State of Michigan

Office of Children's Ombudsman

Annual Report
2008-2009

STATE OF MICHIGAN
OFFICE OF CHILDREN'S OMBUDSMAN
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

VERLIE M. RUFFIN
DIRECTOR

September 2010

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 2008/2009 Annual Report.

This report provides an overview of the activities of the Office of Children's Ombudsman from October 1, 2008 to September 30, 2009, 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.

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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A message from the Ombudsman…..

In July 2008, the State of Michigan and a New York state child advocacy organization reached a settlement agreement in response to a historic class action lawsuit filed against Michigan's child welfare system. As a result, the Department of Human Services (DHS), the legislature, courts, private child-placing agencies, and others have continued throughout fiscal year 2009 to implement sweeping reforms, particularly in the area of foster care. Many of the terms of the agreement reflect recommendations that the OCO has made in past annual reports and in OCO investigative case reports issued to the department; among them, a reduction in worker and supervisor caseloads, mental health screenings for children entering foster care, greater financial supports for relative caregivers, and shorter time frames for achieving permanency. In the months since the settlement agreement was reached, my staff and I have supported these efforts. I continue to be impressed with DHS' commitment and expertise as it implements the terms of the agreement.

In this annual report, we have included three recommendations: two that address CPS investigations – one regarding "sudden or unexplained" infant deaths and one which addresses severely impaired, multiply handicapped, and medically fragile children. The third recommendation addresses smoking in foster homes.

This report also includes a section addressing child death investigations. An agreement with DHS allows the OCO to receive immediate notification when a child dies. In this reporting period, the OCO completed 56 investigations involving children who died. As a result of our investigations involving child deaths, the OCO issued nearly 40 recommendations to DHS to improve child protection and prevent future deaths.

As I enter my fifth year as children's ombudsman, it continues to be my pleasure to serve the citizens of Michigan in our shared goal of protecting children. Please contact me or the OCO staff with any questions you may have as you review this Annual Report.

The Conduct of the Children's Ombudsman

In an effort to bring greater accountability to Michigan's child welfare system, the Michigan Legislature established the Office of Children's Ombudsman (OCO) in 1994. The OCO provides citizens with a way to obtain an independent and impartial investigation of child protective services, foster care, adoption services, and juvenile justice cases under the supervision of the Department of Human Services (DHS).

Independence

The Office of Children's Ombudsman (OCO) is an independent state office within the Department of Technology, Management and Budget (DTMB). The ombudsman is appointed by the Governor with the advice and consent of the senate. The OCO investigates complaints concerning children involved in the child welfare system objectively and independent of influence from the Governor's office, Department of Human Services (DHS), DTMB, and other stakeholders.

Authority

The Children's Ombudsman Act (1994 PA 204) authorizes the ombudsman to obtain information from DHS and other agencies and service providers, including records in the possession of public and private child-placing agencies and medical and mental health providers involved in a child's case. OCO records are confidential and not subject to court subpoena or discoverable in a legal proceeding and are exempt from disclosure under the Freedom of Information Act.

The ombudsman cannot make, change, or set aside a law, policy, agency practice, or agency decision. However, the office can release detailed investigative findings and

recommendations addressing needed improvements in laws, policies, and agency practices in reports to the department, private agencies, the Legislature, and OCO complainants. The ombudsman is also authorized to take legal action on behalf of a child, refer a case to DHS for a children's protective services (CPS) investigation, and pursue legislative advocacy on behalf of children.

Budget and Expenditures

The OCO was appropriated $1,485,000 for fiscal year 2009, allocated from the state general fund: Eighty percent for personnel, with the remainder devoted for facilities, technology, and office supplies. Staff included: the ombudsman, seven investigators, and two administrative staff. The ombudsman maintains offices in Lansing and Detroit.

Multidisciplinary Team

The OCO uses a multidisciplinary team approach to investigations. Investigators have diverse professional and educational backgrounds with a broad range of experience in child welfare. The 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 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, the OCO staff periodically consulted with the DHS Office of Family Advocate (OFA) and DHS policy and administrative staff to discuss individual complaint investigations, agency policies, programs, and practice. OCO staff also regularly review proposed changes to DHS policies related to CPS, foster care, adoption, and juvenile justice.

- **Changes to DHS policy.** During fiscal year 2009, OCO recommendations and advocacy contributed to changes in DHS policy, including modifying the definition of child maltreatment; adding a definition of child torture; a mandatory checklist for CPS investigations; the coordination of CPS investigations with Friend of the Court; and the issuance of revised adoption policy.

- **Statewide advisory boards.** OCO staff served on numerous advisory boards, workgroups, and committees including the Michigan Court Improvement Program, Foster Care Review Board, Child Support Leadership Council, Advisory Board on Overrepresentation of Children of Color in Child Welfare, Michigan Child Death Review, Bureau of Children and Adult Licensing Rules Committee, Kids Count in Michigan, and the Child Welfare Improvement Task Force, among others. OCO staff also participated in federally mandated citizen review panels including Child Death Review Advisory and Prevention.

