annual report

FY 2015

Office of Children's Ombudsman

OFFICE OF CHILDREN'S OMBUDSMAN

Dedicated to Serving Michigan's Children

Mission Statement

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

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

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

OFFICE OF CHILDREN'S OMBUDSMAN

LANSING

ORLENE HAWKS
DIRECTOR

January 2017

The Honorable Rick Snyder, Governor

Honorable Members of the Michigan Legislature

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

In accordance with my statutory responsibility as the Director of the Office of Children's Ombudsman, I respectfully submit the Office of Children's Ombudsman FY 2015 Annual Report.

This report provides an overview of the activities of the Office of Children's Ombudsman from October 1, 2014 to September 30, 2015 and our role in Michigan's child welfare system. This report includes information about the complaints received and an analysis of our investigations. This year's report also contains recommendations derived from case investigations regarding drug-positive newborns and non-custodial parents.

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

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

Respectfully,

Orlene Hawks, Director and Children's Ombudsman

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MESSAGE FROM THE OMBUDSMAN

The Office of Children's Ombudsman (OCO) experienced a very active and productive year.

The OCO team continues to identify and pursue opportunities for reinvention and is committed to continuous improvement. The OCO has made significant progress in complaint responsiveness. This was evidenced in part by the elimination of all backlogged cases – a true testament to staff dedication and commitment to the OCO mission. While we are proud of our successes we remain steadfast in our devotion to improve as an agency.

For the upcoming year, the OCO will continue to look for meaningful case management system improvements in hopes of better serving those who have sought our review. We will diligently implement the goals as outlined in our strategic planning sessions. Specifically, the OCO will focus on:

- Public Education about the mission of the OCO through the utilization of social media aimed at informing a broader public;
- Advocating for children by developing potential statutory amendments based upon our previous findings and recommendations;
- Strengthening our internal data collection and reporting mechanisms; and
- Increasing the effort to identify and engage external partners to participate in the potential development of productive systemic changes.

In this report you will find a description of the work we do, a report of the number and types of contacts and complaints we have processed, and our recommendations for changes in the child welfare system and the Michigan Department of Health and Human Services' response to those recommendations.

Orlene Hawks

Director and Children's Ombudsman

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Executive Summary

Authority

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

Administration and Staff

The Governor is empowered to appoint the Ombudsman. The Ombudsman in turn has the authority to appoint a staff sufficient to efficiently execute the statutory mandate. Presently the staff consists of a Chief Investigator who supervises a multi-disciplinary team with diverse professional backgrounds and a broad range of experience in child welfare, including protective services, foster care supervision and licensing, legal practice, and family support services. The office also employs six investigators, an Intake Analyst, and a Senior Executive Management Assistant.

Operating Budget

The appropriation for fiscal year 2014-2015 was $1,803,313.36 The principal expenditures were for personnel, office facilities and upgrading technology.

VISION STATEMENT

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

Complaints and Contacts

During the period from October 1, 2014 through September 30, 2015, the OCO responded to 1,280 complaints and contacts. The OCO received 106 requests for general information about the child welfare system, referred 383 individuals to other agencies for assistance and opened 238 complaints for investigation.

The top three complaint sources were birth parents (36%), relatives of the child (23%) and the Ombudsman (25%).

Complaints by County

In FY 2015, 41% of the 1,280 complaints and contacts received were from four counties: Wayne, Oakland, Kent, and Genesee. Wayne, the most populous of Michigan's counties, accounted for the largest number of complaints (256). Forty-seven counties reported fewer than ten complaints each, with the remaining 19 counties reporting between 10 and 47 complaints. Six counties had no complaints during 2015.

Quick Facts

- 2,037 children were assisted by the OCO in FY 2015.
- The average age of a child who was the subject of a complaint was seven years.
- 58% of child deaths investigated by the OCO in 2015 involved a child under the age of one year.
- Unsafe sleep practices were involved in the deaths of 21 children in FY 2015 OCO investigations.

Complainant Investigations

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

Of the 112 investigations completed this fiscal year, the majority (74%) focused exclusively on CPS concerns; 15% involved more than one program type (combination); and 10% addressed only foster care concerns.

Child Death Investigations

In addition, upon receipt of a child death alert from DHHS, the OCO must investigate a child's death when:

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

- The foster care case involving the deceased child or sibling was closed within the previous 24 months

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

In FY 2015, the OCO received 277 child death alerts from DHHS resulting in the opening of 117 child death investigations. Fig. 1 shows statistics from those cases.

