State of Michigan
Department of Health and Human Services

Child Fatality Reviews: 1/1/14-12/31/14
Office of Family Advocate Report

Introduction

The Modified Settlement Agreement requires MDHHS to ensure that qualified and competent individuals conduct a fatality review, independent of the county in which the fatality occurred, for each child who died while under court jurisdiction and placed in foster care by MDHHS. The fatality review process is overseen by the Office of Family Advocate (OFA), a unit within central office MDHHS.

OFA Review Process

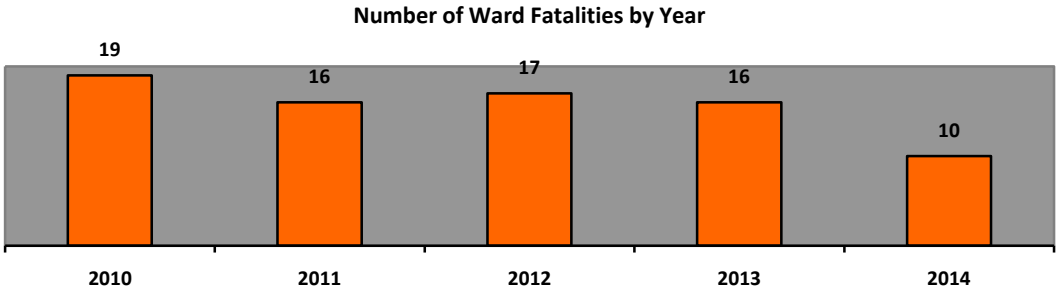
The OFA has developed guidelines to ensure that fatality reviews are consistently independent and comprehensive. Each review is completed by the OFA director or OFA departmental specialist.

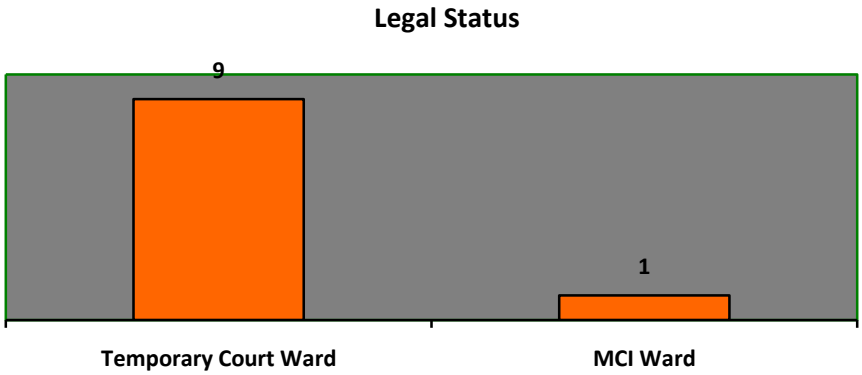
The reviewers examined relevant information, including the child's foster care and adoption file, all Children's Protective Services (CPS) complaints involving the child's foster care home(s), the foster parents' licensing file, police reports, medical, educational and mental health documents, the child's legal file, placement history, and all available information related to the child's death. Among other tools, reviewers consulted existing MDHHS policy, Michigan Child Protection Law, Division of Child Welfare Licensing (DCWL) Rules, and Child Welfare Contract Compliance Unit (CWCCU) Child Placing Agency letters to determine policy compliance and best practice.