- **Presentations.** Each year, the OCO receives requests to provide presentations to interest groups, child advocates, and various child welfare stakeholders throughout Michigan. In fiscal year 2009, the ombudsman and OCO investigators made presentations to DHS staff and various interest groups regarding the work of the office. The ombudsman also met with DHS county directors and state legislators to highlight OCO recommendations to improve child welfare.

Mission

The mission of the OCO 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.

Consistent with the Children's Ombudsman Act and office mission, the OCO performs the following duties:

- **Responds to citizen complaints.** Whenever possible, the OCO provides citizens with meaningful and effective strategies for resolving their concerns. This year, the OCO responded to over 1,000 complaints from citizens related to the child welfare system.

- **Promotes child safety, well-being and permanency.** If the OCO determines a child may be unsafe, an administrative action may be harmful to a child, or further action is needed to ensure a child's well-being or permanency, the ombudsman may request DHS take a specific action; e.g. conduct a CPS investigation or safety assessment of a child believed to be at risk, change the permanency plan, file a termination petition, provide services to a child, conduct a thorough home study, or consider the replacement of a child. The ombudsman may also request a licensing investigation of a child-placing agency or foster home, or may refer a criminal matter to a law enforcement agency.

- **Improves 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 157 recommendations for system-wide improvement or to address problematic decisions affecting individual children. DHS agreed to implement the majority of those recommendations.

Complaints

The primary function of the OCO is to respond to complaints about Michigan's child welfare system. Anyone concerned about how a child's case is being handled by DHS or a private child-placing agency may make a complaint to the OCO.

Complaint Intake

Citizens who contact the OCO have varying degrees of understanding about the child welfare system. The OCO provides complainants 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 knowledgeably and effectively for themselves and the child and resolve their complaint.

The OCO uses the following criteria to evaluate each complaint and decide whether to conduct an investigation:

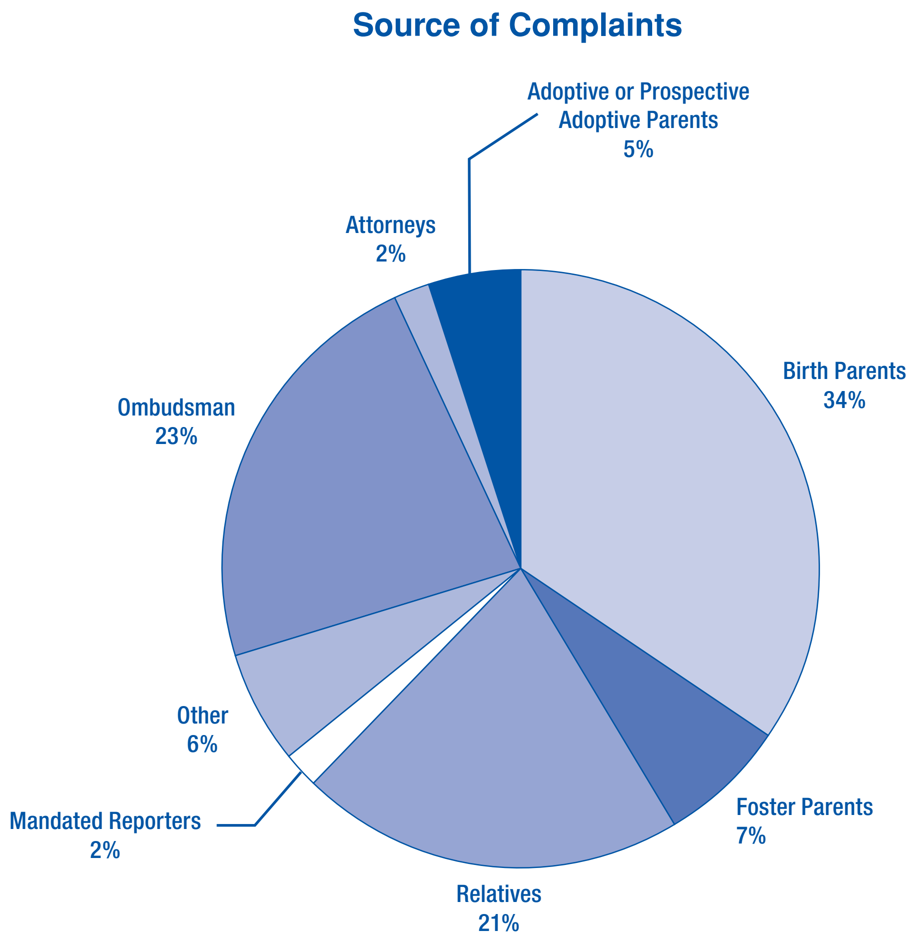
- The complaint concerns a child involved with CPS, foster care, adoption services, or juvenile justice in Michigan.
- The complaint concerns the death of a child who had been involved with the welfare system or whose death may have resulted from abuse or neglect.
- An action or inaction by DHS or a private child-placing agency is alleged to 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 to resolve the complaint without success.
- It is likely that an investigation by the OCO will positively impact the child's situation or children in future cases.

Source of Complaints

Anyone may file a complaint with the OCO. Complaints can be made via telephone, mail, fax, email, or electronic complaint form accessible on the OCO website: www.michigan.gov/oco.