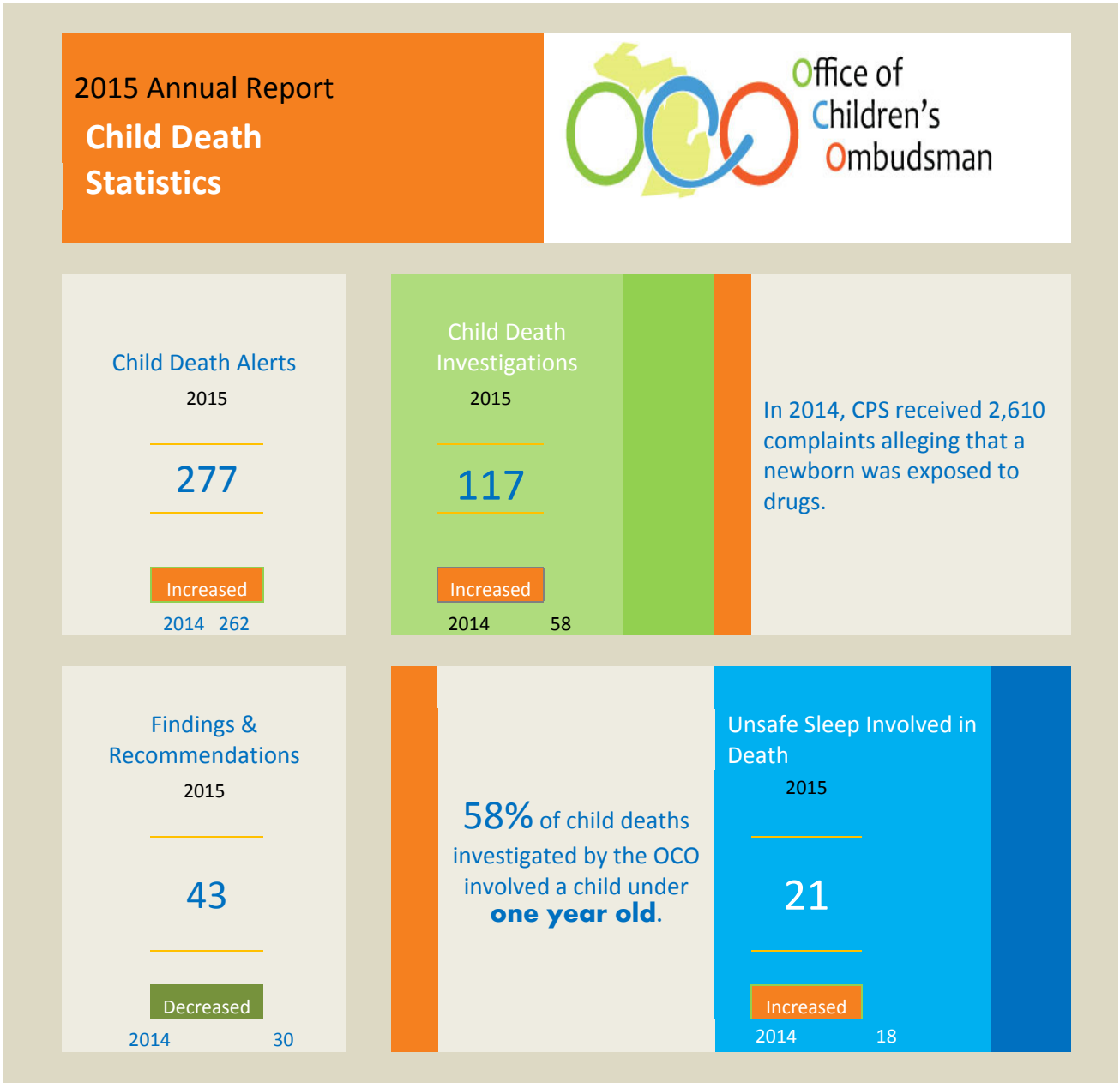


Figure 1: Child Death Statistics – Fiscal Year 2015

Authority

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

The OCO

- **Reviews** complaints about children who are involved with protective services, foster care, adoption services, and juvenile justice;
- **Determines** whether the Department of Health and Human Services (DHHS), foster care agencies, and adoption agencies followed laws, policies and rules;
- **Takes all necessary actions**, including legal action, to protect the rights and welfare of Michigan's children;
- **Reviews and investigates** child death cases that may involve abuse or neglect;
- **Recommends** to the Governor, the Legislature, and the DHHS Director ways to improve the child welfare system; and
- **Educates** the public about laws and policies that affect the welfare of Michigan's children.

Complaints and Contacts

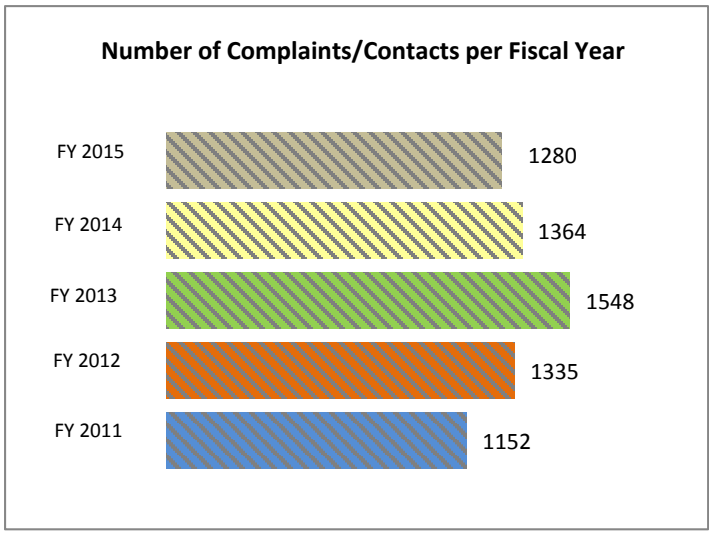


Figure 2: Number of Complaints and Contacts per Fiscal Year

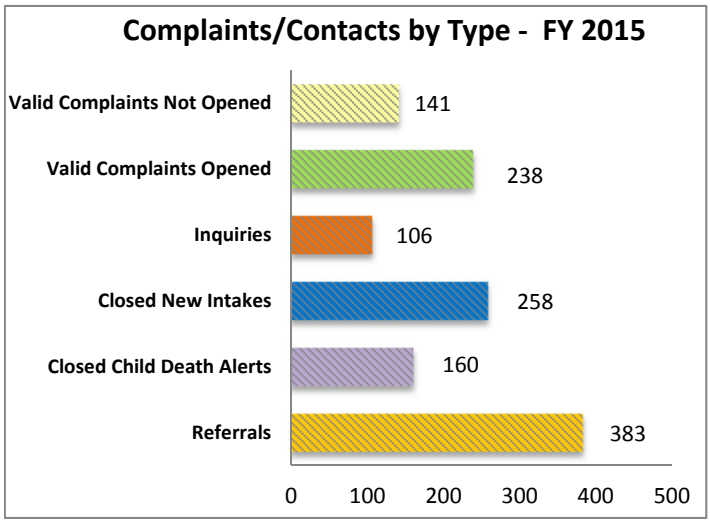


Figure 3: Complaints/Contacts by Type Fiscal Year 2015

In FY 2015 the OCO responded to 1,280 complaints and contacts. Of those, 106 calls were requests for general information about the child welfare system and 383 calls were referred to other agencies for assistance.

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

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

Source of Complaints and Contacts

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

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

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

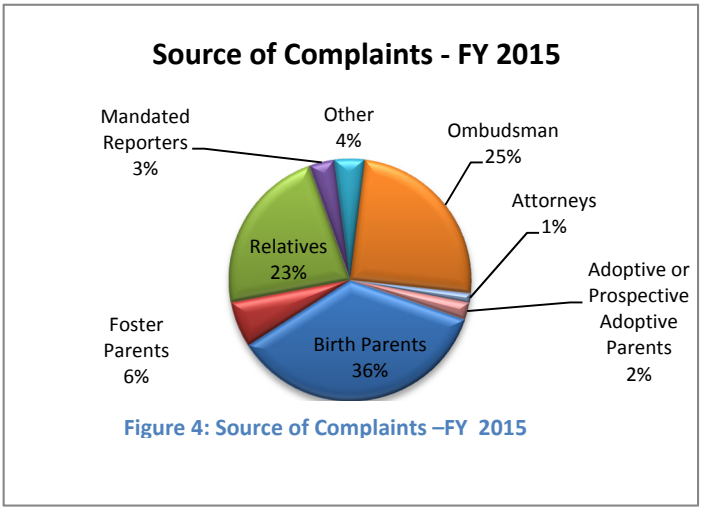


Figure 4: Source of Complaints –FY 2015

The 1,280 complaints and contacts received in FY2015 involved 2,037 children in 77 counties.

The top three complaint sources were birth parents (36%), relatives of the child (23%) and the Ombudsman (25%).

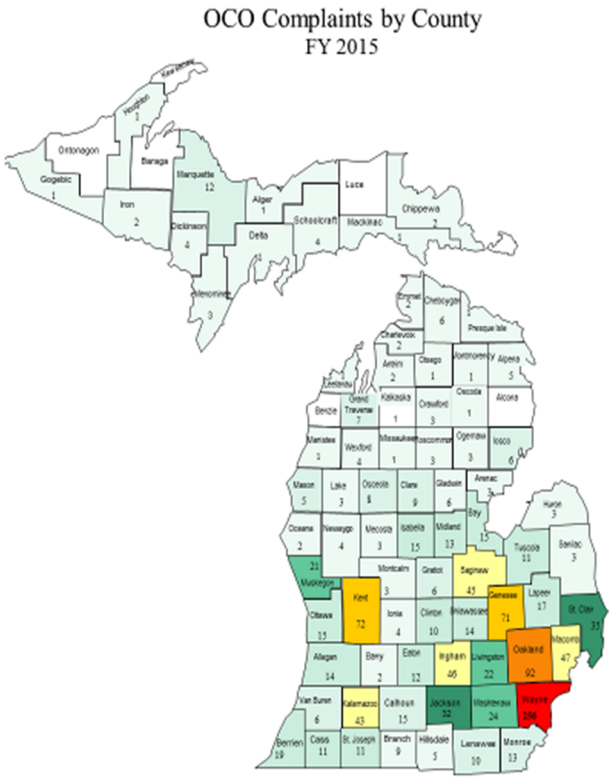


Figure 5: OCO Complaints by County

Complaints by County

In FY 2015, the OCO received 1,280 complaints. The majority of complainants lived in Michigan. Nine complainants resided outside the state.

The OCO tracks the number of complaints received from each county in the state. Figure 5 illustrates the complaint activity in each of the 83 counties for the 2015 fiscal year.

Forty-seven counties reported fewer than ten complaints; seventeen counties reported between 10 and 20 complaints; three counties reported between 21 and 30 complaints; six counties reported 31 to 49 complaints; 71 complaints were reported from Genesee County, 72 from Kent County, 92 from Oakland County, and 256 from Wayne County.