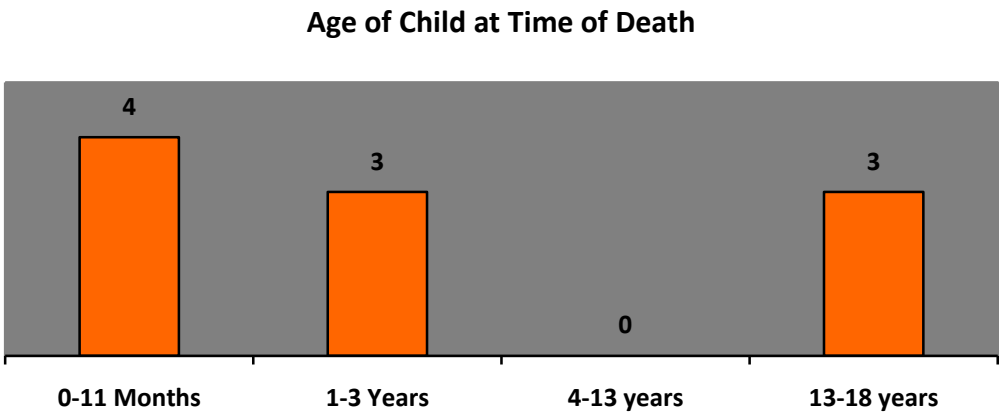
OFA staff completed each fatality review within six months after the child's death, which involved on-site inspection of the original case file, remote inspection of exact copies of case files, or a review of the information available on the Michigan State Automated Child Welfare Information System (MiSACWIS). Each review contained a summary of the case facts, practice strengths identified during the review, and, when applicable, findings and corresponding recommendations. OFA staff sent all completed summaries to the involved agencies and/or appropriate MDHHS program offices for review and response, including identification of corrective action when necessary. In many cases, OFA staff traveled to the county/agency and met with workers involved with the case to give and obtain feedback regarding the review, the strengths and the findings.

Demographics

The following data was compiled for the 10 fatality reviews completed during the review period.







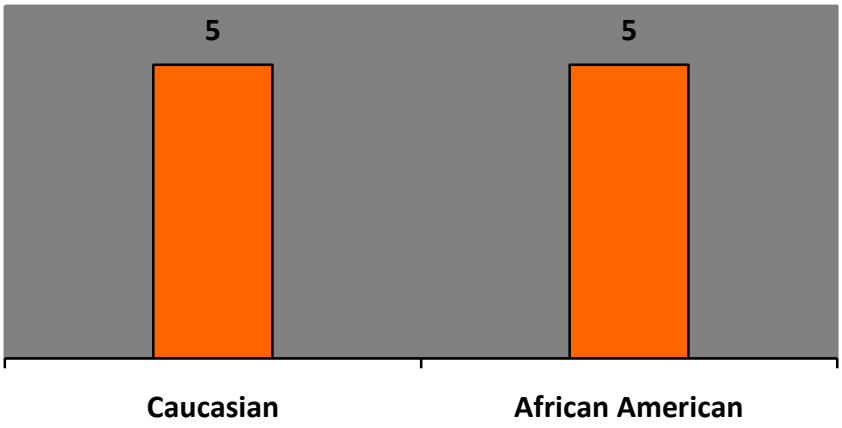
- The range of the children's age was 3 months to 18 years old. Three of the 10 children (10 percent) were less than 6 months old at the time of death.

Counties where ward deaths occurred

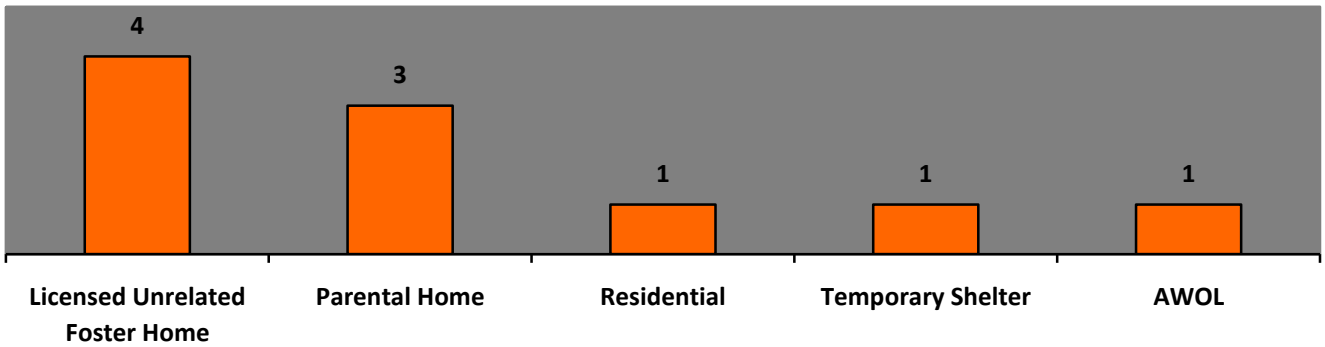
County	Number of 2014 Ward Deaths
Wayne	4
Monroe	1
Genesee	1
Oceana	1
Macomb	1
Kent	1
Kalamazoo	1