The identity of the complainant is kept confidential unless the complainant gives the ombudsman permission to disclose his or her identity.

In fiscal year 2009, the OCO received 1,005 complaints concerning 1,583 children in 75 of Michigan's 83 counties. Birth parents made up the greatest share of complainants (34%) followed by relatives of the child (21%). This data remains relatively consistent.



Complaint Categories

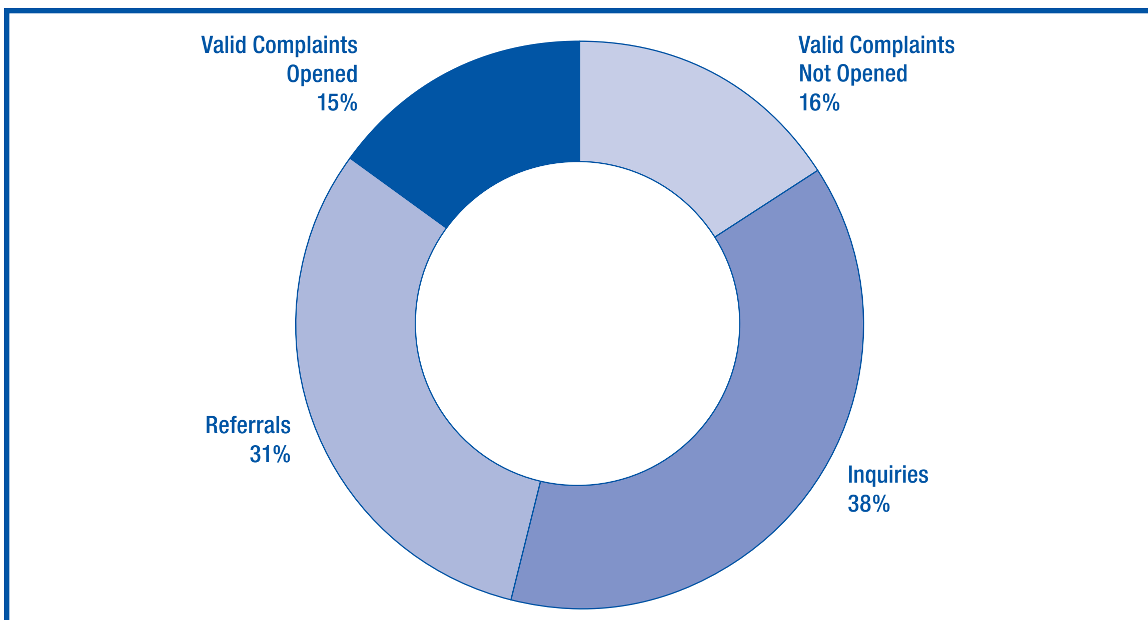
Not all complaints are appropriate for investigation by the OCO. To most effectively manage and respond to citizen complaints, the ombudsman classifies complaints into one of the following four categories:

- **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. **This year, the OCO classified 383 complaints as inquiries.**

- **Referrals** - complaints that concern a child involved with CPS, foster care, adoption, or juvenile justice, but involve actions of an agency or person the OCO is not authorized to investigate, such as the court, law enforcement, or an attorney. **The OCO classified 317 complaints as referrals.**

- **Valid Complaints Not Opened** – complaints that are within the OCO's jurisdiction to investigate, but an investigation will not resolve the complaint issue; e.g. 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. **The OCO classified 162 complaints as valid complaints not opened.**

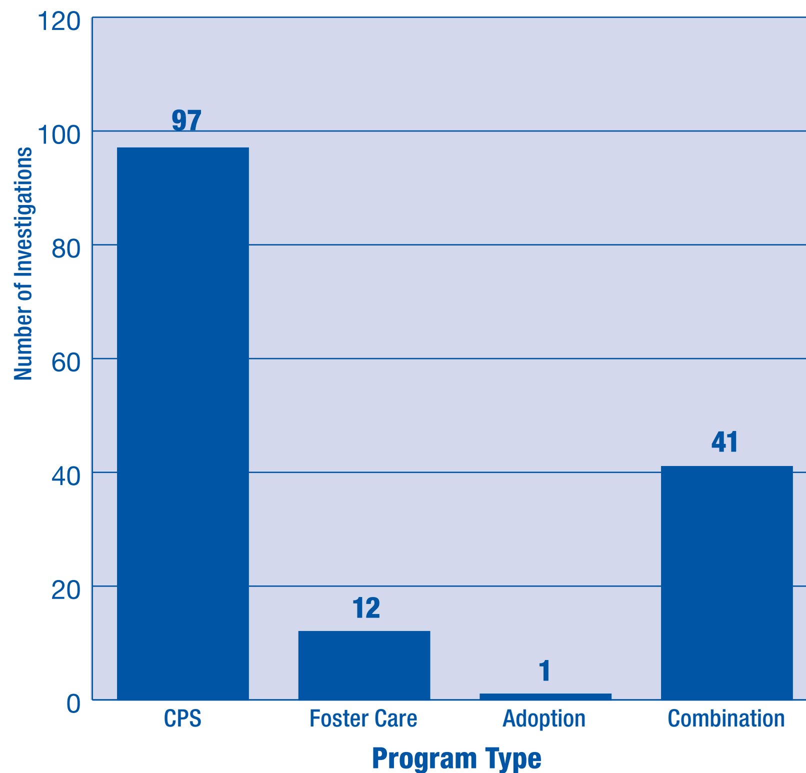
- **Valid Complaints Opened** – complaints that involve CPS, foster care, adoption, or juvenile justice and allege possible violations of law or policy or poor practice that impact a child's safety or well-being. The OCO determines that the complaint satisfies complaint analysis criteria and opens an investigation. **This year, the OCO opened 148 complaints for investigation.**