Child Death Alerts

When DHHS is notified that a Michigan child has died, its Office of Family Advocate (OFA) notifies the OCO by email. This is known as a "child death alert." Information in the death alert can determine whether or not the OCO opens an investigation. In FY 2015, the OCO received 277 child death alerts from DHHS resulting in the opening of 117 child death investigations.

The Children's Ombudsman Act lists specific criteria to determine whether the OCO must open a child death investigation. The focus of an OCO investigation is to determine whether interventions by DHHS and/or a private placing agency prior to a child's death complied with policy and law. The OCO also determines whether a correlation existed between previous agency involvement with the family and the circumstances that led to the child's death.

The OCO received 277 child death alerts in FY 2015.

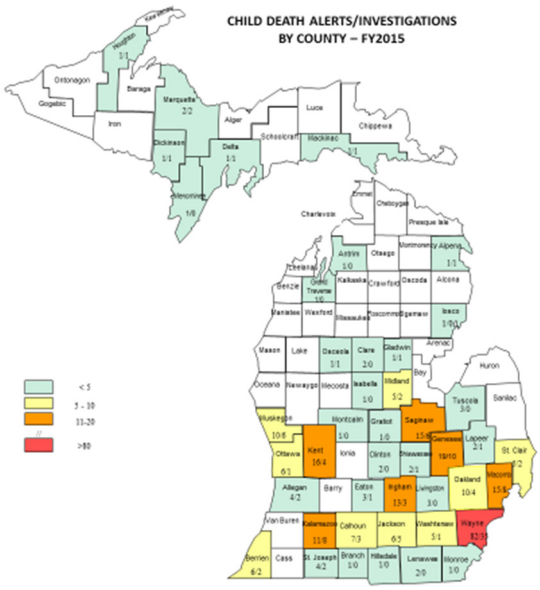


Figure 6: Number of Child Death Alerts by County

Child Death Alerts by County

With 82 child death alerts, Wayne County reported the greatest number of child deaths in FY 2015. Genesee reported 19 deaths, Kent County reported 16, Saginaw and Macomb County each reported 15, Ingham County reported 13 and Kalamazoo County reported 11. All other counties reported 10 or fewer.

Figure 6 shows the number of child death alerts and investigations by county.

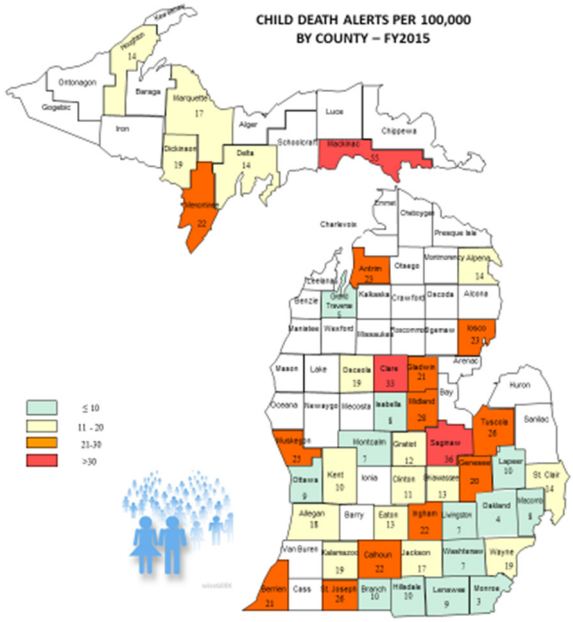


Figure 7: Number of Child Death Alerts per 100,000 Children by County

Figure 7 shows the number of child death alerts per 100,000 children in each county. The counties with the highest rate per 100,000 for child death alerts are Mackinac, Saginaw, Clare, Midland, Tuscola, St. Joseph and Muskegon.

Complainant Investigations

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

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

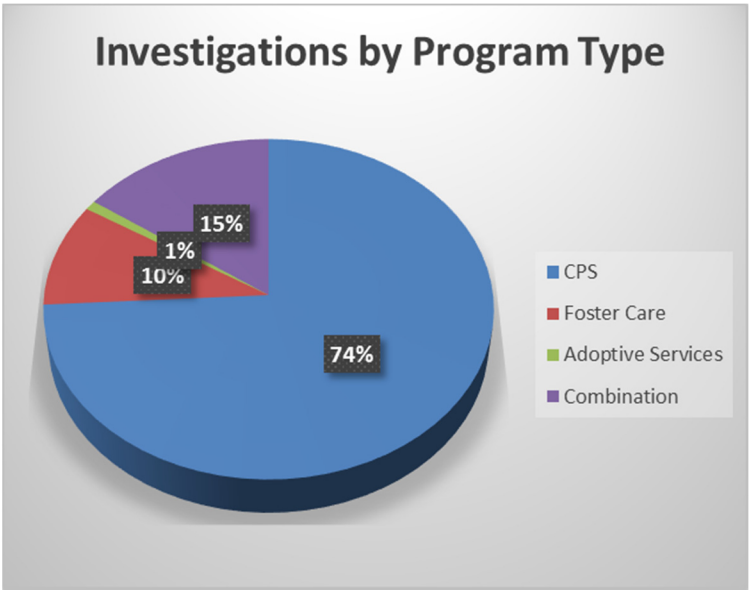


Figure 8: Investigations by Program Type

Of the 112 investigations closed this FY, the majority (74%) focused exclusively on CPS concerns; 15% involved more than one program type; and 10% addressed only foster care concerns.

74% of investigations focused exclusively on Children's Protective Services concerns.

Investigatory Interventions

Based upon a complaint or information discovered at any other time during the course of an investigation, if the OCO determines that immediate action is needed to protect a child or to ensure the well-being of a child, the OCO may issue a Request for Action or Request for Administrative Response.

Request for Action

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

A RFA is issued to DHHS under one or more of the following circumstances:

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

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

Following is a summary of the two RFAs and the agency responses for this fiscal year:

- A relative with placement of two children was listed on central registry. The OCO requested that DHHS confirm that this relative was on Central Registry and verify the well-being of the two children placed in their care.

  DHHS stated in its response that the relative had been placed on central registry in error and removed their name from central registry. DHHS also verified the well-being of the children.

- During an investigation, the OCO found documentation lacking regarding the learning disabilities of the children in the home; a medical examination of the youngest child; the court's decision regarding the petition; supervisory approval of the case disposition; and current verification of the children's well-being.

  In response, DHHS confirmed dates verifying the children's well-being; outlined the children's learning disabilities; provided the dates of the youngest child's medical examination; downloaded the petitions and order into the MiSACWIS system; and documented supervisory approval.

Request for Administrative Response

If the OCO determines that immediate review of an agency action or decision is necessary to protect a child or address a delay in permanency for a child, the OCO may issue a Request for Administrative Response (RFAR) to the agency. This request may be made to the agency following intake (based solely on information reported to the OCO) or during an OCO investigation. The agency must respond within ten business days.

The following is a summary of the five RFARs and the agency responses for this fiscal year:

- The OCO requested that DHHS review their decision to seek court-ordered removal of a child from her mother's custody, given that the mother had executed a temporary placement of the child with a proposed adoptive family and had commenced direct-consent adoption in a county court. It was further requested that DHHS support a pending motion filed by the mother and the proposed adoptive family's attorneys to dismiss the petition

and seek restoration of the child's custody to the proposed adoptive family.

In response to the OCO's requests, DHHS reviewed the adoption paperwork submitted by the mother's attorney and found that the identity of a putative father was not included but later disclosed by the mother, prompting DHHS to begin efforts to locate him per the Absent Parent Protocol. DHHS also found that the adoption packet did not have a scheduled court date and was not signed by a court clerk or a judge. Therefore, upon DHHS' request for a legal review by the assistant attorney general's office, DHHS was advised to file a petition which was authorized by the court.

