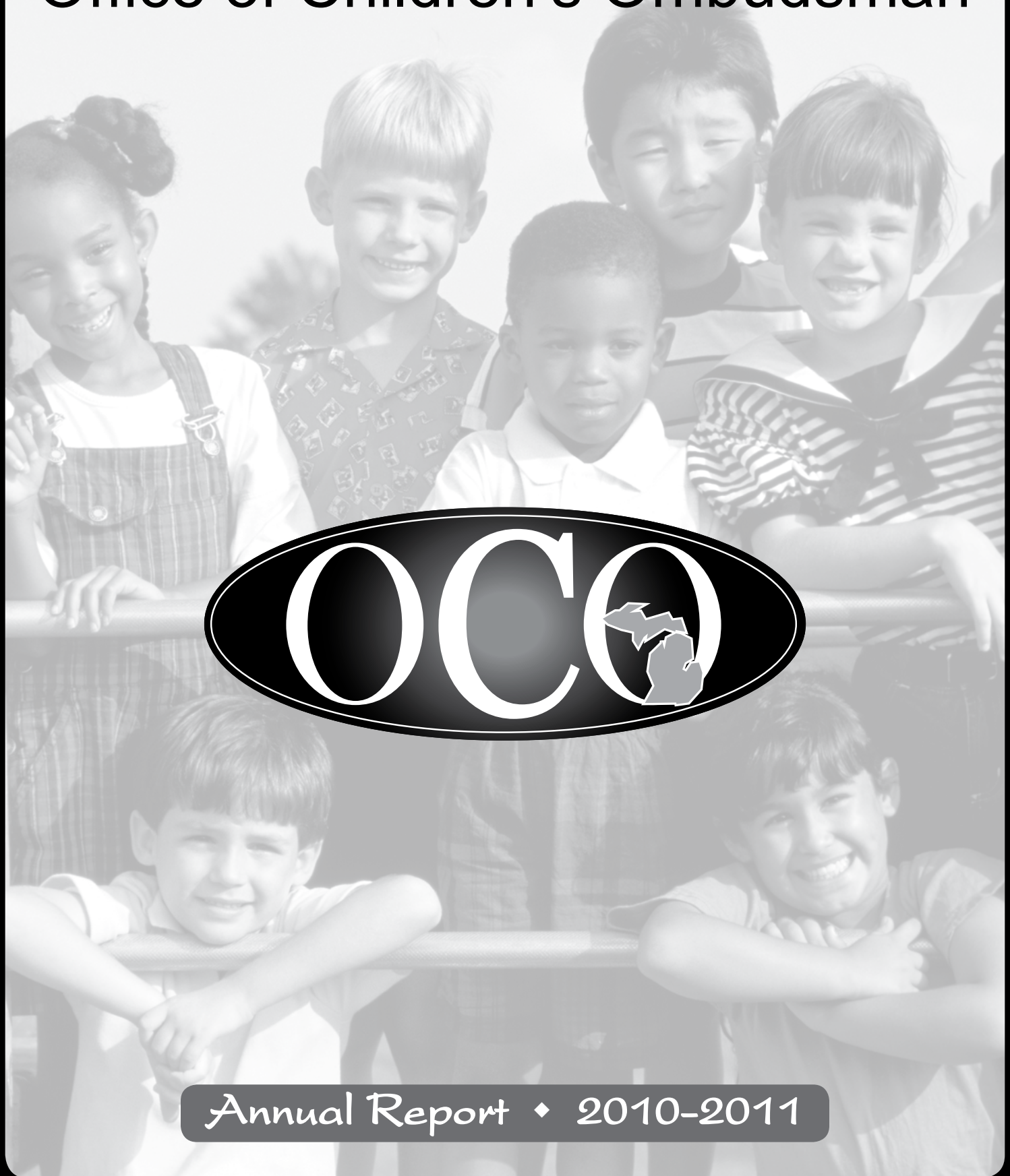
State of Michigan

Office of Children's Ombudsman



Annual Report • 2010-2011

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.

Vision Statement

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

STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

OFFICE OF CHILDREN'S OMBUDSMAN
LANSING

VERLIE M. RUFFIN
DIRECTOR

June 2012

The Honorable Rick Snyder, Governor
Honorable Members of the Michigan Legislature
Ms. Maura Corrigan, Director, Michigan Department of Human Services

In accordance with my statutory responsibility as the Children's Ombudsman, I respectfully submit the Fiscal Year 2011 Annual Report.

This report provides an overview of the activities of the Office of Children's Ombudsman from October 1, 2010 to September 30, 2011, 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 Snyder, the Michigan Legislature, and the Department of Human Services. Thank you for the opportunity to serve the children of Michigan.

Respectfully,

Verlie M. Ruffin

Verlie M. Ruffin, Director
Office of Children's Ombudsman

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Message from the Ombudsman

This is our sixteenth annual report and we believe it provides an informative and visual representation of what we do for the citizens of Michigan.

The OCO continues to work diligently with child welfare partners to change and improve the child welfare system for Michigan's children and families. As described in our Vision Statement, the OCO "strives to be a part of the solution that fosters greater accountability and transparency for Michigan's child welfare system."

The OCO is a "complaint driven," autonomous agency that serves to give voice to citizen concerns about children involved in child protective services, foster care, adoption, and juvenile justice. The annual report analyzes complaint information including the "Most Frequently Identified Complaint Issues," a detailed list of the concerns brought to the attention of the OCO in fiscal year 2011.

Also included in this report is a new section on Affirmations. This section describes a few examples of the types of actions or decisions made by agencies investigated by the OCO that were in compliance with law and policy.

Finally, the annual report contains five recommendations covering various topics with child welfare including: *domestic violence; a checklist for child death investigations; services for families after a CPS investigation; threatened harm; and DHS policy covering multiple CPS investigations*.

Executive Summary

Authority

The Office of Children's Ombudsman (OCO) was established by the Michigan Legislature in 1994 to provide greater accountability and transparency to Michigan's child welfare system. Legislators were concerned that confidentiality laws governing child welfare also served to protect the system from outside scrutiny and accountability. The OCO provides citizens with the means to obtain an impartial and independent investigation of a child's case involving protective services, foster care, adoption services, or juvenile justice under the supervision of the Department of Human Services (DHS).

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

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

- **Respond to citizen complaints**. This year the OCO responded to **1,152** complaints, questions, and concerns regarding **1,435** children from **76** of Michigan's **83** counties.

- **Independently investigate**. The OCO completed **120** investigations of **151** agencies involving **313** children from **49** of Michigan's **83** counties.