Investigations

The OCO completed 151 investigations this fiscal year. Investigations generally focused on resolving issues raised by the complainant. However, if the OCO identified other factors that 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 those issues with DHS, the Bureau of Children and Adult Licensing, the private child-placing agency, the court, or the child's attorney, as appropriate.

Of the 151 investigations completed this fiscal year, the majority (64%) focused exclusively on CPS concerns; 27% of investigations involved more than one program area (CPS, foster care, and/or adoption); and 8% of investigations addressed only foster care concerns. No complaints were received regarding juvenile justice.



Administrative Response Requests

In situations where the OCO determines that an immediate administrative action is necessary to protect a child, to alleviate a situation, or to expedite permanency, the OCO will issue a Request for Administrative Response to DHS and/or a private child-placing agency. This request may be made to the agency at intake or during an investigation. In these elevated response situations, DHS will respond on behalf of the involved agencies within 10 days. In fiscal year 2009, the OCO issued six such requests to eight agencies. Following is a summary of the OCO requests and the responses by the involved agencies:

OCO Concern	DHS Response/Outcome
A young child had been in foster care for over four years and the agency was requested to take immediate steps toward permanency.	The agency agreed and filed a petition for termination of parental rights.
In three months since siblings had been placed in care, the contract foster care agency had not completed a timely Initial Service Plan (ISP); the children had not been referred for counseling; other foster children were at risk in placement with a particular child; and the parents had not yet been engaged in developing a service plan.	The agency responded by completing the ISP and mailing it to the court and attorneys; the children were referred for counseling; a child was determined to be a risk to younger children and was replaced; the agency met with the parents to develop the service plan.
Two sisters were placed separately and were not visiting each other; a relative provider may be allowing unauthorized parental contact deemed dangerous to the children; and one child had not been referred for counseling.	The agency responded by assessing whether the relative providers were meeting the children's needs; ensured sibling visitation and no contact with birth parents; and made a counseling referral for the child who had not yet been referred for services.
A family had not been considered for foster care placement of their adoptive child's newborn sibling; an adoptive home study had not been completed; and a determination had not been made regarding a request for sibling visitation.	The agency responded that the case was reviewed and it was determined the family should have been contacted regarding initial foster care placement; the family was now being considered but not recommended for adoption; a Preliminary Adoptive Family Assessment had been completed; and all information had been sent to the MCI Superintendent for a consent decision. The agency did not support initiating sibling visitation prior to a consent decision.
Lack of service provision to family members was jeopardizing the placement of a sibling group with the non-custodial father and contact with the mother's boyfriend was in violation of a court order.	The agency responded that referrals for services were made and supports provided to maintain the children's placement with their father. The mother's boyfriend had been approved by the court for contact with the children.
A child had been placed in an unlicensed home, there were delays in the provider becoming licensed, and confusion about the court's order regarding counseling for the child.	The agencies responded that an updated court order regarding the unrelated, unlicensed placement would be placed in the case file; licensing delays were addressed and the counseling issues were clarified.

Preliminary Investigations

A complaint may be opened for a preliminary (or "abbreviated") investigation to determine whether further investigation is appropriate or warranted, or if it is believed the complainant's specific concern regarding agency actions can be resolved expediently. A preliminary investigation may consist of requesting pertinent agency or court documents; submitting questions to a caseworker; or conducting interviews with agency staff. After receiving the requested information and reviewing actions by the agency, the complainant receives a letter regarding the determination for closure or further investigation, and providing information to assist the complainant in resolving his or her concerns if warranted.

The ombudsman initiated 18 preliminary investigations in FY 2009. Three cases resulted in further investigation and 15 were closed after the preliminary investigation.

Investigation Results

When an investigation is completed, the ombudsman 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 OCO closes each case in accordance with one or more of the following four closing categories:

- **Preliminary Investigation Closing** – the OCO determines that the complainant's concerns can be resolved by requesting specific information from the involved agency; actions by the agency are generally supported or resolved and no further investigation is warranted.

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

- **Findings and Recommendations (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 details case background information and findings and recommendations in a report to the agency, and the agency responds in writing within 60 days.