- The OCO requested that DHHS reconsider its decision to dispose of three investigations as Category III's after reviewing the risk assessments. If DHHS determined that one or more of the complaints should have been placed in Category II, the OCO requested that DHHS place the perpetrator on central registry. The OCO further requested that the worker and supervisor be advised of the philosophy and policy behind referring Category III cases to prevention.

  As a result DHHS reviewed the three investigations in question, completed a request to the MiSACWIS team to reopen the investigations on the system so that CPS could appropriately score the risk assessments, properly categorize the complaints, place the perpetrator on central registry, and provide them with the appropriate written notification. DHHS management also discussed the philosophy and policy behind referring Category III cases to prevention with the assigned supervisor and worker.

- The OCO requested that DHHS review its decision to seek termination of parental rights at initial disposition in light of MCL 712A.19a (2), which requires the agency to make reasonable efforts to reunify the family unless "aggravated circumstances" are present. The OCO found that the petition filed by DHHS did not include allegations of any of the "aggravated circumstances" mentioned in the child protection law.

  In response to the OCO's request, DHHS met with the prosecutor and the lawyer-guardian ad litem and determined that the request to terminate parental rights was appropriate in this case.

- During its review of a case to assess decisions related to allegations of substance abuse and a drug-positive infant experiencing withdrawal symptoms, the OCO requested that in collaboration with central office, DHHS review the evidence in the investigation report and amend the disposition to reflect a preponderance of evidence of physical abuse related to the infant suffering from withdrawal from methadone, requiring extended medical care, in compliance with policy PSM 716-7. The OCO requested that DHHS file a supplemental petition and include information regarding the negative impact of substance abuse on children in the neglect petition.

  In response to the OCO's request, DHHS determined that after a review of the case a preponderance of evidence of physical abuse did not exist because the mother's doctor confirmed to DHHS that the prescribed methadone was a part of her medical treatment plan to avoid possible miscarriage. After conferring with the child's pediatrician, DHHS determined that in spite of the four-month-old's continued withdrawal from neonatal drug exposure, the exposure did not seriously impact the child's health or well-being. After consulting with the local county

prosecutor prior to filing a neglect petition, it was agreed that substance abuse allegations would not be included in the petition.

- Following an intake complaint regarding DHHS' alleged refusal to provide a legal father with progress reports from the residential facility where his son was placed, the OCO requested that DHHS ensure that the father had access to progress reports from DHHS and the residential facility regarding his son.

  In response to the OCO's concern DHHS reported having previously provided the father's attorney with all DHHS and the residential facility's reports in connection with his son's dispositional hearings. The attorney reported to DHHS the father may have additional concerns about the care of his son while in the residential facility. DHHS reported having previously provided case service plans to the attorney addressing the father's additional concerns. DHHS reported providing the most current case service plan to the father's attorney with a copy for the father.

Case Resolutions

The OCO completed 112 investigations in FY 2015.[1]

Investigations are resolved in three different ways:

Affirmation

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

The OCO affirmed DHHS and/or a child-placing agency 31 times following investigations.

Administrative Close

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

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

The OCO concluded 67 investigations as administrative closings this fiscal year.

Findings and Recommendations

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

In 22 Reports of Findings and Recommendations, the OCO issued 77 findings and 53 recommendations this fiscal year.

[1] Because an investigation may involve more than one agency, and the investigation may involve a different resolution for each agency, the number of resolutions cited here is greater than 110.

Release of Results to Complainants

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

The Children's Ombudsman Act also prohibits the OCO from sending written results to a complainant if there is an ongoing CPS or law enforcement investigation at the time the OCO investigation is completed.

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

Analysis of Findings Regarding Complainant Cases (Violations)

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

The OCO produced **22** F&Rs regarding CPS. encompassing **77** findings and **53** recommendations. As in previous years, the majority of the findings for this fiscal year focused on noncompliance with existing law or policy.

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

PSM 713-1 CPS Investigation – General Instructions and Checklist. This policy describes the actions CPS must take for every investigation. Common areas of non-compliance with this policy included:
Failure to contact mandated reporters
Failure to view and record an infant's sleep environment
Failure to interview the alleged perpetrator and collateral contacts
Failure to interview all children and nonparent adults who reside in the home
Identifying unsafe sleep practices, by themselves, as child abuse or neglect

PSM 713-3 Face-to-Face Contact. This policy defines who caseworkers are required to have face-to-face contact with during an investigation. In many instances the OCO found that DHHS:
Failed to comply with policies concerning interviewing children at school
Failed to make face-to-face contact with non-custodial parents

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

PSM 713-08 Special Investigative Situations. This policy, in part, defines threatened harm and describes the steps that CPS must document if an alleged perpetrator cannot be interviewed. The common areas of non-compliance with this policy included:
Inappropriately finding a parent responsible for threatened harm without evidence of another form of child abuse or neglect
Failure to document efforts made in an attempt to secure an alleged perpetrator's cooperation with the investigation

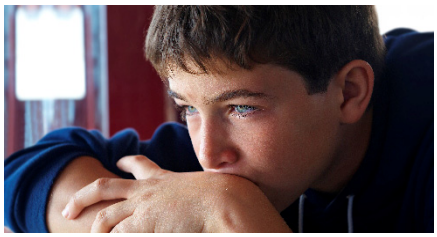
Child Protection Law and the Juvenile Code. Violations of these laws included:

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

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

Specific examples of findings in these areas included:

- Failure to provide services to a parent or other caregiver
- Providing services without an identified and/or justified need
- Failure to contact an alleged victim or perpetrator timely.



CASE EXAMPLE

In 2015, the OCO investigated the death of a 10-year-old child that was possibly due to medical neglect. The child's family had an extensive CPS history that included numerous allegations of physical abuse, physical neglect, improper supervision, and medical neglect. The OCO found the county violated the Child Protection Law (CPL) and Children's Protective Services (CPS) policies during several of its complaint investigations, including missed opportunities to file a petition with the court to compel the mother to participate in services. The county CPS office agreed with the OCO's findings and recommendations and initiated a review of selected cases. CPS discovered additional instances of the issues identified during the OCO investigation and implemented the following measures to improve compliance with law and policy:

- The county CPS management team reviewed policy and law with supervisors and staff to ensure an awareness and understanding of the requirements under the CPL and CPS policies and to encourage compliance moving forward.
- The county CPS management team established a workgroup to identify available resources in the community, including transportation services, for families.
- The county reassigned supervisors to support policy compliance for ongoing services in CPS.
- The county implemented a county-wide systematic change by reassigning an ongoing services worker to each CPS investigation unit. This will help ensure a smooth transition between investigations and ongoing services while working with families.
- The county will continue case reviews to confirm the new measures put in place are effective.

In addition to the county's actions, CPS Program Office agreed to evaluate the need to amend current policy to further ensure compliance with the Child Protection Law in regards to escalating cases and filing petitions.

Investigation Results by Agency in Complainant Cases

The 112 investigations completed in FY 2015 involved 38 DHHS county offices and 13 private child placing agencies. Some cases involved investigations of multiple agencies.

The following charts list the outcome(s) by DHHS county office and private child placing agency for OCO investigations completed in FY 2015.