- **Promote child safety, well-being and permanency**. In cases where the OCO determines that a child may be unsafe, an agency decision may be harmful to a child, or additional steps are needed to ensure a child's well-being or permanency, the ombudsman requested that DHS take a specific action. For example, conduct a Children's Protective Services (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 foster child into another home. 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.

- **Make recommendations to improve the child welfare system**. One of the OCO's primary functions is to identify problems and make recommendations to improve the child welfare system. Based upon case analysis and investigative findings, the office issued **173** recommendations from case investigations addressing compliance with state laws and policies this fiscal year, and that address problematic decisions affecting individual children. DHS agreed to implement the majority of those recommendations.

Budget and Expenditures

The OCO is an independent state office housed administratively within the Department of Technology, Management and Budget. The OCO was appropriated $1,214,900 for fiscal year 2011, allocated from the state general fund. Eighty percent of budget expenditures were for personnel and the remainder for facilities and support services. OCO staff for the fiscal year included: the ombudsman; five investigators; one supervisor, and two administrative staff. The OCO maintains offices in Lansing and Detroit.

Team Approach

The OCO utilizes a team approach to case investigations. Each case is assigned to a primary investigator, who is responsible for conducting interviews and analyzing the case to determine if state policy and procedure were followed. Prior to completion of all investigations, investigative team members participate in the analysis of case facts, findings, and conclusions. Findings and recommendations made in individual cases are the result of input and discussion by the OCO investigative team.

Staff Training

Investigators have a broad range of experience in child welfare. The OCO staff attends training conferences and routinely consults with professionals outside the office on issues related to child welfare. For instance, at monthly OCO staff meetings, guest speakers from within and outside state government share experiences from various roles within the child welfare system and answer questions from OCO staff.

Collaboration and Outreach

Throughout the year, the OCO staff periodically consults 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 reviews proposed changes to DHS policies related to CPS, foster care, adoption services, and juvenile justice.

The ombudsman and investigators serve on advisory boards, workgroups, and committees including the DHS SACWIS design process, Foster Care Review Board, Advisory Board on Overrepresentation of Children of Color in Child Welfare, Michigan Child Death Review, and the Child Welfare Improvement Task Force, among others. OCO staff also participated in the federally mandated Citizen Review Panel, the Child Death Review Advisory and Prevention.

Complaint Intake and Referral

The primary function of the OCO is to respond to complaints about children who are involved in Michigan's child welfare system.

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 at www.michigan.gov/oco. The ombudsman also has the discretion to be a complainant on a case.

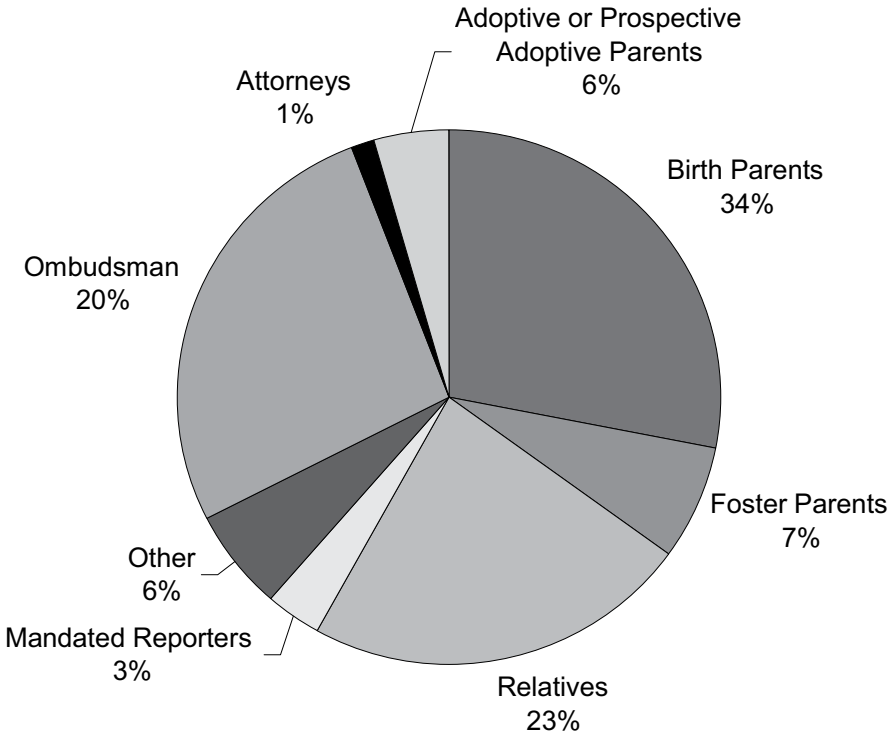
The identity of the complainant is kept confidential unless permission is given to disclose his or her identity such as in situations when doing so would be helpful in expediting a resolution to their concern.

Source of Complaints

In fiscal year 2011, the OCO was contacted by **1,152** individuals concerning **1,435** children in **76** of Michigan's **83** counties. Birth parents **(34%)** and relatives of the child **(23%)** made up the greatest share of complainants, followed by the ombudsman **(20%)***.

*Note: Includes **210** child death alerts received by the OCO.

Source of Complaints



Most Frequently Identified Complaint Issues

For this fiscal year, the OCO began tracking the types of complaints and concerns received from individuals who contact the office. The 10 main categories have several subcategories that generally describe each complaint issue. When individuals contact the OCO, they often have more than one concern. The numbers next to each main category reflect the grand total for that heading, and the totals for each subcategory reflect the number of times the concern was raised by someone who contacted the OCO.

Children's Protective Services – 178
- Inappropriate disposition – 29
- Refusal to investigate complaint – 11
- Other – 138

Child Safety - 141
- Failure to protect children from parental abuse/neglect, physical abuse – 26
- Failure to protect children from parental abuse/neglect, sexual abuse – 20
- Failure to protect children from parental abuse/neglect, neglect – 15
- Failure to protect children from parental abuse/neglect, other – 31
- Current unsafe placement (home) – 34
- Current unsafe placement (out-of-home) – 15

Removal Issues - 36
- Unnecessary/"illegal"/inappropriate removal from parental/guardian's care – 30
- Unnecessary removal from relative placement – 2
- Removal not in child's best interest – 4

Placement/Replacement – 95
- Failure to consider or place with a "fit and willing relative" – 32
- Failure to consider relative for placement – 5
- Failure to provide proper notice of removal for TCW/PCW – 5
- Inappropriate sibling split – 3
- Placement/replacement not in child's best interest – 36
- Other – 14

Service Provision - 54
- Related to needs of parent – 16
- Related to needs of child(ren) – 31
- Delay in referral for/availability of services – 7