- **Administrative Closing** – the OCO is not able to affirm the actions of the agency and determines one or more of the following:

    - The agency did not comply with all applicable 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

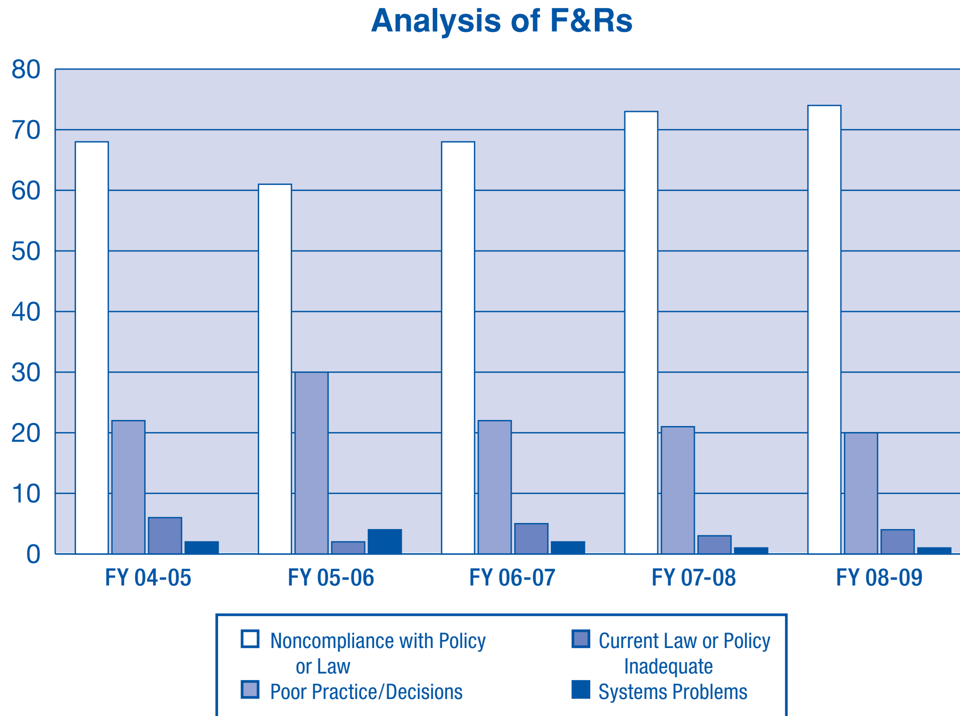
responds by taking action to rectify them. For example, the OCO may have requested the agency conduct a safety assessment, reconsider a placement decision, provide medical or mental health services to a child, or change a permanency goal. The OCO verifies that the requested action was taken and closes its case if no further concerns are identified.

- 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 OCO 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.

In the 151 investigations completed in fiscal year 2009, 19 cases were closed after a preliminary investigation; case handling was affirmed to 66 involved agencies and there were 43 reports of Findings and Recommendations issued. Also issued were 62 Administrative Closing reports in which the complainant's concerns were either resolved by the agency or the OCO determined that no further action was needed.

Analysis of F&Rs

The OCO issued 43 Reports of Findings and Recommendations (F&Rs) in fiscal year 2009 encompassing over 150 findings. Consistent with each year prior, the overwhelming majority (95%) of findings were the result of noncompliance with existing law or policy or poor practice and decision-making.



Analysis of Administrative Closings

The OCO issued Administrative Closing letters in 43 cases in fiscal year 2009. Following are the numbers and rationales for case closing:

Number of Cases	Rationale
14	Agency self-corrected the problem.
8	Circumstances changed; issues that gave rise to the complaint no longer existed.
4	OCO lacked jurisdiction to affect the outcome for the child.
21	Further investigation or action by the OCO would not resolve the complaint issue.

OCO Investigations by Agency and Outcome

Of the completed investigations, 127 (84%) involved DHS only, 21 (14%) involved both DHS and one or more private child-placing agency, and three involved only a private child-placing agency.

The following chart lists the outcome(s) by county DHS offices and private child-placing agencies for OCO investigations completed in fiscal year 2009:

Agency	Number of Investigations	Outcome			
DHS		**Preliminary Close**	**Affirm**	**F&R**	**Administrative Close**
Allegan	2		1		1
Antrim	1			1	
Barry	4	1	2	1	
Bay	2				2
Berrien	2		1	1	
Branch	2		2		
Calhoun	2		1		1
Cass	2		1		1
Charlevoix	2		1	1	
Cheboygan	1			1	
Chippewa	1		1		
Eaton	2		2		
Emmet	1				1
Genesee	19	2	5	9	3
Grand Traverse	2	1	1		
Gratiot	2		1		1
Houghton	1		1		
Ingham	3		2		1
Ionia	1				1
Iosco	1		1		
Isabella	2		1		1
Jackson	1				1
Kalamazoo	5	1	1	2	1
Kent	8		4		4

