staff and others knowledgeable about the family's history and the child's current situation. Investigations generally focused on resolving issues raised by the complainant. However, if the OCO investigator identified other factors that significantly impacted the child's well-being, such as delayed permanency, untimely service provision, lack of parenting time or sibling visits, or improper placement decisions, the OCO also addressed these issues with DHS, the Bureau of Children and Adult Licensing, the private child-placing agency, the court, or the child's attorney.

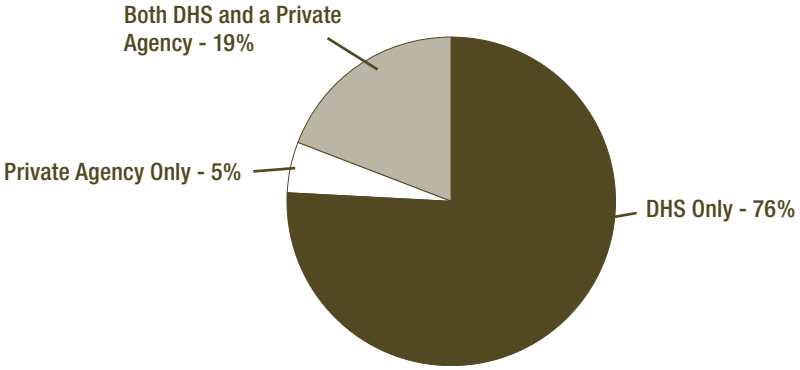
Of the 134 investigations completed this fiscal year, the majority focused on CPS concerns (52%), while the smallest share (1%) involved adoption services.

Investigations by Program Type



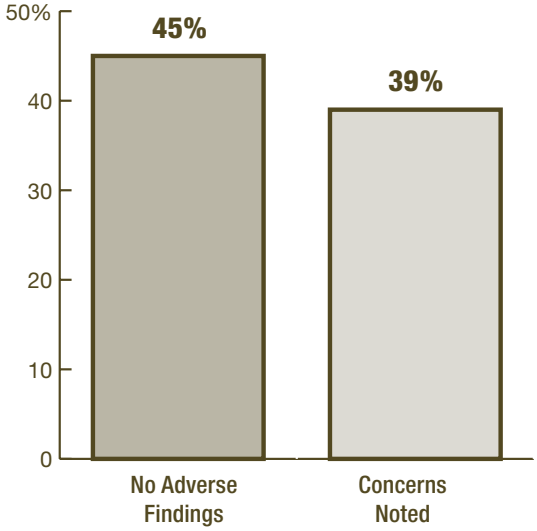
Of the 134 investigations completed this fiscal year, 101 (76%) involved DHS only, 7 (5%) involved a private child-placing agency only, and 26 (19%) involved both DHS and one or more private child-placing agency.

Investigations by Agency Type



Investigation Results

In fiscal year 2006/07, 45% of OCO investigations resulted in no adverse findings, while concerns with case handling were noted in 39%. The OCO made no findings in the remainder of complaint investigations because the complaints were either resolved by the agency or the ombudsman determined that no further action was needed.



After an investigation is completed, the ombudsman notifies the complainant in writing of the actions taken by the OCO and the results of the investigation. When applicable, the ombudsman also informs the complainant of any action taken by DHS or the private child-placing agency to address the complaint issues. Lastly, the OCO issues a closing letter to each agency involved in accordance with one of the following four closing categories:

Affirmation - the OCO determines that the agency complied with applicable laws, rules, and policies, and agency decisions and actions were consistent with case facts and the child's best interests.

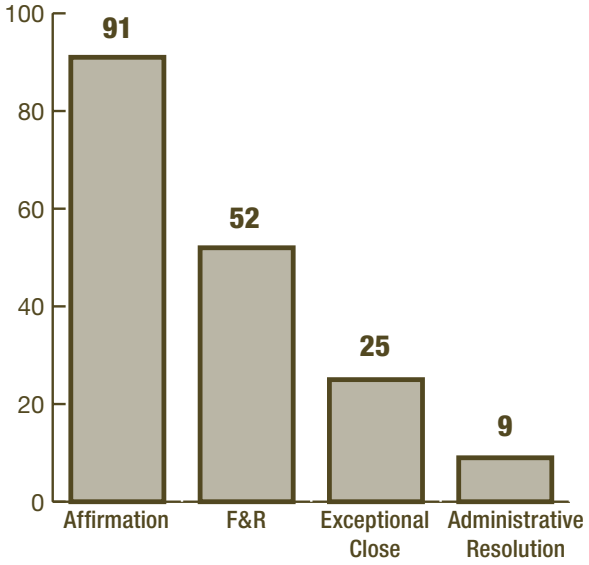
F&R - the OCO concludes that the agency did not comply with laws, rules, and/or policies, or agency actions and decisions were not consistent with the case facts or the child's best interests. The ombudsman sends a Report of Findings and Recommendations (F&R) to the agency, and the agency responds in writing within 60 days.