Permanency – 67
- Permanency plan not in the child's best interest – 38
- Unnecessary delay in returning children to parent/guardian – 28
- Lack of adequate planning/transition to adoptive home - 1

Adoption - 84
- Someone not considered (relative, non-relative) – 22
- Someone not recommended for or granted consent – 10
- Other (including "process taking unnecessarily long") – 52

Child Death Notice (from DHS to OCO) - 216
- DHS/private agency involvement within previous 24 months – 48
- DHS/private agency involvement more than 24 months ago – 26
- Open CPS investigation or ongoing CPS case at time of death – 14
- Child a court ward at time of death (temporary or permanent court ward) – 9
- Unsafe sleep environment – 41
- Abuse/neglect – 7
- Accidental – 21
- Natural causes – 9
- Other (including suicide) – 41

— continued —

— continued —

Other Child Welfare Related Issues/Concerns - 201
These concerns are about guardianships; the court; where termination of parental rights has occurred and parent either has or has not filed an appeal; the unprofessional conduct of case worker; foster home licensing issues (including payment related issues); and Family Independence Program (FIP) and other payments for an unlicensed relative caregiver.

Other (non-child welfare related) – 79
Friend of the Court/custody issues, public assistance, school concerns, Corrections Ombudsman, other various concerns.

Educating the Public

Citizens who contact the OCO have varying degrees of understanding about Michigan's child welfare system. Educating the public about how the child welfare system works is a statutory duty of the office and an essential component of system accountability. Citizens who are informed about the relevant laws and policies that govern practice are better able to navigate the system and advocate knowledgeably and effectively for themselves and the child. One of the functions of the intake process is to provide complainants with detailed information about laws and policies related to their specific concerns.

Two categories of complaints/questions/concerns that focus solely on educating the public and do not result in an investigation are:

- **Inquiries:** Complaints that are not about a child in the child welfare system such as: how to become a licensed foster parent; adoption questions; complaints from other states about a child not in Michigan's child welfare system; or requests for information. In addition, inquiries include complaints involving non-child welfare related issues that the OCO does not have jurisdiction to investigate such as Friend of the Court, child custody matters, or school concerns. **This fiscal year, the OCO received 302 inquiries**.

- **Referrals:** Complaints that concern a child involved in the child welfare system (CPS, foster care, adoption services, or juvenile justice) but may involve actions of an agency or person the OCO is not authorized to investigate, such as the court, law enforcement, or an attorney. Other complaints that are considered referrals include situations where parents request OCO's assistance in the restoration of their parental rights; foster parents who have not received payment; adoption subsidy denials; or complaints about alleged unprofessional conduct of a case worker. **The OCO referred 446 complaints to other agencies or provided information to complainants this fiscal year**.

Valid Complaint Criteria

The OCO uses the following criteria to evaluate complaints and determine whether an investigation is warranted:

- The complaint concerns a child involved with Michigan's CPS, foster care, adoption services, or juvenile justice system and one or both of the following apply: 1) an action or inaction by DHS or a private child-placing agency may have violated law, rule, or DHS policy; or 2) 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 complaint concerns the death of a child whose family had been previously involved with the child welfare system and whose death may have resulted from abuse or neglect.

- 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.

Valid complaints are divided into two categories: valid complaints not opened and valid complaints opened.

Valid Complaints Not Opened

Investigation criteria for these complaints may be met but an investigation will not resolve the complaint issue. For example, a complaint about CPS but a termination trial has already commenced, or a complaint from a relative regarding placement in their home but the child has already been adopted. **The OCO classified 165 complaints as valid complaints not opened**.

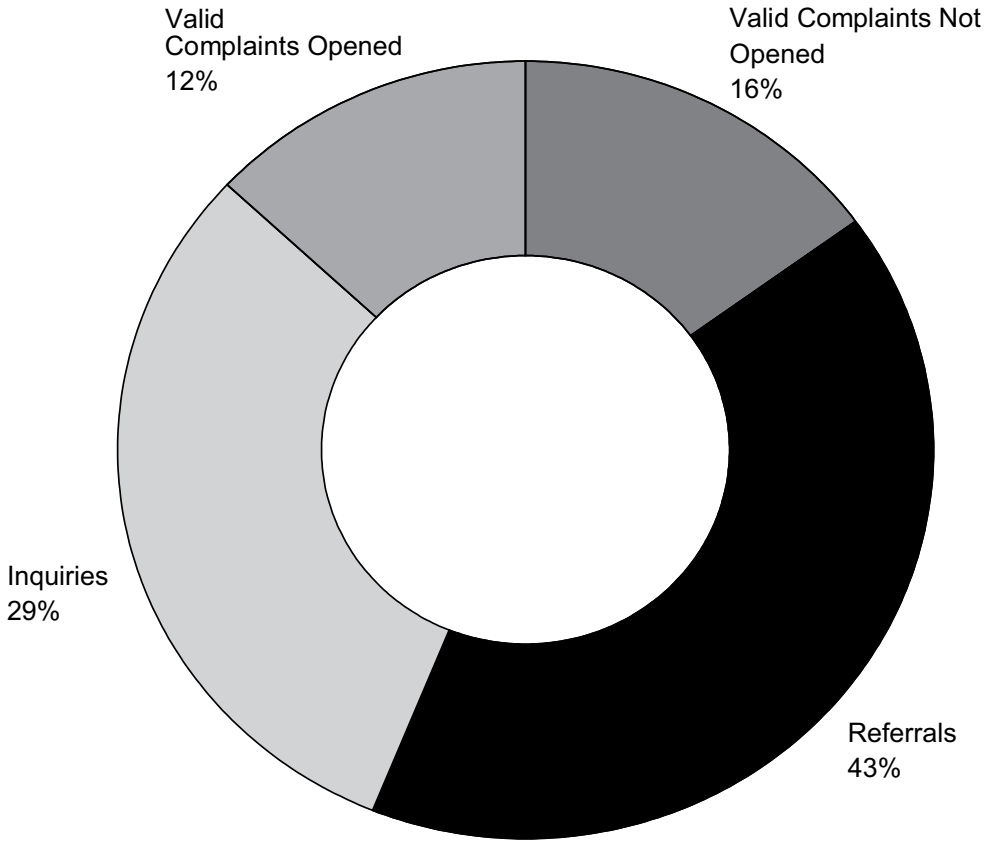
Valid Complaints Opened

Complaints that satisfy one or more investigation criteria in addition to a determination by the OCO that an investigation may resolve the complainant's concerns result in the opening of a case for investigation. This year, the OCO opened 133 complaints for investigation. Some examples of valid complaints that were opened for investigation involve:[1]

- Whether CPS properly considered prior child welfare history while investigating a complaint.