Lapeer	3	1		1	1
Lenawee	2	1	1		
Mackinac	1		1		
Macomb	11		3	1	7
Mecosta	1			1	
Midland	2		2		
Montcalm	2	2			
Muskegon	2		2		
Oakland	10	1	2	4	3
Ottawa	1		1		
Roscommon	1	1			
Saginaw	1		1		
St. Clair	7		1	2	4
Tuscola	3	1	1	1	
Van Buren	1			1	
Washtenaw	5	1	2		2
Wayne	41	5	15	9	12
Wexford	2		2		
Private Agencies					
Alternatives for Children	1			1	
Catholic Charities of Shiawassee	1	1			
Child and Family Services of NW MI	1	1			
Community Living Services	1			1	
Ennis Center for Children	2			1	1
Evergreen Children's Services	1			1	
Federation of Youth Services	1			1	
Judson Center	1				1
Lutheran Adoption Services	3				3

Lutheran Child & Family Services	1				1
Lutheran Social Services	6			1	5
Methodist Children's Home Society	1		1		
St. Francis Family Center	1				1
St. Vincent Catholic Charities	1				1
Spectrum Human Services	1	1			
The Children's Center	2	1		1	
Whaley Children's Center	1				1
Wolverine Human Services	2		1		1

Child Deaths

In 2008, the OCO and the DHS Office of Family Advocate entered into an agreement that resulted in DHS sending an electronic "Child Death Alert" to the OCO when DHS becomes aware that any child has died.[1] Specific criteria is used to determine whether the OCO will open a case for investigation. The focus of an OCO investigation is to determine whether previous interventions by DHS and/or a private child-placing agency were handled in accordance with policy and law. The OCO also determines whether there is a possible correlation between previous DHS involvement with the family and the circumstances that led to the child's death. An investigation may be conducted when at least one of the following criteria is met:

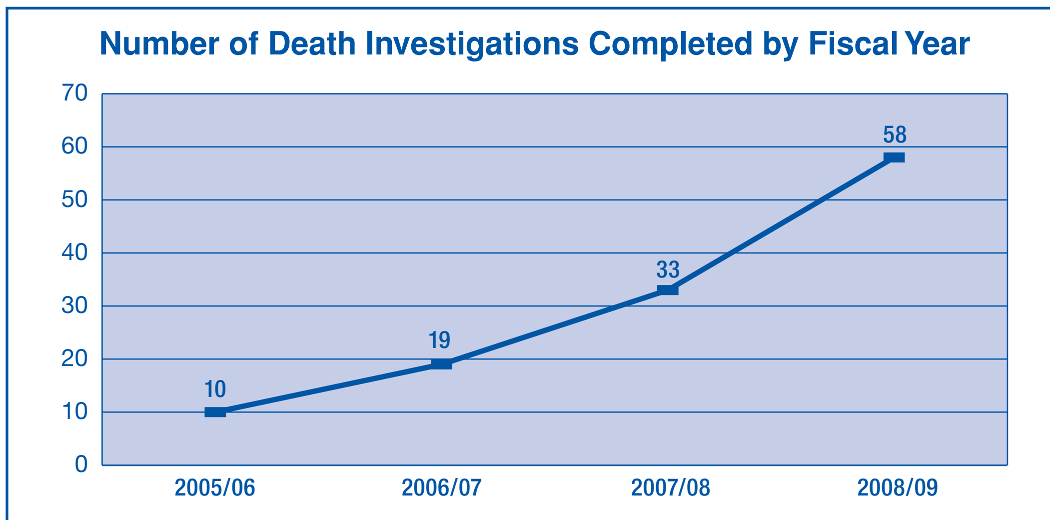
- A child died during an active investigation or open CPS case.
- A child died while in foster care unless it is clear that the death was the result of natural causes and there were no prior CPS or licensing complaints concerning the foster home.

[1] While many of the child death alerts involve children currently or previously involved in the child welfare system, not all do. Some death alerts allege that child abuse and/or neglect may have contributed to the child's death, including murder. Others involve a child who may have died as a result of natural causes. Alerts are also received when a child dies due to positional asphyxia, drowning, suicide, or other accidents.

- A child was returned home from foster care and there is still an active foster care case.
- The foster care case involving the deceased child or sibling had been closed within the last two years.
- The most recent CPS complaint was within the last two years, including rejected complaints.
- Media interest.
- Legislator request.
- Ombudsman discretion.

In fiscal year 2009, the OCO received 212 child death alerts and from those initiated 74 investigations.

In the past five years, the OCO has greatly increased the number of completed investigations involving the death of a child. For fiscal year 2009, 38% of OCO investigations involved a child death.