Administrative Resolution - the OCO concludes that the agency did not comply with laws, rules, and/or policies, or agency actions and decisions were not consistent with case facts or the child's best interests. Upon notification by the ombudsman of the concerns, the agency responds by taking action to rectify them. For example, the OCO may have requested an action by the agency, such as conducting a safety assessment of a child, reconsidering a placement decision, providing medical or mental health services to a child, or changing a permanency goal. The OCO verifies that the requested action was taken and closes its case.

Exceptional Close - the OCO determines that the agency either resolved the complainant's issue on its own, or the circumstances in the case have changed and issues that gave rise to the complaint no longer exist. Alternatively, the ombudsman may have determined that it lacked jurisdiction to affect the outcome for the child or that further investigation by the OCO would not achieve the outcome desired by the complainant.

As a result of investigations completed in fiscal year 2006/07, the OCO issued 91 affirmation letters, 52 F&Rs, 25 exceptional closes, and 9 administrative resolution letters.

Case Closure Type
FY 2006/07



The following chart lists the OCO outcome(s) for each county DHS office and private child-placing agency.

OCO Investigations by Agency and Outcome FY 2006-07

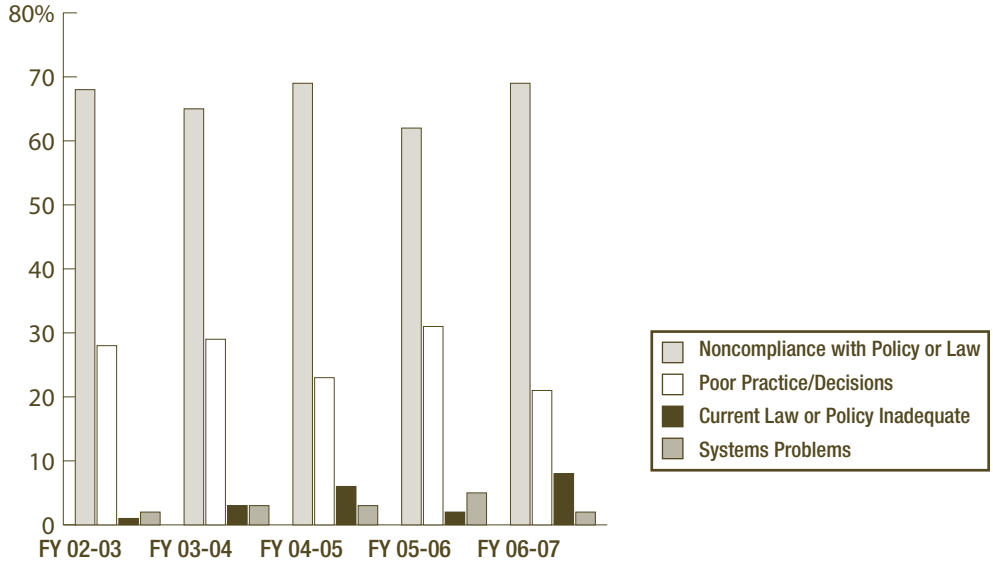
Agency	Number of times Investigated	Outcome			
		Affirm	F&R	Admin. Res.	Except. Close
Antrim	1	1			
Barry	1	1			
Bay	2	1	1		
Berrien	1	1			
Calhoun	3	2	1		
Cheboygan	1	1			
Clinton	2	1			1
Crawford	2	1			1
Eaton	2	2			
Genesee	12	7	3	1	1
Gladwin	1	1			
Gratiot	1	1			
Huron	1	1			
Ingham	5	1	3		1
Ionia	1		1		
Iron	1		1		
Jackson	6	1	2	1	2
Kalamazoo	7	4	3		
Kent	9	6	2		1
Lake	1	1			
Lapeer	1	1			
Leelanau	1	1			
Lenawee	2	2			
Livingston	2	1	1		
Macomb	12	5	3	2	2
Mason	1				1
Mecosta	1		1		
Midland	1				1
Monroe	1	1			
Montcalm	1	1			
Muskegon	1	1			
Oakland	15	8	6		1