[1]Each complaint has a unique set of facts and because a complaint may be similar to concerns presented here, this information is not meant as a guarantee that a case will be opened for investigation.

- Whether relatives were properly considered for placement of a child.
- Referrals made to CPS may have been improperly rejected for investigation.
- Closing an open CPS case without adequate resolution of the family's issues that put the child at risk.
- Foster children not being contacted or visited by their caseworker according to policy.



Administrative Response Requests

In situations where the OCO determines that immediate review of an action or decision by the involved agency is necessary to protect a child, to alleviate a situation, or to address a delay in permanency for a child, the OCO issues a Request for Administrative Response to DHS and/or a private child-placing agency. This request may be made to the agency following intake or during an OCO investigation. In these elevated response situations, the DHS Office of Family Advocate will respond on behalf of the involved agency within 10 business days. In fiscal year 2011, the OCO issued two administrative response requests. Following is a summary of the OCO requests and the responses:

OCO Concern	DHS Response/Outcome
Several CPS complaints from mandated reporters were rejected for investigation by DHS even though they involved a pregnant minor and her family.	CPS conducted a preliminary investigation and contacted numerous professionals about the family and ensured that all of the children were receiving services and support.
A child was severely physically abused and required medical treatment. It was reported to the OCO that the required referral to law enforcement and the prosecuting attorney had not been made by CPS.	DHS reviewed Law Enforcement Notification information and determined that the proper referrals had been made.

Request for Action

The OCO issued one Request for Action this fiscal year. A Request for Action is issued to DHS under one or more of the following circumstances:

- Immediate risk to a child(ren).
- Inappropriate placement of a child(ren) leaving the child(ren) at risk.
- Employee misconduct.

The Request for Action issued this fiscal 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.

DHS 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.

Investigation Results

The OCO completed **120** investigations this fiscal year. An investigation may involve more than one DHS county office or private child-placing agency. During this fiscal year, the OCO investigated **151** separate DHS county offices and private child-placing agencies.

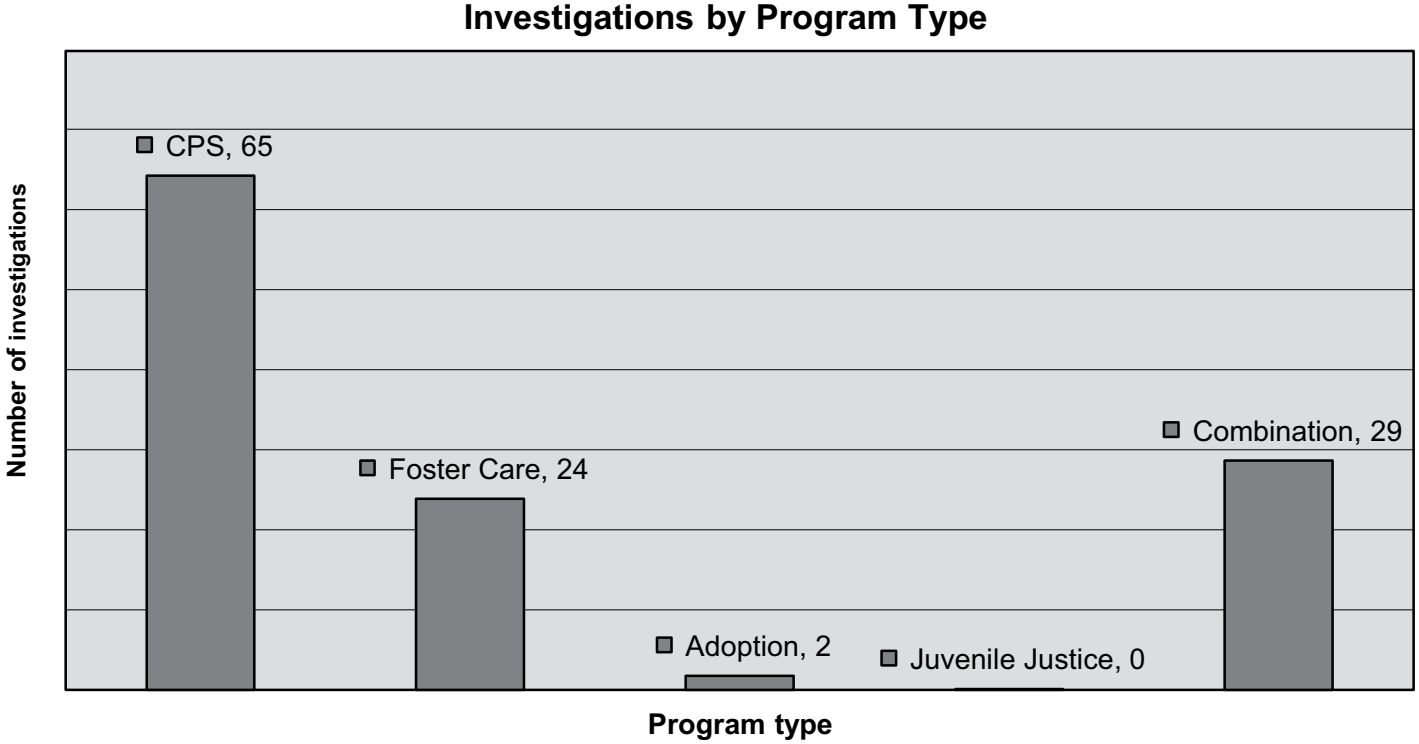
Release of Information to Complainants

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; hence, 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 releasing the results of its investigation if there is an ongoing CPS or law enforcement investigation. Once those investigations are closed, the ombudsman may release the written results.

Program Type (CPS, Foster Care, Adoption Services or Juvenile Justice)

Investigations primarily focus on resolving concerns identified by the complainant. However, if other issues were identified during the OCO's investigation, those issues or concerns were also included as part of the OCO's review. These additional issues may be incorporated into the closing report to the complainant and/or addressed with the involved agency.

Of the **120** investigations completed this fiscal year, the majority (**54%**) focused exclusively on CPS concerns; **24%** involved more than one program type; and **20%** addressed only foster care concerns. Also this fiscal year, **2%** of completed investigations involved concerns about adoption case handling.



Investigation Types (Preliminary or Full)

There are two types of OCO investigations, preliminary and full. All investigations are assigned to one primary investigator; however, each case is reviewed by at least two additional investigators prior to the conclusion of the investigation.