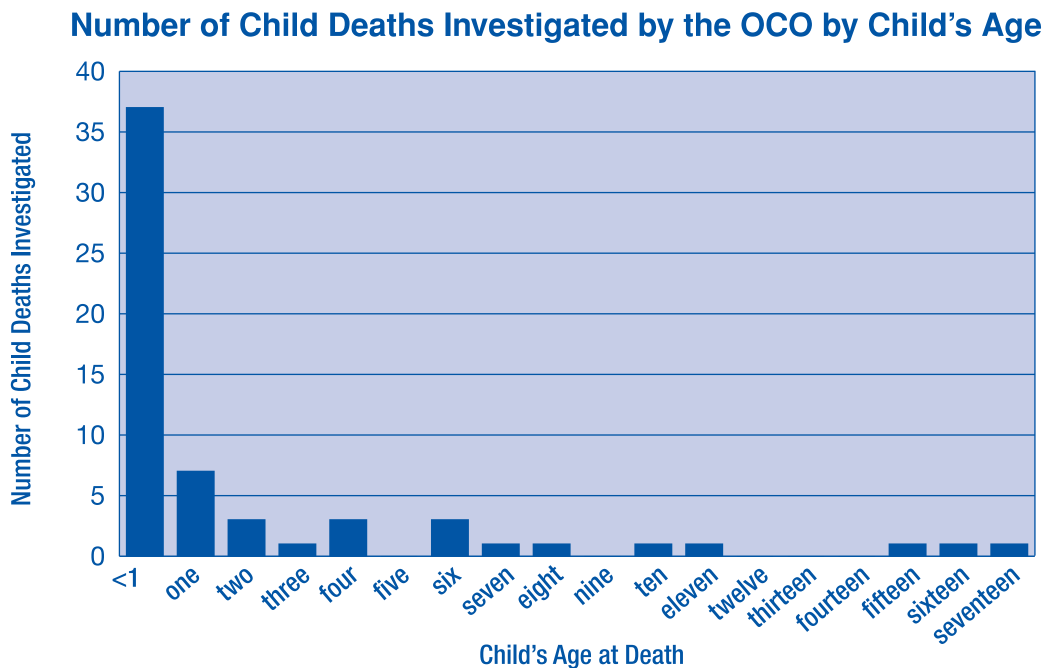


In the majority of these investigations, the OCO became aware of the death from the DHS alert or from a media report.

Child Death Investigation Analysis

Statistical information regarding the 58 death-related OCO completed investigations indicates:

- 15 children died in parental care during an active investigation or an open CPS service case.
- 3 children died while in foster care.[2]
- 4 children died as a result of severe physical abuse.
- In 9 deaths, the child's previous medical condition was identified as a factor.
- In 62% of the deaths, the child was under the age of one.
- 96% of the investigations involved a child (or siblings) and the family had prior contact with CPS.
- In 45% of the investigations, CPS confirmed abuse and/or neglect, but not necessarily related to the actual death.
- In over 50% of the investigations, the child's sleep environment was identified as a factor.



[2]Child deaths due to "unsafe sleep" practice, malnutrition, and congestive heart failure.

Investigation Results

Of the 58 child death related investigations in fiscal year 2009, the following results are reported:

- In 30 cases, the OCO affirmed the actions of the agency.
- In 14 cases where concerns were identified, the OCO wrote a report of Findings and Recommendations. In those reports, 62 individual findings were issued to DHS or private child-placing agencies. The majority of those findings identified agency noncompliance with existing law or policy or poor practice and decision-making.
- An additional 14 cases were closed as an "Administrative Closing," indicating that any identified concerns had already been addressed.

OCO Investigations of Child Deaths by Agency and Outcome
FY 2009

Agency	Number of Investigations	Outcome		
DHS		**Affirm**	**F&R**	**Administrative Closings**
Barry	1	1		
Bay	1			1
Berrien	2	1	1	
Branch	1	1		
Calhoun	1	1		
Cass	1	1		
Chippewa	1	1		
Genesee	7	2	5	
Gratiot	1	1		
Houghton	1	1		
Ingham	3	3		
Kalamazoo	2	1	1	
Kent	3	2		1
Lapeer	1		1	
Macomb	2			2
Mecosta	1		1	
Midland	1	1		
Muskegon	1	1		
Oakland	6		3	3
Ottawa	1	1		
Saginaw	1	1		
St. Clair	3	1		2
Tuscola	1		1	
Washtenaw	2	2		
Wayne	21	11	3	7
Private Agencies				
Community Living Services	1		1	
St. Francis Family Center	1			1

OCO Annual Report Recommendations and DHS Responses

CPS Investigations Involving Sudden or Unexplained Infant Deaths

OCO Recommendation 1:
With respect to a Children's Protective Services (CPS) investigation of a "sudden or unexplained" infant death (e.g. SIDS, overlay, where an unsafe sleep environment may have been a factor, etc.) the OCO recommends that DHS:

- Amend DHS policy PSM 711-5 "CPS Operational Definitions" to include "sudden and unexplained death of an infant."[3]
- Require CPS workers to complete the Child Death Investigation Checklist (DHS-2096) for all investigations involving the death of a child.
- Expand CPS policies for investigating child deaths (PSM 713-8 "Special Investigative Situations – Child Death") to include clear guidelines for investigating cases of sudden or unexplained infant deaths, and circumstances that may warrant a disposition confirming child abuse or neglect.[4]
- Ensure that the DHS Child Welfare Training Institute curriculum includes training specific to investigating "sudden or unexplained infant deaths."

DHS Response to Recommendation 1:
In February 2010, the CPS program office created policy to address a lack of consistency in dispositions assigned to complaints involving sudden and unexplained infant deaths. To determine policy effectiveness, DHS will review a sample of applicable fatality cases that were handled before February 2010 and after February 2010 and assess consistency in investigation process and complaint disposition. In addition, CPS program office will explore the areas noted by the OCO to determine whether expanded policies and investigation procedures could be beneficial for CPS workers and the families they serve. Finally, CPS program office will work with the Child Welfare Training Institute (CWTI) to review current training curriculum on sudden or unexplained infant deaths to determine whether current training meets the needs of CPS workers and supervisors.