Agency	Number of times Investigated	Outcome			
		Affirm	F&R	Admin. Res.	Except. Close
Ogemaw	1		1		
Ottawa	1		1		
Roscommon	2	1			1
Saginaw	3			1	2
St. Clair	1	1			
St. Joseph	2	1	1		
Tuscola	2	1	1		
VanBuren	2	1			1
Washtenaw	2	2			
Wayne	26	10	10	2	4
Wexford	1				1
Alternatives for Children	1	1			
Bethany Christian Services	3	2	1		
Catholic Charities of Lenawee County	1	1			
Catholic Charities of Shiawassee and Genesee County	1				1
Catholic Social Services	1	1			
D.A. Blodgett	2		1		1
Ennis Center for Children	4	3	1		
Homes for Black Children	1		1		
Judson Center	2		1		1
Lula Belle Stewart Center	1		1		
Lutheran Child & Family Services	1		1		
Lutheran Social Services	7	5	1		1
Michigan Indian Child Welfare Agency	1			1	
Oakland Family Services	1	1			
Spaulding for Children	2	2			
Spectrum Human Services	3		2	1	
St. Vincent Catholic Charities	2	2			
St. Vincent Sarah Fisher	1	1			

Analysis of F&Rs

Consistent with years prior, the overwhelming majority (90%) of findings made in F&R reports this year were the result of noncompliance with current law or policy or poor practice and decision-making. The 52 Reports of Findings and Recommendations included 176 individual findings.

Trends in OCO Findings



Analysis of Administrative Resolutions

The OCO intervened in cases when it determined that action was necessary to protect a child from an unsafe situation or to correct a mistake that might result in harm to a child. The ombudsman issued nine Administrative Resolution letters to agencies this year. Following are examples of requests that the OCO made to DHS or a private child-placing agency in cases investigated this year and the corresponding responses by the involved agencies:

Ombudsman Action	*Response/Outcome*
The ombudsman sent a Request for Administrative Response to the child-placing agency asking it to provide developmental, mental health, and educational services for three siblings placed in foster care.	As a result of the ombudsman's request, the agency ensured that all of the services occurred.
The ombudsman sent a Request for Action to the agency asking it to reach a disposition that was consistent with the evidence that the children were abused in the foster home and to reassess the children's safety in the foster home.	DHS convened a conference call among involved professionals and completed a comprehensive reassessment of the evidence of abuse. As a result of the review, placement decisions were reassessed to ensure the safety of the children in foster care.
The ombudsman sent a Request for Administrative Response to the child-placing agency asking it to file a timely court petition for termination of parental rights.	The agency filed the petition and forwarded a copy to the ombudsman.
The ombudsman sent a Request for Action to DHS asking it to check on the well-being of a child placed in a particular foster home and ensure that the foster home was in compliance with all applicable policies and regulatory rules. The ombudsman asked DHS to take appropriate action to ensure the child's safety and that his needs were consistently met in foster care.	DHS commenced a CPS investigation of the foster home. DHS replaced the child into another home, where the foster parent was specifically trained to handle the child's special needs.
The ombudsman asked the county DHS management staff to review a particular CPS investigation and identify corrective action to prevent future mistakes.	DHS responded by reviewing applicable policies with management and field staff. A meeting was convened between the DHS and staff at the county prosecutor's office to review the law and protocols related to coordinated responses to child abuse and neglect.
Following a child's death, the ombudsman identified and discussed with the local DHS systemic concerns related to DHS interface with the family court.	The county DHS office responded by implementing a local office interim policy to prompt a comprehensive review of CPS case file and evidence by second line supervisors in cases where the family court refused to authorize a court petition filed by CPS. The DHS county director agreed to contact the family court or prosecuting attorney to resolve any concerns or barriers to filing petitions to protect children.

Ombudsman Action	*Response/Outcome*
The ombudsman sent a Request for Administrative Response to DHS asking it to complete the proper procedure when considering placing a child with an unlicensed relative. The ombudsman also asked DHS to address the barriers that led to delays in services to the children in foster care.	DHS agreed to work with the local county DHS office to improve compliance with existing policies governing relative placement consideration. The county DHS agreed to review and rectify the barriers to appropriate services provision to the children in this case.
The ombudsman sent a Request for Administrative Response to the agency asking it to file a petition to terminate parental rights to the child, consistent with case facts and the court order.	The agency submitted a supplemental petition to the prosecutor's office seeking termination of parental rights. The petition was filed with the court and a copy sent to the ombudsman.
The ombudsman sent a Request for Action to the local DHS office asking it to immediately verify the safety of the involved child. The ombudsman asked the DHS to determine the appropriate CPS disposition and level of protective intervention needed.	DHS took the actions requested by the ombudsman and filed a petition with the court to ensure protection of the child.