INVESTIGATIONS 2015 – OUTCOMES BY AGENCY [PCPAs]

Private Child-Placing Agency (PCPAs)	Number of Investigations	Case Closure Type (Outcome) Distribution			
13 PCPAs		Affirmation	Findings & Recommendations	Administrative	Preliminary
Bethany Christian Services	3	3			
Spectrum Human Services	1		1		
Alternatives for Children	2			1	1
Ennis Center for Children	1			1	
Lutheran Social Services of Michigan	3			3	
Catholic Social Services	1			1	
Children's Center	1			1	
Family & Children's Services of Midland	1				1
Vista Maria	1			1	
Anishnaabek Community and Family Services	1		1		
Homes for Black Children	1		1		
Lutheran Adoption Services	3			2	1
Wolverine Human Services	1				1
Totals PCPAs	**20**	**3**	**3**	**10**	**4**

OCO INVESTIGATIONS 2015 – OUTCOMES BY AGENCY					
DHHS	Number of Investigations	Case Closure Type (Outcome) Distribution			
38 County Offices		Affirm	Findings & Recommendation	Administrative	Preliminary
Allegan	2			2	
Alpena	1			1	
Arenac	1			1	
Bay	1		1		
Branch	2			2	
Calhoun	6	3		1	2
Centralized Intake	3	1	1	1	
Dickinson	1		1		
Eaton	2	1			1
Genesee	3			3	
Grand Traverse	1			1	
Gratiot	1	1			
Hillsdale	1			1	
Houghton	1		1		
Ingham	7	3	1	2	1
Iosco	1				1
Jackson	2		1	1	
Kalamazoo	3	1		1	1
Kent	4	1	1	2	
Lenawee	3	1	1	1	
Livingston	1				1
Mackinac	1			1	
Macomb	7	1	2	1	3
Midland	2			1	1
Monroe	2	1	1		
Muskegon	4		1	2	1
Oakland	3	1		1	1
Otsego	1	1			
Ottawa	3			2	1
Saginaw	5	1	2	2	
Schoolcraft	1		1		
Shiawassee	1			1	
St. Clair	6	1	1	3	1
St. Joseph	1			1	
Washtenaw	2	1		1	
Wayne	31	7	4	19	1
Wexford	1	1			
Total DHHS	**119**	**28**	**20**	**55**	**16**

Table 1: OCO INVESTIGATIONS OUTCOMES BY– DHHS

Child Death Investigations

The Children's Ombudsman Act lists specific criteria to determine whether the OCO must open a child death case for investigation. The focus of an OCO investigation is to determine whether interventions by DHHS and/or a private child-placing agency prior to a child's death complied with policy and law. The OCO also determines whether a correlation existed between previous agency involvement with the family and the circumstances that led to the child's death.

The OCO opened 117 new death investigations in FY 2015.

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

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

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

Analysis of Findings

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

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

Child Death Statistics

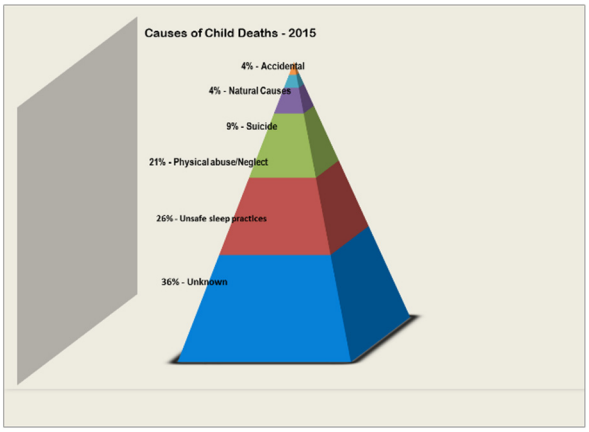


Figure 9 shows the causes of child deaths in FY 15. In 36% of the deaths, the cause is unknown.

Figure 9: Causes of Child Deaths Fiscal Year 2015

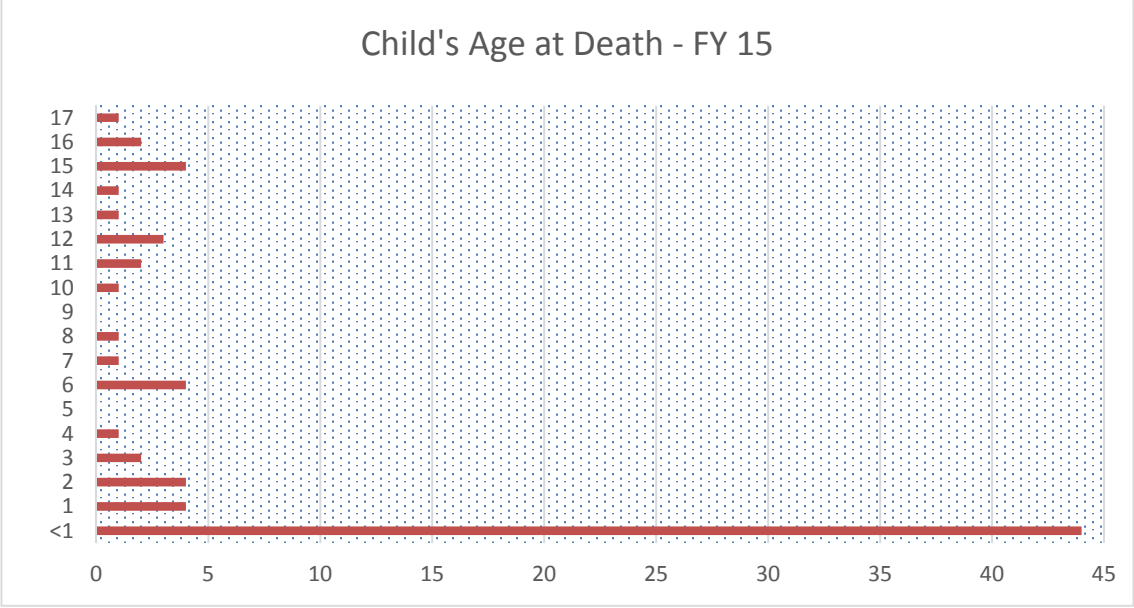


Figure 10: Child's Age at Death FY 2015

FIG. 10 shows that 44 (58%) of the children in the 76 death investigations completed in 2015 were under age one at the time of death, and 71% were three years old or younger.

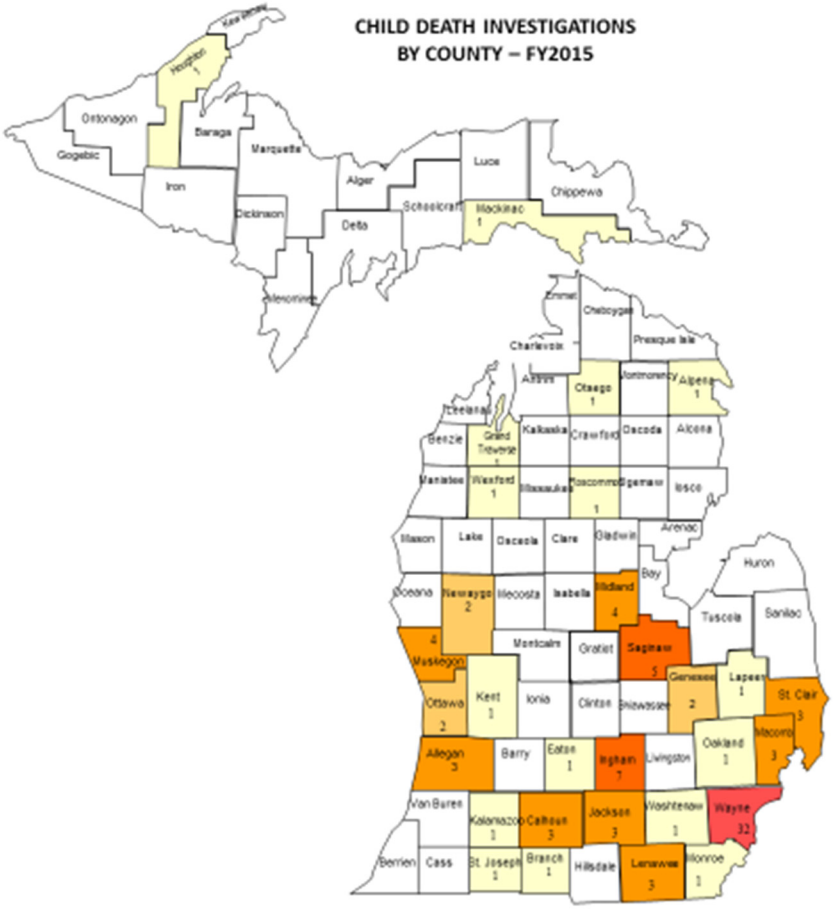


Figure 11: Child Death Investigations by County

FIG. 12 shows the location of child deaths that were investigated in FY 2015. Of the 31 counties where a child death occurred, the highest numbers of investigations per county were from Wayne (32), Ingham (7), and Saginaw (5).