If necessary, DHS will modify or enhance training opportunities to ensure staff is adequately prepared to respond to fatality complaints and investigations.

[3]PSM 711-5, CPS Operational Definitions – The legal definitions for child abuse, child neglect and child sexual abuse are found in PSM 711-4, CPS Legal Requirements and Definitions and are narrowly defined, based on the language of the Michigan Child Protection Law (CPL) and other laws that provide the legal base for Child Protective Services (CPS). The following [operational] definitions are broader in scope and are intended to assist workers in the intake, investigation and dispositional phases and in the provision of post-investigation services."

[4]Of note, in cases where CPS does confirm neglect, the law requires the agency to file a mandatory court petition.

Severely Impaired, Multiply Handicapped, Medically Fragile Children

OCO Recommendation 2:

The OCO recommends DHS revise CPS policy[5] to outline CPS investigation requirements when a severely impaired, multiply handicapped or medically fragile child resides in the home. The investigation worker should be required to secure a medical examination of the child, consult with medical professionals, school personnel, or other collateral sources as necessary to accurately determine the impaired child's safety and well-being.

The investigation report should document a comprehensive assessment of the caretaker's ability to adequately provide for the physical, medical, emotional, and educational needs of the impaired child.

Rationale:

- CPS workers are not trained to assess children with significant physical, mental and developmental impairments that render them medically fragile and totally dependent. Worker observation alone is not sufficient to assure child safety and well-being for children with severe physical or mental impairments, children who are multiply handicapped or medically fragile.

- Medical examination of the child and assessment of the caretaker will provide a point-in-time "baseline" or "benchmark" of the child's condition and care for comparative evaluation in any subsequent DHS interventions.

- Collateral contact with medical, school, or other community sources knowledgeable of the child's or family's needs will facilitate better assessment and service provision to high risk children and families.

DHS Response to Recommendation 2:

Agree. Effective June 1, 2010, DHS implemented policy enhancing the steps that a CPS worker must take to investigate the safety of medically fragile children. During an investigation that involves a medically fragile child, policy requires the CPS worker to gather information from professionals and others in the community who may be familiar with the child's needs. If these contacts do not assist the worker in determining whether the child's needs are being met, then a medical examination is required. If the investigation includes an allegation that a medically fragile child's needs are not being met by the caregiver, the CPS worker must contact the child's primary doctor to evaluate the child's care.

[5]Consider changes/clarifications to: PSM 712-6 (CPS Intake - Special Cases), PSM 713-8 (Special Investigative Situations), PSM 713-4 (Medical Examination and Assessment) and 716-8 (Medical Neglect of Disabled Infants and Medical Neglect Based on Religious Beliefs).

Non-smoking Foster Homes

OCO Recommendation 3:
The OCO recommends that Michigan implement a statewide ban on smoking in foster homes and in the vehicles in which foster children are transported.

According to the Environmental Protection Agency and the U.S. Surgeon General, exposure to second hand smoke presents health hazards to children, including increased risk of asthma, Sudden Infant Death Syndrome, lower respiratory infections such as pneumonia and bronchitis, and middle ear infections.

Several states, including Alaska, Arizona, Colorado, Kansas, Maine, Maryland, Montana, New Jersey, Oklahoma, Oregon, Texas, Vermont, Washington, and Wyoming have enacted explicit legislation or policy prohibiting smoking in foster homes and in the vehicles in which foster children are being transported.[6]

In 2005, State legislation[7] required the Michigan Department of Human Services to distribute materials to foster parents on risks to children from tobacco use and second hand smoke; introduce a smoking cessation program; and determine the number of foster children residing in homes where **caretakers** smoke. DHS was also required to determine the resulting health costs for foster children and the impact on recruiting foster parents if being a non-smoker was a requirement for foster parenting.

In a report to the legislature issued in September 2006, DHS estimated that 4,400 foster children were living in households where caregivers smoked. The report also indicated that if a foster parent or relative caregiver was required to be a nonsmoker, 92 percent would still foster, including 93 percent of the relative caregivers. Finally, the total health care costs for foster children exposed to second hand smoke in their households were estimated at $1.7 million to $3.7 million.[8]

DHS Response to Recommendation 3:
Agree in part. In June 2010, a DHS workgroup, led by the Bureau of Children and Adult Licensing, began a review of the Administrative Rules for Foster Family Homes and Foster Family Group Homes for Children. A staff person from the Office of Children's Ombudsman is a member on the workgroup. The workgroup will consider the recommendation to ban smoking in foster homes.

[6] National Resource Center for Family-Centered Practice and Permanency Planning at the Hunter College School of Social Work: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/policy-issues/Smoking_Policies.pdf
[7] Public Act 147, Sections 550, 551 of enrolled Senate Bill No. 271.
[8] http://www.michigan.gov/documents/dhs/DHS-BoilerplateSec550-551PA147-2005_176411_7.pdf

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