Analysis of Exceptional Closes

Following is the number of exceptional closing letters issued by main rationale for closing:

7	Agency self-corrected
6	Circumstances changed/ Issues that gave rise to complaint no longer exist
5	OCO lacked jurisdiction to affect outcome for the child
7	Further investigation or action by the OCO would not have resulted in complainant's desired outcome

Child Deaths

On January 3, 2005, Governor Jennifer M. Granholm signed Ariana's Law, aimed at improving the state's ability to investigate and prevent future deaths of children who have come to the attention of Michigan's child protection system.

Ariana's Law

- ✓ Named for two-year-old Ariana Swinson, who was beaten and drowned by her parents in 2000.
- ✓ Sponsored by State Representative Lauren Hager.
- ✓ Gave the OCO access to information about a child whose death may have resulted from abuse or neglect.

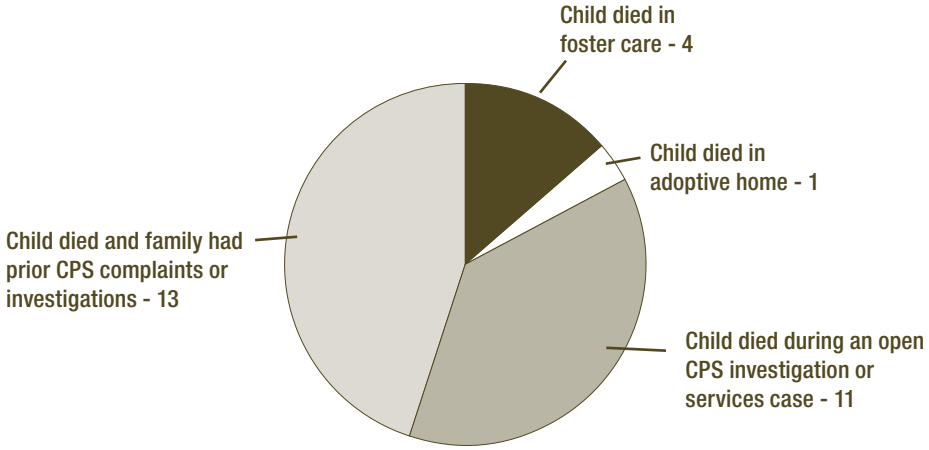
In the past three years, the OCO has made greater efforts to identify cases where a child died due to alleged abuse or neglect. The OCO and DHS Office of Family Advocate entered into an agreement to enable DHS to promptly notify the OCO when DHS has received notice that a child has died. If the child's family had prior CPS involvement or the death occurred during an open CPS or foster care case, the OCO may investigate to determine whether the agency(ies) followed applicable laws and policies prior to the child's death. In fiscal year 2005/06, the OCO investigated 10 child deaths, compared to 19 in 2006/07.

Death Investigation Analysis

Of the 29 deaths that the OCO investigated over the past two fiscal years, children less than four years old accounted for 75% of the victims. In the majority of cases investigated (19), the child's death resulted from physical abuse. Eight deaths were determined to be the result of neglect while two deaths resulted from other factors.

Of the 29 child deaths investigated by the OCO, the majority involved children who had prior involvement with CPS, while the fewest involved a child in an adoptive home.