- The OFA reviewed 10 ward fatalities that occurred in seven different counties. Seven of the 10 deaths (70 percent) occurred in one of the six MDHHS urban counties (Wayne, Oakland, Genesee, Kent, Macomb or Ingham).

Race of the children



Living Arrangement at Time of Death

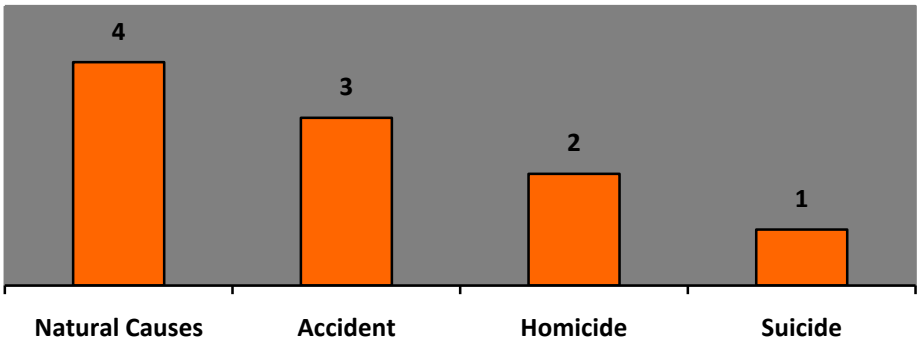


- Four of the 10 children (40 percent) died while living in an unrelated foster home. Three of those children died because of chronic medical issues that existed prior to placement or were the result of parental abuse. The other child in a foster home died after the foster parent put the child in a compromised sleeping position.

- Three of the 10 children (30 percent) died while living with a biological parent. One of the children died of medical issues that existed prior to placement. One child died after the parent placed the child in a compromised sleeping position. The last child died of injuries the parent inflicted after MDHHS placed the child in the home.

- Three of the 10 (30 percent) children were teenagers. One of the three teenagers resided in a residential placement and died of medical complications. One teenager resided in temporary shelter and committed suicide. The last teen was absent without legal permission from her placement and died of an accidental overdose.

Manner of Death



- Individual autopsies were used to determine the manners of death for all 10 children.

- The causes of death range from various medical issues unrelated to abuse or neglect in four cases, positional asphyxia in two cases, drug overdose in one case, hanging in one cases, and blunt force trauma inflicted by the parent in two cases.

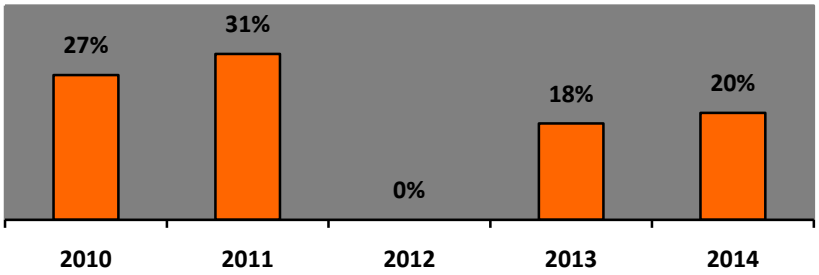
Manner of death for children UNDER the age of 13 years

Manner of death for children OVER the age of 13 years

- Only three of the seven children (43 percent) UNDER the age of 13 died from natural causes. Two of the seven children (29 percent) died by accident after their caretaker put them in a compromised sleeping position. Two of the seven children (29 percent) died from homicide related to abuse suffered at the hand of their parent.