Preliminary Investigations

A complaint may be opened for preliminary investigation to determine whether a full investigation is warranted, or if it is determined at intake that the complainant's specific concern regarding agency actions may be quickly resolved. Preliminary investigations are usually closed within 30 days. A preliminary investigation may consist of obtaining pertinent agency or court documents, submitting questions to a caseworker via email, or conducting interviews with agency staff. A preliminary investigation is concluded as either an affirmation or administrative close. If it is determined that a more extensive investigation is warranted, the preliminary investigation will be changed to a full investigation.

The OCO closed **20** preliminary investigations this fiscal year.

Full Investigations

A full investigation consists of requesting case file documents: agency records and reports; court documents; service provider reports; and other information deemed relevant by the OCO. The primary investigator reviews the documents and conducts interviews with agency staff and other sources as needed. Information obtained during the investigation is reviewed and compared with DHS policy, procedure, and applicable laws to determine compliance.

Case Closure Types

OCO case investigations are closed in three different ways:

Affirmations

Both full and preliminary investigations may be closed as an affirmation. In an 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.

The OCO affirmed DHS and/or a child placing agency 47 times for full investigations and 21 times for preliminary investigations and notified the complainant in writing. Below are examples of actions by agencies that were affirmed by the OCO:

- Clear documentation by CPS.
- CPS investigations were thorough and services provided were commensurate with the identified safety risk and the needs of family members.
- Actions taken by CPS were supported by case facts and in the best interest of the child, i.e. placement decisions, permanency plans.
- Appropriate services were provided through foster care and monitored according to policy.
- Treatment plans were formulated with behavior specific goals for family members that provided a clear understanding of how to overcome barriers to family reunification.

Administrative Close

Both full and preliminary investigations may be closed in this manner. Cases are closed as administrative closing when the involved agency's actions cannot be affirmed but the OCO concluded the investigation because of one or more of the following:

- The agency is currently addressing the complaint.
- The identified issues would not have altered the actions taken or the outcome of the case.
- An investigation by the OCO would not affect the outcome of the case.
- Other

In another example of an administrative closing, the OCO identifies policy violations or other concerns made by a local DHS office or a private child-placing agency and requests that the agency review the issue and respond during the OCO's investigation. If the issues are adequately resolved, the OCO closes its case. Prior to notifying the complainant in writing of the investigation results, the DHS Office of Family Advocate is provided an opportunity to review the issues and how they were resolved and, if desired, may submit a written response to accompany the OCO's closing letter to the complaint. The OCO concluded **38** cases as administrative closings this fiscal year.

Reports of Findings and Recommendations (F&R)

Only full investigations may be closed via a Report of Findings and Recommendations. An F&R is issued by the OCO to DHS when it has determined 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 F&R contains background information about the case, specific findings outlining the violations, and corresponding recommendations in a report to the involved agencies. DHS Office of Family Advocate responds to the OCO in writing within 60 days on behalf of the involved agencies.

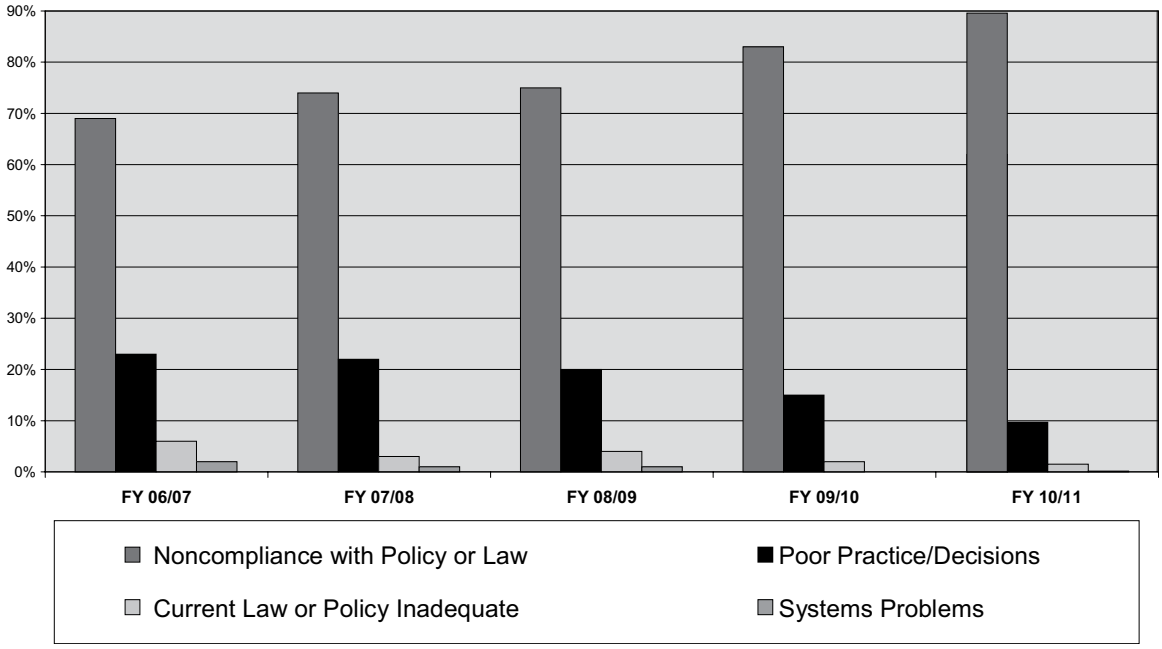
Analysis of Reports of Findings and Recommendations (F&Rs)

The **36** F&Rs issued in fiscal year 2011 encompassed over **168** findings and **173** recommendations. Consistent with each year prior, the overwhelming majority, **89%** of the findings were the result of noncompliance with existing law or policy. In the majority of cases, DHS either agreed with the OCO's finding or provided an explanation describing how policy was followed but compliance was not apparent in the documentation reviewed by the OCO. For instance, DHS may neither agree nor disagree with the OCO finding, but may instead explain that although a certain action or decision was not documented in the applicable report, agency staff did in fact comply with the policy.

Examples of prevalent findings include:

- Inaccurate completion/scoring of safety and risk assessments.
- Lack of face-to-face contact with required individuals during a CPS investigation.
- Extending beyond the 30-day time frame for completing CPS investigations.
- Lack of documentation of family history.

Analysis of Reports of Findings & Recommendations



Investigation Results by Agency and Outcome

Of the **120** *completed OCO case investigations,* **151** agencies were investigated. In cases where more than one agency was involved there may be more than one outcome. For example, one case investigation may result in affirming how a county CPS office handled an investigation of a family, in addition to an F&R regarding inadequate foster care services provided to the children in that family by a private child-placing agency.

Ninety-seven *(**81%**)* cases involved only DHS, **13** *(**11%**)* involved both DHS and one or more private child-placing agency, and **10** *(**8%**)* involved only a private child-placing agency.