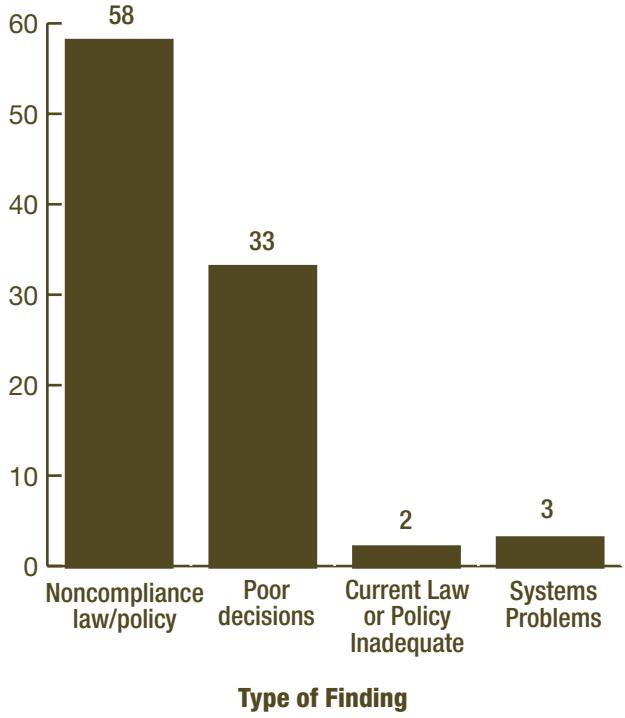
Case Status at the Time of Child Death



Death Investigation Results

Of the 29 child deaths investigated, the OCO identified concerns with agency case handling in 59% and made no adverse findings in 41%. In the past two years, the OCO issued 96 individual findings to DHS or private child-placing agencies concerning children who died. The overwhelming majority of the findings (95%) were the result of agency noncompliance with current law or policy or poor practice and decision-making.

Summary of Findings in Child Death Investigations



The following lists the OCO investigation outcome for each county DHS office and private child-placing agency.

OCO Investigations of Child Deaths by Agency and Outcome
FY 2005/06 - 2006/07

Agency	Number of times agency involved in an OCO death Investigation	Outcome			
		Affirm	F&R	Admin. Res.	Except. Close
Allegan	1	1			
Barry	1	1			
Berrien	1	1			
Calhoun	1	1			
Genesee	2	2			
Ingham	4		4		
Jackson	3	1	1	1	
Kalamazoo	1		1		
Kent	1	1			
Macomb	4	3	1		
Monroe	2	1	1		
Montcalm	1	1			
Ogemaw	1		1		
Saginaw	1			1	
Shiawassee	1		1		
St. Joseph	1		1		
Washtenaw	2	1	1		
Wayne	5	2	3		
Homes for Black Children	1		1		
Lula Belle Stewart Center	1		1		
Lutheran Social Services	1	1			
St. Vincent Catholic Charities	1	1			

OCO Annual Report Recommendations and DHS Responses

The following recommendations were submitted to DHS for response. The DHS responses appear after each recommendation.

1. Permanency:
The OCO recommends that DHS and private child-placing agencies strengthen compliance with policy 722-7 requiring foster care workers to document "compelling reasons" in Updated Service Plans and court reports prepared for the permanency planning hearing, when it determines that termination of parental rights is not in the child's best interest.

Rationale: With the enactment of the Adoption and Safe Families Act of 1997, Public Law 105-89 (ASFA), Congress took note of the substantial and unjustified delays in legally freeing children in foster care for adoption. Congress specified time frames and defined circumstances in which states must seek termination of parental rights. After a child has been in foster care for a year, the court must hold a permanency planning hearing to decide whether to return the child home or order the agency to initiate proceedings to terminate parental rights. If the supervising agency believes that termination is clearly not in the child's best interest, the agency is required to document "compelling reasons" why not. A "compelling reason" must be based on the individual circumstances of the child and the family, with an emphasis on what is in the best interest of the child.

The OCO reviewed cases in which the foster care worker did not recommend that the child be returned home, but failed to document a compelling reason why termination of parental rights was clearly not in the child's best interest. As a result, children in these cases remained in temporary foster care for reasons that were not clearly identified. More consistent compliance with the law and policy that requires workers to identify compelling reasons may decrease substantial delays in achieving permanency for children.

DHS Response to Recommendation 1:
DHS is committed to appropriate case planning and documentation regarding "compelling reasons" to ensure the best decisions for children. Therefore DHS will take the following actions to strengthen policy compliance:

- Field Operations Administration and the Purchased Service Division will require that each local/district DHS office and private child placing agency director or second-line manager review policy (CFF 722-7) regarding documentation of "compelling reasons" with foster care supervisors and workers by 9/30/08. The policy review will include discussion of the rationale and purpose of the policy. The discussion will also include a review of available services that may assist parents and caregivers in accomplishing their goals toward reunification.

- Field Operations Administration and the Purchased Service Division will issue instructions for front-line supervisors to convene monthly case conferences with each worker to ensure child safety and appropriate case/permanency planning. Monthly case conferences will include a review and appropriate degree of discussion of each case on the worker's caseload. Effective 10/1/08, supervisors will also be required to document each monthly case conference held and maintain the documentation for review by upper administration within DHS or the private child placing agency. Field Operations Administration will add this requirement to the FOA Business Plan for Fiscal Year 2008-2009. The Bureau of Children's Services' Purchased Care Division will likewise issue this communication to private child placing agencies, and will seek to amend these agencies' contracts to include this requirement.