- One of the three children OVER the age of 13 (33 percent) died by suicide. One of the three children OVER the age of 13 (33 percent) died from natural causes and one of the three children (33 percent) OVER the age of 13 died by accident after a drug overdose.

Percent of deaths involving infant unsafe sleeping conditions



- One of the two children (50 percent) that died from positional asphyxia did so after a foster parent put the child in a compromised sleeping position. The other child died after the birth parent failed to utilize safe sleep practices.

- Both children that died of positional asphyxia were Caucasian.

OFA Identified Strengths:

In 2014, the OFA continued to identify strengths related to exceptional practice taken by child welfare staff. Strengths may include an action taken by the worker or other staff

member that went above and beyond general expectations or an exceptional practice that contributed to the child's wellbeing or safety.

Reviewers identified strengths in all 10 fatality reviews; in total there were 20 strengths identified.

Identified Strengths:

Exceptional documentation: Eight of the 10 cases (80 percent) involved MDHHS and private agency foster care staff completing detailed documentation throughout a case, exceeding required standards.

Excellent support of a worker/client by a supervisor: In two of the 10 cases (20 percent), the MDHHS CPS supervisor went above and beyond to support the worker or parent involved with a CPS investigation.

Exceptional coordination with outside agencies: Two of the 10 cases (20 percent) involved a MDHHS worker successfully coordinating efforts with an outside agency such as a law enforcement or medical agency.

Exceeding parenting time standards: Two of the 10 cases (20 percent) involved MDHHS or private agency foster care staff developing plans that enabled parents to have extraordinary amounts of parenting time with their children that exceeded policy expectations.

Exceeding face to face visits with foster parents: Two of the 10 cases (20 percent) involved a MDHHS or private agency foster care worker exceeding the number of face-to-face visits required with the foster parent and child within the first 60 days of placement.

CPS moved swiftly and decisively to keep children safe: One of the 10 cases (10 percent) involved the CPS worker making decisive time-sensitive decisions effectively in order to maintain the safety of a child.

OFA Findings and Recommendations

For each fatality review, the OFA may identify findings or concerns that may have adversely impacted the child's safety or wellbeing at all stages of the child's involvement with the child welfare system. Because the OFA looks at a case in its entirety, a finding might relate to a policy or action not related in any way to the child's death and should be viewed as an opportunity to focus on improving overall practice at all levels of intervention.

Of the 10 completed fatality reviews, four cases (40 percent) resulted in no findings, meaning no areas of concern with compliance were noted. Six of the 10 (60 percent) cases resulted in findings that either impacted the child's safety or wellbeing or had the potential to impact these areas and required further attention.

***Fatality Review Findings*:**

For the six fatality reviews completed during 2014 in which findings and recommendations were identified, the OFA issued 16 findings related to areas affecting a child's safety and wellbeing and made 21 recommendations to the MDHHS local county, central office, and private agency foster care agencies.

***Summary of the OFA Findings*:**

Incorrect CPS disposition: In three of the 10 cases (30 percent), the OFA made a finding that CPS made an incorrect disposition following an investigation. Two of the three investigations involved the county incorrectly determining whether threatened harm existed or not. In each case, the county corrected the disposition after review.

Incomplete investigations: In three of the 10 cases (30 percent), the OFA made a finding that CPS closed an investigation before completing all required activities including interviews, medical exams or criminal history checks.

Insufficient contacts: In three of the 10 cases (30 percent), a child welfare worker did not make sufficient contacts with children, family members, and/or collateral contacts while monitoring services.

Failure to document safe sleep information: In two of the 10 cases (20 percent), the worker did not document observing an infant's sleeping arrangement or providing education to foster/biological parents regarding a safe sleep environment for infants under 12 months of age. One of the cases without documented safe sleep information involved a child who died while in a compromised sleeping position.