The following chart lists the outcome(s) by county DHS office and private child-placing agency for OCO investigations completed in fiscal year 2011:

Agency	Number of Times Agency Investigated	Outcome			
DHS County		Affirmed Full	F&R	Administrative Close	Affirmed Preliminary
Alpena	1		1		
Arenac	1	1			
Barry	2	1	1		
Bay	2		2		
Berrien	6	4	1		1
Calhoun	2		1		1
Charlevoix	1				1
Clare	3	1	1	1	
Clinton	2		1	1	
Eaton	1	1			
Genesee	7	1	3	2	1
Gladwin	1		1		
Grand Traverse	1		1		
Gratiot	1		1		
Hillsdale	1				1
Huron	1			1	
Ingham	4	1	2		1
Ionia	1		1		
Isabella	2	1			1
Jackson	2	2			
Kalamazoo	7	1	2	2	2
Kalkaska	1	1			
Kent	4	1	2	1	
Lapeer	1			1	
Lenawee	4	2	1	1	
Livingston	2			1	1
Macomb	5	1		2	2

Agency DHS County	Number of Times Agency Investigated	Outcome			
		Affirmed Full	F&R	Administrative Close	Affirmed Preliminary
Manistee	1		1		
Mecosta	2	1	1		
Midland	1		1		
Missaukee	1			1	
Montcalm	1		1		
Muskegon	1	1			
Newaygo	1	1			
Oakland	5	1	2	2	
Osceola	1	1			
Oscoda	1		1		
Otsego	1			1	
Ottawa	4	3		1	
Saginaw	2	1			1
Sanilac	1			1	
Shiawassee	3	1	2		
St. Clair	3	1	1	1	
St. Joseph	1		1		
Tuscola	2		1		1
Van Buren	4	2		2	
Washtenaw	2		2		
Wayne	21	5	6	7	3
Wexford	1	1			
Totals	**73**	**21**	**26**	**14**	**12**
Private Child-Placing Agencies					
Adoption Options	1				1
Bethany Christian Services	3		1	1	1
ChildHelp USA of MI	1	1			
Children's Center	1			1	
DA Blodgett	1		1		
Ennis Center for Children	2		1	1	
Family & Children's Services	3	2			1
Girlstown Foundation	1	1			
Holy Cross Children's Services	1	1			
Judson Center	1			1	
Lutheran Child and Family Services	1			1	
Lutheran Social Services	3	2		1	
Orchards Children's Services	1	1			
Spectrum Human Services	2			2	
St. Vincent Catholic Charities	2			1	1
Youth Guidance Foster Care	1	1			
Totals	**25**	**9**	**3**	**9**	**4**
Grand Totals	**151**	**47**	**45**	**38**	**21**

Child Death Case Investigations

Specific criteria are used to determine whether the OCO will open a child death case for investigation. The main focus of an OCO investigation is to determine whether interventions by DHS and/or a private child-placing agency prior to a child's death were handled in accordance 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 DHS Office of Family Advocate emails a "child death alert" to the OCO when DHS becomes aware that a child has died. An OCO investigation may be conducted when at least one of the following criteria is met:

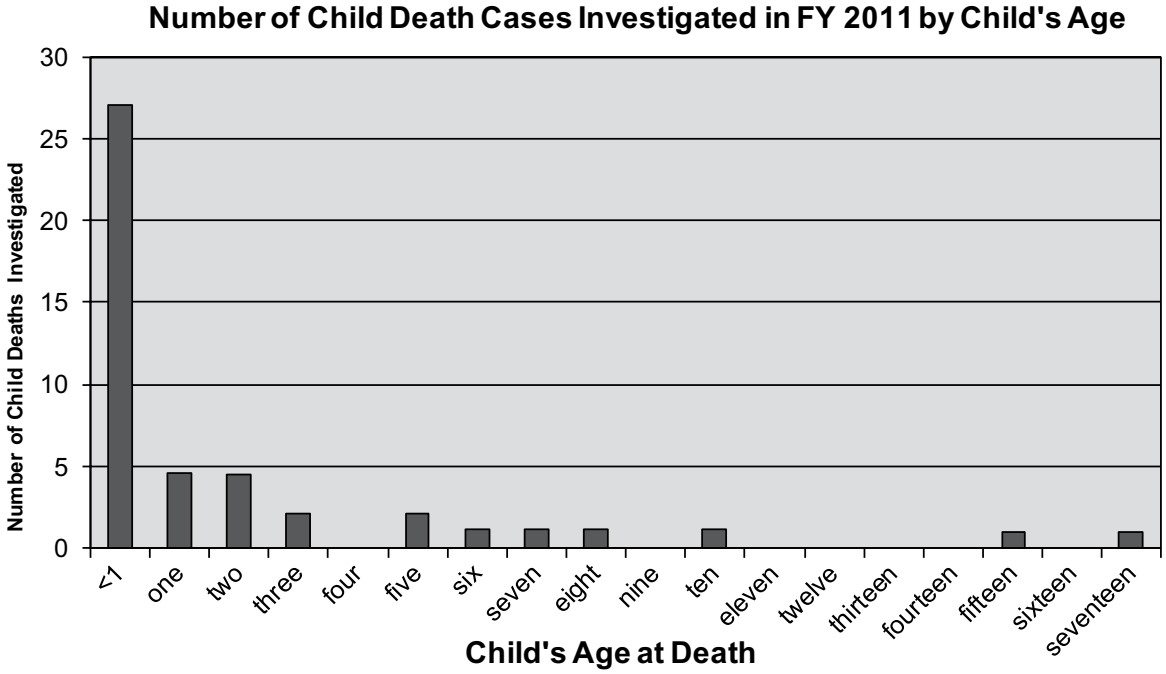
- A child died during an active CPS investigation or open services case, or there was an assigned or rejected CPS complaint within the previous 24 months.
- A child died while in foster care, unless the death resulted from natural causes and there were no prior CPS or licensing complaints concerning 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.
- Media interest.
- Legislator request.
- Ombudsman discretion.

In fiscal year 2011, the OCO received **210** child death alerts from DHS resulting in the opening of **68** child death case investigations. The number of child death case investigations opened by the OCO each fiscal year is dependent upon information in the child death alert or separate information obtained from DHS as it compares to the OCO's criteria. Many children die as a result of an accident, medical condition or for other reasons that do not fit the criteria.