Child Death Investigations – Results by Agency

The OCO completed 84 child death investigations[2] in FY 2015. These included cases pending from FY 2013 and cases opened in FY 2014, and involved **30** DHHS county offices and **1** private child-placing agency. The numbers in the chart below reflect investigations involving multiple agencies.

Agency	# of Child Death Investigations	Case Closure Type (Outcome) Distribution		
DHHS		**Affirm**	**F&R**	**Administrative**
Allegan	3		1	2
Alpena	1			1
Branch	1			1
Calhoun	3	2		1
Centralized Intake	3	1	1	1
Eaton	1	1		
Genesee	2			2
Grand Traverse	1			1
Houghton	1		1	
Ingham	7	2	2	3
Jackson	3		1	2
Kalamazoo	1			1
Kent	1			1
Lapeer	1	1		
Mackinac	1			1
Macomb	3	1	1	1
Midland	4		1	3
Monroe	1	1		
Muskegon	4		1	3
Newaygo	2		1	1
Oakland	1	1		
Otsego	1	1		
Ottawa	2			2
Roscommon	1	1		
Saginaw	5		2	3
St. Clair	3	1	1	1
St. Joseph	1			1
Washtenaw	1	1		
Wayne	31	6	6	19
Wexford	1	1		
Totals	**91**	**22**	**18**	**51**
Vista Maria	1			1
Grand Totals	**92**	**22**	**18**	**52**

Figure12: Child Death Investigation – Results by Agency –FY2015

[2] Several of the investigations involved more than one agency and resulted in 92 separate outcomes.

Recommendations

Recommendation 1: Drug-Positive Infants

DHHS has determined that prenatal drug exposure is sufficient evidence to determine that a newborn has been physically abused. Under current DHHS policy, Children's Protective Services (CPS) must confirm that a parent physically abused their newborn if it is determined that the infant was exposed to drugs or alcohol prenatally and that exposure was not due to medical treatment of the mother or infant.

Based on a standard risk assessment tool used by CPS, the case is then designated as Category I, II, or III. This category designation, along with an evaluation of the parents' capacity to care for the newborn, determines the level of services that will be offered to the parents in order to reduce any future risk of harm to the newborn or other children in the family.

Cases placed in Category I are determined to have the highest assessment of risk and require a petition to be filed with the family court requesting jurisdiction over the child(ren). High and intensive risk cases are classified as a Category II requiring the CPS worker to open the case and provide services to decrease future risk of harm. A Category II case[3] requires CPS to develop a service agreement with the family based on the identified risk and needs of the family, with the goal of reducing future risk of harm. CPS monitors the case to determine if the risk has been reduced to an acceptable level.

Moderate and low risk cases are classified as Category III and only require that CPS refer the family/parent to community-based services. Participation in those services is voluntary. Although a CPS worker has the option of keeping a category III case open for monitoring for up to 90 days, the alternative that is often used is closing the case without any monitoring or documentation that the family has made contact with service providers and engaged in services.

Although the CPS worker is tasked with evaluating the parent's capacity to care for the newborn, CPS policy does not provide sufficient guidance regarding how to assess the parenting skills of a parent who uses mood-altering substances. Consequently, having sufficient physical items and a pledge by the parent to not

[3] This also applies to Category I cases if the children remain in the home under court jurisdiction.

use mood-altering substances while caring for their infant child is often the only thing CPS documents related to the ability of a parent to care for their newborn.

The OCO regularly reviews CPS cases where a mother has delivered a drug-positive infant on more than one occasion.[4] Despite this, these cases are regularly classified as Category III and closed even though the parent is repeatedly, per CPS policy, knowingly abusing their children. The family is referred to community-based services but no monitoring of compliance with those services or documentation of a reduction of risk takes place.

Attachment D *"Neonatal Drug Withdrawal among Michigan Infants Factsheet"* provides information regarding neonatal drug exposure.

To increase the safety of children born drug-positive, the OCO recommends the following:

- **The Michigan Legislature amend MCL 722.628d(1)(c) to include the following language:**

If the department places a complaint in Category III because an infant is born with alcohol, a controlled substance, or a metabolite of a controlled substance in his or her body, the department shall monitor the family for at least 90 days and develop and document a plan for the safe care of the infant (and any siblings) as it relates to the use of mood-altering substances.

MDHHS Response to Recommendation 1, part 1: MDHHS supports children, youth, and families by partnering with them to help them reach their full potential and ensure their safety, permanency and well-being. For each CPS investigation involving children born substance-affected, it is critical that CPS consider *how* the parent's substance use affects his or her ability to function effectively in a parental role. CPS workers also consider several other factors such as the frequency and timing of neonatal exposure, type of substances used, co-occurring environmental deficits, and whether the parent sought prenatal care.

Existing law and policy already allow MDHHS to develop comprehensive safety plans, keep a case open to monitor progress, or close the case after referring the family to maternal and infant health services, like evidence-based home visitation, depending on the outcome of risk and safety assessments. It is important to recognize that not all children of parents with substance use issues will suffer abuse, neglect or other negative outcomes, and not all families require ongoing CPS involvement. If the child is unsafe, CPS must initiate protecting intervention, including filing a petition with the court, when warranted.

In addition to existing Michigan law and policy, the recent passage of the federal Comprehensive Addiction and Recovery Act (CARA) of 2016 will strengthen MDHHS's ability to protect infants born exposed to substances by requiring the development of an "*Infant Plan of Safe Care.*" Under the new law, states must develop a monitoring

[4] The OCO identified nine cases in FY 2015 and 2016.

system to determine whether and how local entities are providing referrals to and delivery of appropriate services for the infant and affected family or caregiver. Michigan's implementation of CARA provisions is underway.

In an effort to better determine whether policy and training adequately provide guidance and emphasis to staff on *how* to assess the impact of a parent's substance use on their ability to safely care for their children, MDHHS has initiated a review of its policies governing substance exposed infants.

- The OCO also recommends **CPS Program Office amend policy (PSM 716-7) to include the requirement that CPS cases in which a mother gives birth to more than one drug-positive baby be automatically escalated to Category II (if not already scored as Category II) requiring active participation in services to decrease risk of harm related to the use of mood-altering substances.**

MDHHS Response to Recommendation 1, part 2: Consistent with MDHHS's guiding principles, families, children, youth, and caregivers should be treated with dignity and respect while having a voice in decisions that affect them. Based on the information gathered by CPS during an investigation involving a substance-affected infant, existing CPS policy already allows workers to develop comprehensive safety plans, keep a case open to monitor progress, or close the case after referring the family to maternal and infant health services. Provisions of the federal Comprehensive Addiction and Recovery Act (CARA) of 2016 will strengthen this process as now CPS will work with its community partners to develop an "*Infant Plan of Safe Care*" for every infant born exposed to substances.