Insufficient Supervision: In one of the 10 cases (10 percent), documentation did not reflect required monthly consultation between the worker and supervisor.

Missed opportunity to provide services: In one of the 10 cases (10 percent), services should have been offered to the non-custodial parent who obtained custody of his child.

Failure to follow policy: In one of the 10 cases (10 percent), the county failed to follow Absent Without Legal Permission policy.

***Summary of the OFA Recommendations*:**
The OFA made 21 recommendation for the six cases where the review made findings. Recommendations were directed towards the MDHHS local county offices, the private agencies involved and CPS program office.

- Eleven of the 21 recommendations (52 percent) required the MDHHS local or private agency to review a policy or practice with workers and develop a plan to ensure future compliance with the specific policy. The policy most recommended

for review was PSM 713-01 "*CPS Investigation – General Instructions and Checklist.*"

- Three of the 21 recommendations (14 percent) requested the MDHHS local or private agency to review a random sample of cases to determine whether an identified issue was specific to the Fatality Review or part of a larger systematic agency issue. In all cases where the OFA made this recommendation, the issues identified were case specific.
- Two of the 21 recommendations (9 percent) required administrators at a MDHHS local county to review or provide more training on CPS Threatened Harm policy.
- Two of the 21 recommendations (9 percent) required MDHHS Program Office to consider amending/clarifying a policy.
- Two of the 21 recommendations (9 percent) required a MDHHS local agency to review a CPS disposition.
- One of the 21 recommendations (5 percent) required an agency to consider taking disciplinary action against staff.

OFA Fatality Assessment

The Michigan Department of Health and Human Services provides protection and care for Michigan's most vulnerable children. When a child enters into foster care, MDHHS assumes the responsibility to provide for the safety, well-being and permanence of that child. Though many of the OFA findings and recommendations involve non-compliance with current policy or practice, none of the 10 fatalities occurred as a result of actions or omissions on the part of MDHHS or private agency workers. The findings and recommendations do, however, provide an opportunity for MDHHS to examine and improve its delivery of service, training and supervisory oversight.

Many children entering the foster system do so with medical conditions. The conditions may be naturally occurring or a result of the abuse/neglect they suffered before entering care. Four of the 10 cases (40 percent) reviewed by the OFA in 2014 documented the child died as a result of medical issues that existed prior to entry into foster care.

Though MDHHS often provides numerous services to children and families, some children die from tragic events that MDHHS could not have prevented. Two of the 10 cases (20 percent) involved a child dying after suffering abuse by a parent, which resulted in death. One of the 10 cases (10 percent) involved a teenager dying of a drug overdose while she was absent without leave from her placement. One of the 10 cases (10 percent) involved a teenager committing suicide just hours after his removal from the home.

In 2014, two of the 10 (20 percent) were related to issues involving infants put in compromised sleeping conditions. One of the children died while placed in a foster home and one died when placed with the biological parent.

Secondary Trauma

Some child welfare workers who experience a child fatality may suffer secondary trauma. Secondary trauma, or the stress resulting from helping or wanting to help a traumatized or suffering person, can affect a child welfare worker physically, mentally and emotionally if not successfully dealt with.

After completing a Fatality Review, OFA staff attempt to make a face-to-face visit with the local MDHHS/private foster care agency workers involved in the case to determine what, if any, support they receive related to secondary trauma.

OFA staff visited five local agencies in 2014 and met with a variety of workers involved with a child fatality including those from foster care, CPS, and licensing. Some workers related experiencing symptoms of secondary trauma after their involvement with the child death including inability to make decisions, depression or guilt...even after the OFA affirmed the case and actions taken by the worker. Some workers felt that they would lose their job after the child death, even when the death was expected. Some workers denied experiencing any secondary trauma issues. Through our interviews, the OFA determined that although many counties provide ample support to workers experiencing secondary trauma, others are only beginning to examine what resources are available. Many workers lauded the Traumatic Incident Stress Management Program (TISM), others found it less helpful or refused to call it. Most workers cited the support they received from their supervisor as most important, though the level of support varied between counties.