- For the purpose of determining whether "Compelling Reasons" have been adequately documented, Field Operations Administration will require each local/district DHS office director or second-line manager to complete case reads of an appropriate sample of foster care Updated Service Plans that have been read by the supervisor. This will ensure proper supervisory oversight and will be completed by 9/30/08. The Bureau of Children's Services' Purchased Care Division will likewise issue this communication of needed second-line review to private child placing agencies.

- By 12/31/08, Field Operations Administration will require each local/district DHS office director to review the results of the case reads that have been completed. The local/district DHS office director will then work with staff in their office to ensure appropriate supervision and aid in improved supervisory oversight based on the review of cases moving toward termination. The Bureau of Children's Services' Purchased Care Division will likewise issue a communication of this need for director-level review to private child placing agencies.

- The unit with the primary responsibility for training all of Michigan's child welfare staff, including both DHS and private child placing agency workers is the DHS Child Welfare Institute. In February 2008, the Child Welfare Institute was moved under the supervision of Children's Services Administration. As a result, by 12/31/08, Children's Services Administration will complete an evaluation to ensure that foster care training appropriately addresses policy (CFF 722-7) regarding "compelling reasons."

- Beginning in the summer of 2008, several local DHS offices within Region 2 will begin piloting Semi-Annual Reviews (SAR) of foster care cases. This review is similar to a TDM meeting in that it is conducted by a team of individuals involved with the foster care case. The SAR team will evaluate the appropriateness of the child's permanency plan. If changes in the permanency plan are needed, the changes will occur based on the recommendation of the SAR team.

2. TDM:
The OCO recommends that DHS develop policies and procedures to require statewide uniformity in conducting Team Decision-Making meetings (TDMs). The OCO further recommends that policy require the caseworker to inform participants in writing of the purpose of the meeting, the anticipated participants, confidentiality requirements or restrictions, and the potential outcomes or consequences of the meeting.

Rationale: A TDM is held prior to removing a child, changing a placement, or making a permanency plan. A goal is to reach a consensus decision. The meetings are informal and intended to involve the child, parents, foster parents, relatives, caseworkers, children's attorneys, service providers, and other supportive community members in decisions regarding a child in need of protection.

Although DHS issued a letter to TDM operating sites in 2005 clarifying TDM protocols, these guidelines have not resulted in statewide uniformity in conducting TDMs. Lack of written department policy and accountability for compliance with policy may result in widely divergent and ineffective TDMs.

DHS Response to Recommendation 2:
The Family-to-Family initiative has not been fully implemented at every local office around the state. However, each Family-to-Family county has developed a protocol for the Team Decision Making (TDM) process. DHS has convened a TDM Uniformity Committee to review issues related to TDM meetings and protocols from around the state. The TDM Uniformity Committee will develop and submit to the Program Office a statewide TDM protocol to be in place by 9/30/08. In addition, DHS is reviewing all child welfare policies to ensure that once the Family-to-Family model is implemented statewide and the TDM protocol is in place, each program's policy will include the principles and practices of Family-to-Family, including TDM meetings.

3. Supervisory Oversight:
The OCO recommends DHS identify a strategy for ensuring children's protective services, foster care, and adoption services supervisors provide timely and effective oversight of child welfare programs.

Rationale: Although supervisors play a critical role in enhancing and monitoring practice, the OCO reviewed cases in which supervisory oversight was inadequate and/or untimely. In 5 of the 6 most recently issued OCO Annual Reports, the OCO identified lack of effective supervisory oversight as a significant problem. Improving supervisory oversight is necessary to:

- Improve the safety and protection of children who come to the attention of DHS.
- Increase the likelihood that worker actions and decisions are objective and in the best interests of children.
- Ensure scrutiny of placement decisions and permanency recommendations.
- Increase worker compliance with laws, rules, and policies.

- Improve worker and supervisor adherence to performance expectations.
- Enable timely identification and correction of mistakes.

In our continued effort to improve supervision, the OCO recommended in its 2005-2006 Annual Report that all child welfare supervisors attend Child Welfare Institute (CWI) training in the area(s) that they supervise. DHS agreed with this recommendation.

DHS Response to Recommendation 3:
DHS's child welfare reform efforts have resulted in several actions to strengthen the role of CPS supervisors. However, additional actions are in the process and others will be taken to ensure appropriate supervisory oversight in all child welfare programs including CPS, foster care and adoption services.