Mandating the escalation of every CPS case involving mothers who have given birth to more than one substance-affected baby to a Category II and requiring those families to participate with CPS-monitored services could potentially interfere with CPS's ability to allow the family to have a voice in deciding what types of interventions it may best benefit from, determining specific interventions concurrent with the family's risk level, and collaborating with the local community to develop an "*Infant Plan of Safe Care*." Additionally, the escalation of those investigations would also mandate MDHHS to list all of the parents on the Child Abuse and Neglect Central Registry, which may create unintended consequences for parents' struggling to overcome addiction and may be counterproductive to recovery.

Recommendation 2: Non-Custodial Parents

Under current DHHS policy, face-to-face contact with noncustodial parents is required as soon as possible for all CPS complaints that are assigned for investigation. If face-to-face contact is not made with the noncustodial parent during the investigation, policy requires that the reason why be documented in the CPS Investigation Report (DHHS-154).

Despite these policy requirements, the OCO encounters multiple cases from various counties on an annual basis where face-to-face contact with the noncustodial parent is either not attempted at all or the attempts are incidental to the investigation itself. In

many instances these attempts are either a phone call to a non-working number or a letter mailed to a last known address on the same day the investigation is closed. Regardless of whether attempts are made, there is rarely documentation why face-to-face contact was not made.

Engaging noncustodial parents as soon as possible in CPS investigations is vital to the well-being of all children, particularly if it becomes necessary for a child to be removed from a custodial parent's home. In such instances noncustodial parents can provide placement resources, important adult connections and meaningful emotional, financial or other support to a child. This in turn can help to reduce the trauma a child experiences when being removed and potentially eliminate the need for a foster care placement.

Currently, the only guidance in the Child Protection Law (MCL 722.621 – 722.638) regarding contacting and engaging the noncustodial parent is to inform a noncustodial parent of the investigation and the specific allegations as soon as their identity is discovered. The OCO believes that an increased emphasis is needed on when to engage noncustodial parents and that contacting a noncustodial parent as soon as possible in CPS investigations is paramount.

To improve practice in this area, **the OCO recommends that the Michigan Legislature enhance section 8 of the Child Protection Law, MCL 722.628, by requiring CPS to:**

- **Make reasonable efforts to identify, locate and engage noncustodial parents within a timeframe that will reasonably allow for that parent to respond before the CPS investigation is closed.**
- **Make face-to-face contact with noncustodial parents as soon as possible during a CPS investigation or document the reasons why not in the investigation report.**

MDHHS Response to Recommendation 2:
MDHHS agrees that engaging non-custodial parents is critical during a CPS investigation. State law already requires CPS to contact the non-custodial parent as soon as their identity is known and MDHHS policy outlines specific steps every CPS investigator must complete and document when they are unable to locate a non-custodial parent. MDHHS will enhance this policy to require identification of and contact with non-custodial parents at the earliest point possible during a CPS investigation or clearly document the reasons why not in the Michigan Statewide Automated Child Welfare Information System, known as MiSACWIS.

Attachment A: Contact the OCO

There are several ways to contact the OCO.