Child Death Investigation Analysis

Statistical information regarding the 46 completed child death case investigations indicates:

- **83 percent** of the child deaths occurred in the parental home.
- In **38 percent** of the investigations, the child's sleep environment was identified as a factor associated with the death.
- **Ten** children died in parental care during an active investigation or an open CPS services case.
- In **12** cases the child's previous medical condition was identified as a contributing factor.
- **Eight** children died while in foster care; however, only two deaths occurred in licensed foster homes.
- **Sixty-one percent** of the child deaths involved a child under the age of one year.
- **5** children died as a result of a caregiver's violent/criminal behavior.



Child Death Case Investigation Results by Agency and Outcome

The **46** completed child death investigations involved **25** DHS county offices and **1** private child-placing agency. The one investigation involving the private agency did not also involve a DHS county office.

Agency	Number of Times Agency Investigated	Outcome			
DHS County		Affirmed Full	F&R	Administrative Close	Affirmed Preliminary
Arenac	1	1			
Bay	1		1		
Berrien	4	2	1		1
Clare	1			1	
Genesee	2		1	1	
Huron	1			1	
Ingham	3	1	2		
Ionia	1		1		
Kalamazoo	2		1	1	
Kent	2	1		1	
Lapeer	1			1	
Lenawee	2	1		1	
Macomb	3			2	1
Mecosta	1		1		
Midland	1		1		
Montcalm	1		1		
Muskegon	1	1			
Oakland	4	1	2	1	
Otsego	1			1	
Ottawa	2	1		1	
Shiawassee	1	1			
St. Clair	1		1		
Washtenaw	1		1		
Wayne	13	3	5	3	2
Wexford	1	1			
Totals	**52**	**14**	**19**	**15**	**4**
Private Child-Placing Agency					
Bethany Christian Services	1		1		
Grand Totals	**53**	**14**	**20**	**15**	**4**

OCO FY 2011 Annual Report Recommendations and DHS Responses

When violations of policy, law, and/or procedure are identified, new policy should be created, or existing policy should be modified, the OCO writes a Report of Findings and Recommendations. The five recommendations below are highlighted in this annual report in part because the OCO has noted areas of concern that repeatedly arise during case investigations. Two of the recommendations were included in previous annual reports and are repeated below because of their continued importance to children and families.

Domestic Violence

OCO Recommendation 1:
The OCO recommends that for every complaint assigned for investigation, DHS ensure compliance with CPS policies PSM 713-1, 713-8 and 713-10, by determining whether domestic violence (DV) is currently an issue or has been in the past and documenting how the worker assessed the effect of DV on the child and family.

Rationale: The OCO has investigated cases where domestic violence was identified as a factor by CPS. However, documentation was inconsistent and not in compliance with DHS policies.

- PSM 713-1: "General Instructions Checklist" requires completion of the safety assessment which addresses potential harm to the child as a result of domestic violence.
- PSM 713-8: "Special Investigative Situations-DV" requires an assessment of threatened harm as it relates to the safety of the child. Policy outlines specific steps for interviewing alleged victims and perpetrators; documenting the steps a parent has taken or agreed to take with respect to ensuring the continued safety of the children and providing assistance and support to the victimized parent; and considerations in reaching a disposition.
- PSM 713-10: "CPS Investigation Report" requires the completion of the DHS-1442 "Investigation Checklist" prior to concluding an investigation. This checklist requires the worker to document *"consider[ation] [of] the impact of domestic violence dynamics on each child/adult's response to the investigation."*

DHS Response to Recommendation 1:
DHS policy currently requires CPS workers to assess safety and risk factors associated with domestic violence and its impact on child safety and well-being.

In December 2011, CPS policy was modified to require monthly case consultation between CPS workers and first-line supervisors. New and existing domestic violence policy will be reviewed at monthly conferences and issues of domestic violence in individual cases will be discussed when pertinent.

DHS Continuing Quality Improvement (CQI) is developing a quality assurance and improvement protocol for CPS investigations. The CQI protocol will specifically address potential harm as a result of domestic violence through completion of the safety assessment (PSM 713-1), assessments of threatened harm (PSM 713-8), documentation of steps taken by a parent to ensure child safety, the provision of assistance to victimized parents and completion of the DHS-1442 (PSM 713-1 0), prior to completion of the investigation.

Mandatory Use of the Child Death Investigation Checklist

OCO Recommendation 2:
(This recommendation was previously published in the FY 2009 OCO Annual Report under the heading: "CPS Investigations Involving Sudden or Unexplained Infant Deaths.") The OCO requests an update of the DHS response.

With respect to a Children's Protective Services (CPS) investigation of a "sudden or unexplained" infant death; namely 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."[2]
- 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.[3]
- Ensure that the DHS Child Welfare Training Institute curriculum includes training specific to investigating "sudden or unexplained infant deaths."

2009 DHS Response to Recommendation 2:
In February 2010, the CPS program office created policy to address a lack of consistency in dispositions assigned to complaints involving sudden and

[2]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.*

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

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.

Post-Investigative Services and Ongoing CPS

OCO Recommendation 3:
The OCO recommends DHS ensure that CPS workers comply with policy for face-to-face contacts with the family on ongoing cases. During the time the case is being monitored, policy PSM 714-1 requires monthly face-to-face contact commensurate with the identified risk level and safety and needs assessments.

Rationale: The OCO has reviewed cases where there is insufficient face-to-face contact by the CPS worker with the families on ongoing CPS cases. Aside from verifying the child's well-being, the required number of face-to-face contacts is necessary to assess the family's progress and ensure that appropriate service needs are being met. Observation and documentation is crucial in determining whether clients have benefitted from the services provided and to assess the need for additional services.

DHS Response to Recommendation 3:
It is an expectation of the department and a requirement of the Modified Settlement Agreement (MSA) that face-to-face standards be met. In August 2010, CPS policy was amended to clarify the requirement that investigators maintain at least monthly contact with each child in every open CPS case. DHS has developed data reports that enable local offices to monitor compliance with meeting investigative and ongoing face-to-face contact requirements. DHS is monitoring local county office performance on a monthly basis. If needed, follow up action will be taken when a county has not met performance requirements. Efforts to proactively address this OCO recommendation include the development of reports to project required face-to-face contacts. DHS has also implemented monthly case conferences between CPS workers and first-line supervisors to address barriers pertaining to compliance with existing policy, including timely face-to-face contacts.

Threatened Harm

The OCO has made two prior recommendations to DHS regarding threatened harm; one in 2003 and another in 2005. The 2003 recommendation requested DHS include an operational definition of "threatened harm" in policy and the 2005 recommendation addressed threatened harm use when another child is born to parents whose rights had been previously terminated.

OCO Recommendation 4:
The OCO recommends that DHS ensure CPS workers document an assessment of threatened harm when conducting field investigations and reaching dispositions as required in the CPS Investigation Checklist.