Follow-up of Past Findings and Recommendations
Since the publication of the previous fatality report, *Child Fatality Reviews: 1/1/13 – 12/31/13, Office of Family Advocate Report,* MDHHS has taken the following steps to improve practices:

Children Services Agency: The OFA made a previous recommendation to determine what, if any, barriers exist at the local level which may prevent or deter workers from consistently making required home visits and develop a comprehensive statewide plan of action to address those barriers.

In 2014, the Children's Services Agency received feedback from counties and staff regarding the barriers to conducting face-to-face home visits. Field staff cited that the largest barrier was the time it took to meet all policy standards. As a result, the Foster Care Workload study was initiated to assess workload and available time a caseworker has to complete expectations. Findings from that study are pending. MDHHS has met the federal goal of 90 percent of caseworker visits at least once each calendar month.

Child Welfare Training Institute, Children's Services Agency and Office of Family Advocate: The OFA made a previous recommendation to continue efforts to provide online and classroom training for all MDHHS child welfare staff regarding the consistent development of behaviorally based safety plans which address immediate risk and structuring for safety between home visits.

In 2014, staff from the Child Welfare Training Institute (CWTI), Children Services Agency (CSA), and the OFA continued to provide training to field staff around safety assessment, safety planning and threatened harm. "Safety by Design,", a three-hour training developed by staff from CSA and OFA focuses on assessing and documenting for safety, developing safety plans, and determining threatened harm. To date, staff have completed the training at 26 local counties, half-a-dozen statewide conferences and its content has been integrated into the new worker pre-service institute mandatory for all child welfare staff.

Additionally, CSA and OFA staff trained nearly 70 MiTEAM peer educators from across the state to present the training, monitor and coach staff regarding safety assessment and planning.

Office of Family Advocate, Children's Services Agency: A previous recommendation was made to continue efforts to develop a suicide prevention/depression management initiative concerning adolescents in foster care by assisting in planning the statewide conference slated for 2015 and examining data concerning these cases to determine what, if any, additional efforts MDHHS should be making with this high risk population.

On April 30, 2015, MDHHS partnered with the Michigan Association for Suicide Prevention (MASP) to host the 2015 Michigan Suicide Prevention Conference in Lansing, Michigan. With nearly 400 people in attendance from nearly 40 Michigan counties, Lt. Gov. Brian Calley and MDHHS Director Nick Lyon kicked off the conference which featured Detroit Lion Eric Hipple as the keynote speaker. Reviews from the conference were extremely positive.

Additionally, MDHHS received a Substance Abuse Mental Health Services Administration (SAMHSA) grant whereby MDHHS and private agency child welfare workers, along with selected foster parents, will attend safeTALK training within the next five years. SafeTALK is a half-day alertness training that prepares anyone over the age of 15, regardless of prior experience or training, to become a suicide-alert helper. The grant also allows for select staff to continue on and become safeTALK instructors, ensuring that future staff will also benefit from the suicide prevention information. MDHHS will oversee the rollout of the training and coordinate it with its appropriate local partners.

OFA Unit Recommendations:

Threatened Harm:

> -The OFA recommends that the MDHHS Children's Services Agency consult with the Michigan Domestic and Sexual Violence Prevention and Treatment Board and the Office of Workforce Development and Training to develop policy and training that clarifies for CPS staff how to better recognize, document and utilize 'threatened harm.' especially regarding investigations involving domestic violence.

Secondary Trauma:

-The OFA recommends MDHHS Children's Services Agency consider developing a statewide initiative to educate child welfare supervisors around identifying and supporting workers experiencing secondary trauma as a result of cases that end in a fatality or severe injury.