Call: 1-800-642-4326

Call: 517-373-3077

Fax: 517- 335-4471

Web: www.michigan.gov/OCO

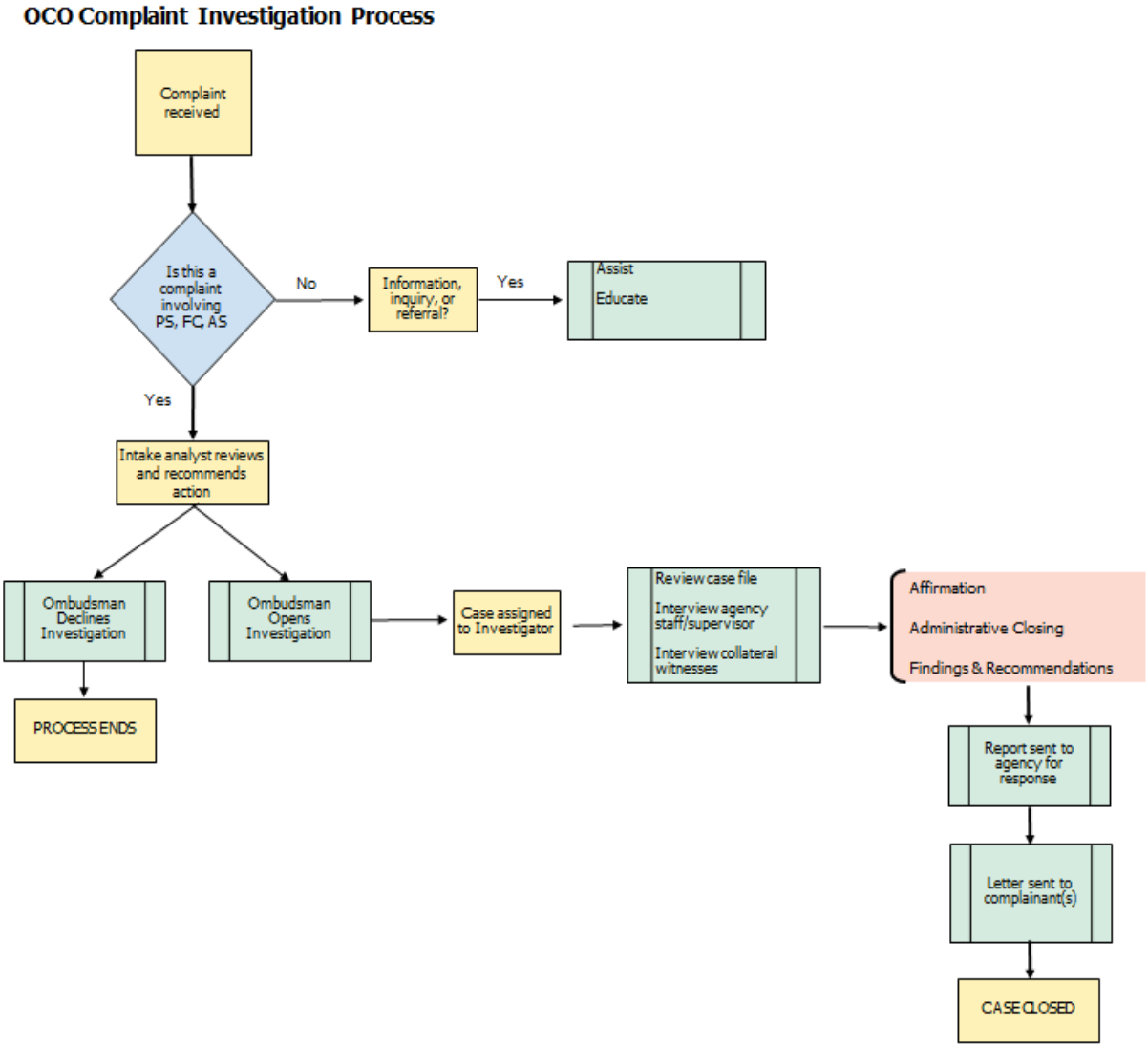
Email: childombud@michigan.gov

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

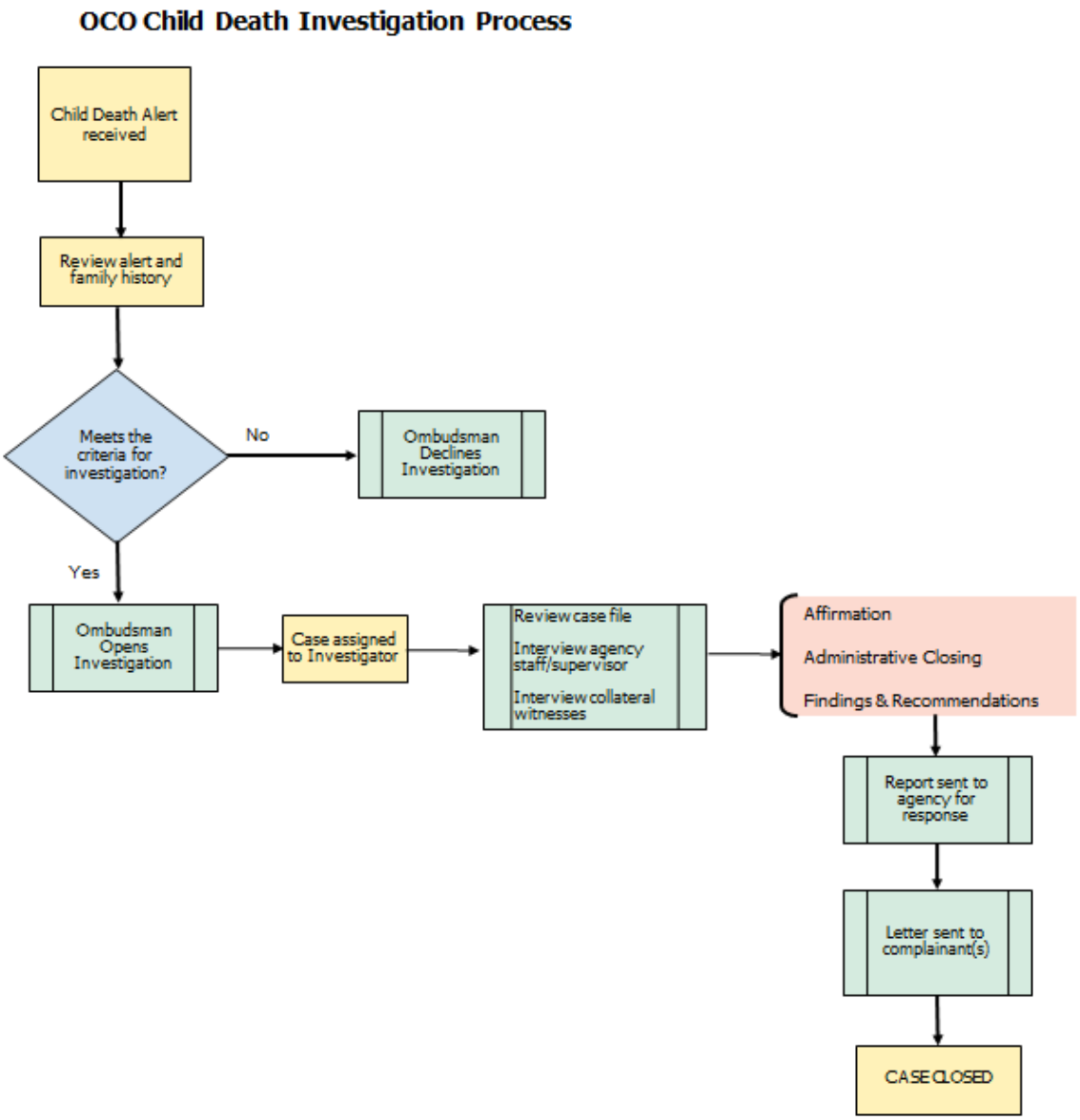
Please provide the following information:

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

Attachment B: OCO Complaint Investigation Process



Attachment C: OCO Child Death Investigation Process



Attachment D: MDHHS "Neonatal Drug Withdrawal among Michigan Infants" Factsheet

Neonatal Drug Withdrawal among Michigan Infants

Michigan Department of Community Health

- When mothers use illicit or prescription drugs during the pregnancy, infants can present with drug withdrawal symptoms after birth, called neonatal withdrawal syndrome (NWS).
- The risk for NWS is greatest when the mother uses prescription pain relievers known as opioids analgesics or heroin during the pregnancy.[1,2]
- Between 2000 and 2009, there were a total of 1,509 infants in Michigan hospitalized with a diagnosis of NWS*.

*NWS was identified using the ICD-9-CM diagnosis code 779.5

Figure 1. Rate of Neonatal Withdrawal Syndrome by Year among Michigan Infants, 2000-2009

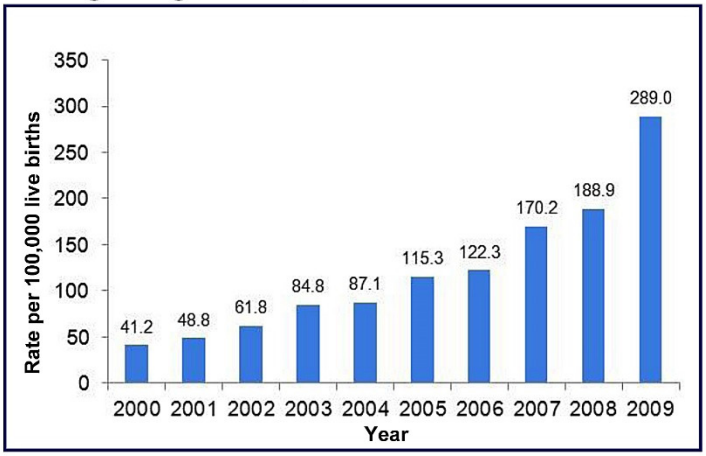
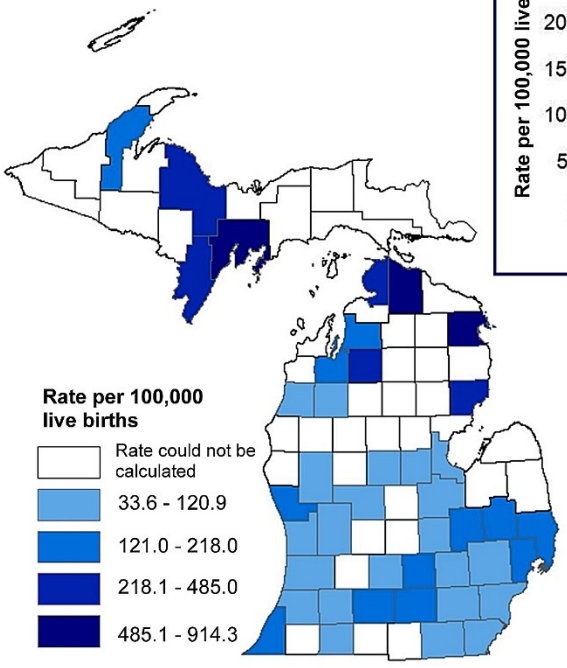


Figure 2. Rate of Neonatal Withdrawal Syndrome among Michigan Infants by County, 2000-2009



- The rate of NWS among Michigan infants increased from 41.2 to 289.0 per 100,000 live births from 2000 to 2009, representing a 601% increase (Figure 1).
- Rates of NWS between 2000 and 2009 varied by county (Figure 2). The highest county rates were in northern portion of the Lower Peninsula and the Upper Peninsula.
- NWS infants have longer hospital stays, which cost over $35 million between 2000 and 2009.[3]

References: 1.O'Donnell M, Nassar N, Leonard H, et al. Increasing prevalence of neonatal withdrawal syndrome: population study of maternal factors and child protection involvement. *Pediatrics.* Apr 2009;123(4):e614-621. 2. Wagner CL, Katikaneni LD, Cox TH, Ryan RM. The impact of prenatal drug exposure on the neonate. *Obstet Gynecol Clin North Am.* Mar 1998;25(1):169-194. 3.Hekman K et.al. Neonatal withdrawal syndrome, Michigan, 2000-2009. *Am J Prev Med.* 2013; 45(1): 113-117.

Produced by: Bureau of Disease Control, Prevention, & Epidemiology. Data Sources: Live Birth Certificates & Michigan Inpatient Database. Data provided by the Division for Vital Records and Health Statistics.
For more information, visit: www.michigan.gov/substanceabuseepi.

The Office of Children's Ombudsman

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