Rationale: The OCO continues to review cases where CPS has failed to document the assessment of threatened harm when conducting and concluding child abuse and neglect investigations. Policy states that threatened harm is based on current and historical circumstances that may present *"a situation where harm **is likely to occur**."* Policy goes on further to provide a list of factors to take into consideration before making a determination whether or not threatened harm does or does not exist. This includes length of time since past incidents; an evaluation of services the family participated in and a determination of whether they benefited from those services; and a comparison of the past and current situation and the vulnerability of the child(ren).

DHS Response to Recommendation 4:
Threatened harm occurs when a child is found in a situation where harm is likely to occur based upon a current or historical circumstance. Current CPS policy provides significant guidance for investigators to make an assessment and document threatened harm in relevant and applicable situations. The CPS Safety Assessment requires an evaluation of previous maltreatment and a family's current circumstances. This assessment is required for every investigation and a re-assessment is required if safety factors change. DHS supervisors will continue to monitor appropriate assessment and documentation of threatened harm through required monthly case conferences with workers.

Multiple Complaint Investigations

OCO Recommendation 5:
The OCO recommends DHS ensure CPS workers document and apply policy relevant to multiple complaint investigations when there is a child age three or under and there have been at least two prior CPS complaints made on the family.

- PSM 712-5 requires that CPS must, at a minimum, conduct a preliminary investigation covering and documenting specific areas of concern. The OCO is aware of the Multiple Complaint Decisions checklist used to guide intake and CPS workers; however, in the cases reviewed by the OCO, this form is often incomplete or inaccurate.

- PSM 713-9 requires a documented face-to-face meeting between the CPS worker and supervisor prior to disposition. The meeting "must include discussion concerning the disposition of the investigation and any post-investigative services. This meeting and its results must be documented in the DHS-154."

In order to ensure a consistent use of the multiple complaint investigation policy, DHS should add multiple complaints on the CPS Investigation Checklist.

Rationale: The OCO continues to review cases where CPS has failed to document compliance with the multiple complaint policies. Workers are not consistently documenting the required face-to-face meeting with supervision to discuss the current investigation and post investigative services. Additionally, there have been CPS complaints rejected without documentation of the required preliminary investigation. The addition on the checklist will help ensure policy compliance.

DHS Response to Recommendation 5:

In March 2012, Michigan established a statewide Centralized Intake to receive all complaints of suspected abuse and neglect. Based in part on the implementation of Centralized Intake, a review of recommended changes to the multiple complaint policy is underway. Centralized Intake is responsible for completion of preliminary investigations and has established a protocol for how to record the steps required in PSM 712-5.

CPS policy was modified in December 2011 to require monthly case conferences between supervisors and workers to ensure that active and ongoing investigations are appropriately reviewed for policy compliance. Each review must be documented in the DHS-154 and include discussion concerning the disposition of the investigation and any recommended post-investigative services.

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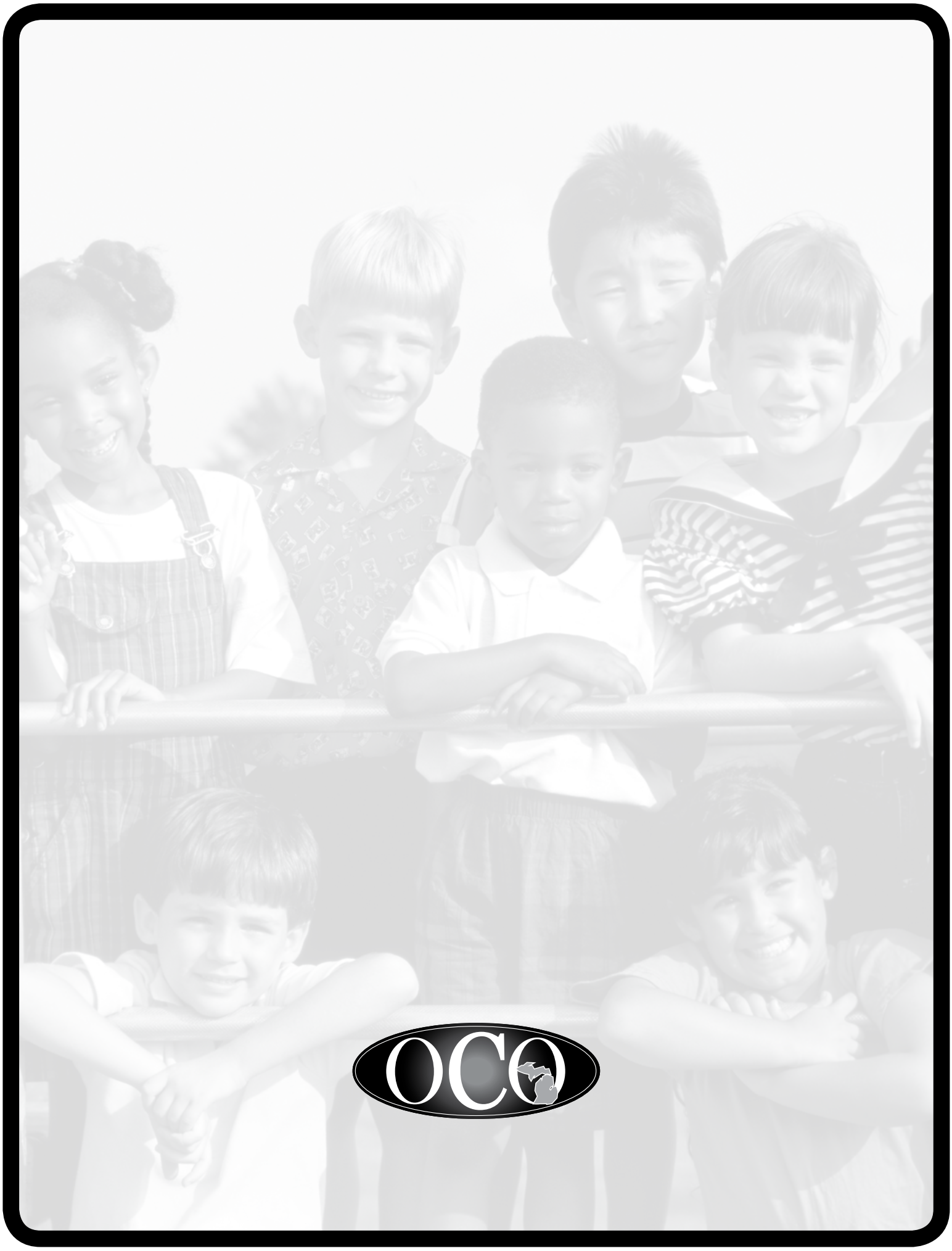
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