- Field Operations Administration mandated the following training for CPS supervisors in 2006-2007:
  - CPS Supervisor Training. This training focused on the critical role of the supervisor in ensuring child safety in Children's Protective Services. The training includes, among other things, lessons related to critical child safety policies and laws, management of employees and appropriate review of worker actions.
  - Advanced Investigative and Interview Training. This training is required for both workers and supervisors with a focus on thorough CPS investigations, documentation and advanced interview skills.
- Field Operations Administration, through the Child Welfare Institute, began developing Foster Care and Adoption Supervisor Training. Preliminary work began in fiscal year 2006-2007 to develop training for foster care and adoption supervisors. A draft training curriculum has been completed and the pilot for Foster Care and Adoption Supervisor Training is scheduled for summer 2008. The training will be mandated for all foster care and adoption supervisors from DHS and private child placing agencies.

- DHS has completed statewide implementation of the CPS Service Worker Support System (SWSS-CPS), which includes an automated case reading tool to be used by every CPS supervisor during review of a CPS report.

DHS is currently taking, or will require the following actions to be taken, within each local/district DHS office to ensure that appropriate supervisory oversight occurs:

- DHS is in the process of adding multiple new reports in SWSS-CPS and SWSS-FAJ (foster care, adoption and juvenile justice) that will serve as tools for improved supervisory practice. These tools are expected to be operational by 12/31/08. Supervisors will be required to use these tools to monitor staff performance.

- Field Operations Administration will direct front line supervisors to convene monthly case conferences with each worker by adding the requirement to the FOA Business Plan for fiscal year 2008-2009. To ensure child safety and appropriate case/permanency planning, every case conference will include review and discussion of each case on the worker's caseload. Effective 10/1/08 supervisors will also be required to document each monthly case conference held and maintain the documentation for review by upper administration within DHS. The Bureau of Children's Services' Purchased Care Division will likewise issue this communication to private child placing agencies, and will seek to amend these agencies' contracts to include this requirement.

- Field Operations Administration will require each local/district DHS office director or second-line manager to complete case reads of an appropriate sample of child welfare cases that have been read by the supervisor. This will ensure proper supervisory oversight and will be completed by 9/30/08. The Bureau of Children's Services' Purchased Care Division will likewise issue this communication of needed second-line review to private child placing agencies.

- By 12/31/08, Field Operations Administration will require each local/district DHS office director to review the results of the case reads that have been completed. The local/district DHS office director will then work with staff in their office to ensure appropriate supervision and aid in improved supervisory oversight based on the review of the cases. The Bureau of Children's Services' Purchased Care Division will likewise issue a communication of this need for director-level review to private child placing agencies.

- Upon completion of the above two actions and by 3/31/09, Field Operations Administration and the Purchase Service Division will review the outcome of the reviews and determine the frequency with which these actions need to be required to occur.

- The unit with the primary responsibility for training all of Michigan's child welfare staff, including both DHS and private child placing agency workers is the DHS Child Welfare Institute (CWI). In February 2008, the CWI was moved under the supervision of Children's Services Administration to ensure appropriate training is provided to staff. As a result, the Children's Services Administration will be completing assessments of child welfare training module(s) by 12/31/08.

- Beginning in the summer of 2008, several local DHS offices within Region 2 will begin piloting Semi-Annual Reviews (SAR) of foster care cases. This review is similar to a TDM meeting in that it is conducted by a team of individuals involved with the foster care case. The SAR team will consider the appropriateness of the child's permanency plan. If changes in the permanency plan are needed, the changes will occur based on the recommendation of the SAR team. Based on the results of the SAR process, each local/district DHS office will review the issue of supervisory oversight and determine if additional steps will be taken toward improvement.

4. CPS Conclusions:
The OCO recommends that DHS strengthen compliance with policy 713-9 that requires *"the systematic and objective examination of facts and evidence which support or refute the determination that a preponderance of evidence of child abuse/ neglect exists or does not exist."*

Rationale: DHS policy provides comprehensive guidelines for workers to follow when completing CPS investigations to ensure dispositions are accurate and supported by the evidence. CPS workers also receive training on conducting thorough investigations, documenting evidence, and reaching dispositions. The OCO has identified inconsistent CPS dispositions as a recurring issue in four of the six most recent OCO Annual Reports. This year, the OCO investigated cases in which the CPS worker identified a disposition without documenting sufficient evidentiary support. Depending on the case, the problem may be the result of poor documentation, lack of thorough investigation, or failure to

accurately consider and weigh case facts and evidence. Accurate completion of CPS investigations is crucial to reaching an objective disposition and deciding what level of intervention is needed to protect the child.

DHS Response to Recommendation 4:
In 2006, DHS developed and implemented mandatory CPS supervisor training, with a focus on child safety and managing to ensure safety. Additionally, in 2007, DHS collaborated with MSP to provide advanced investigation and interview training for all CPS supervisors and workers to ensure more thorough investigations and better case decisions. Lastly, in 2007, DHS rolled out the new CPS computer system to allow workers access to all case information regardless of location. DHS is committed to strengthening the decision making within CPS. Therefore, DHS will take the following actions:

- Field Operations Administration will require that each local/district office DHS program manager or director review policy (CFF 713-9) regarding how CPS must come to investigative dispositions based on "the systematic and objective examination of facts and evidence which support or refute the determination that a preponderance of evidence of child abuse/neglect exists or does not exist" by 6/30/08. The policy review will include discussion regarding the rationale and purpose of the policy. The discussion will also include a review of policies and practices that ensure thorough CPS investigations take place.

- Field Operations Administration will require each local/district DHS office manager or program manager to complete a review of an appropriate sample of CPS Investigation Summaries (for the purpose of determining whether case disposition has been adequately determined) that have been read and approved by the supervisor. This will help to ensure proper supervisory oversight and will be completed by 9/30/08. Field Operations Administration will require each local/district DHS office director to review the results of these reviews by 12/31/08.

- The unit with the primary responsibility for training all of Michigan's child welfare staff, including both DHS and private child placing agency workers is the DHS Child Welfare Institute (CWI). In February 2008, the CWI was moved under the supervision of Children's Services Administration to ensure

appropriate training is provided to staff. As a result the Children's Services Administration will be completing assessments of child welfare training module(s) by 12/31/08.

5. Licensing:
The OCO recommends the Legislature amend PA 116 of 1973, the Child Care Organization Act, to require the Bureau of Child and Adult Licensing (BCAL) to provide regulatory oversight of licensed child-placing agencies' actions in cases where the agency is responsible for court-ordered placement and supervision of a child placed in unlicensed relative care. This may be accomplished by amending the definition of "child-placing agency" contained in MCL 722.111.

Rationale: Within Michigan's child welfare system, a child-placing agency is responsible for placement and supervision of abused and neglected children removed from home by court order. BCAL is the division within DHS that issues licenses to child-placing agencies and certifies that a child-placing agency is in compliance with state licensing rules, some of which relate directly to child safety and well-being. Regulatory oversight ensures a crucial check on the quality of service delivered to children removed from home and supervised by a child-placing agency.

In recent years, licensed child-placing agencies have placed and supervised increasing numbers of children in unlicensed relative homes. Under DHS interpretation of the current law, a licensed child-placing agency's actions are subject to state regulatory oversight only if the agency is performing duties related to servicing a child placed in a licensed foster home. The same regulatory oversight does not apply if the licensed child-placing agency is servicing a child placed in unlicensed relative care. This leaves children placed with unlicensed relatives without the same protections afforded to children placed in licensed homes.

DHS Response to Recommendation 5:
While children placed in the home of a relative do not currently have the same state regulatory (BCAL) oversight as children placed with licensed providers, DHS notes that foster care policy sets the same case standards for all children whether in licensed or unlicensed care. In addition, in fiscal year 2007-2008, the Purchased Service Division began to complete reviews of foster care cases being serviced by private child placing agencies in which the children are placed with unlicensed caregivers. This adds an

additional level of regulatory oversight to those cases being handled by private child placing agencies.

Further, DHS is currently working to ensure that all relatives who are providing care to foster children under the supervision of DHS receive information, encouragement and support in becoming a licensed foster parent. Prior to providing this information on potential licensing, DHS will now be performing additional safety reviews of each relative caretaker. The efforts to license all willing relative caregivers are being undertaken by both DHS and private child placing agency staff. Once licensed, a relative home becomes subject to the same regulatory oversight through BCAL as children who are placed with unrelated licensed foster care providers, in addition to being subject to the same case standards related to policy.

In fiscal year 2008, BCAL will be reviewing the feasibility of expanding child welfare licensing's oversight of child placing agencies to include the placement and supervision of children in unlicensed care. BCAL is convening a child placing agency rule advisory committee this fiscal year and will form a sub-group of the committee to identify statutory changes needed to implement new rules.

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