Michigan Department of Health & Human Services

State of Michigan
Department of Health & Human Services

Child Fatality Reviews: 1/1/17-12/31/17
Office of Family Advocate Report

INTRODUCTION

The Office of Family Advocate (OFA), a unit within the Children's Services Agency (CSA) at the Michigan Department of Health and Human Services (MDHHS), oversees the fatality review process. One of the unit's duties is to review cases in which a child died while under court jurisdiction and in the care and custody of the Department. Though these cases are rare, they provide an opportunity for the OFA to examine the effectiveness of statewide policy, local practice, and systemic factors.

OFA REVIEW PROCESS

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

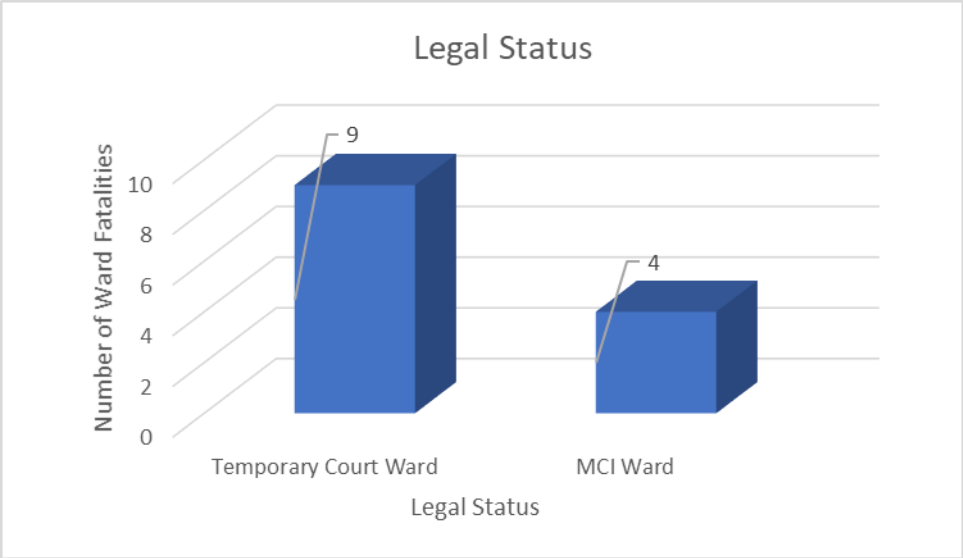
The reviewers examined relevant information, including any Children's Protective Services investigation involving the child, the foster care and adoption file, all Children's Protective Services complaints involving the child's foster care home(s), the foster parents' licensing file, placement history, all available information related to the child's death, and any relevant records held by the Department of Child Welfare Licensing to determine policy compliance and best practice.

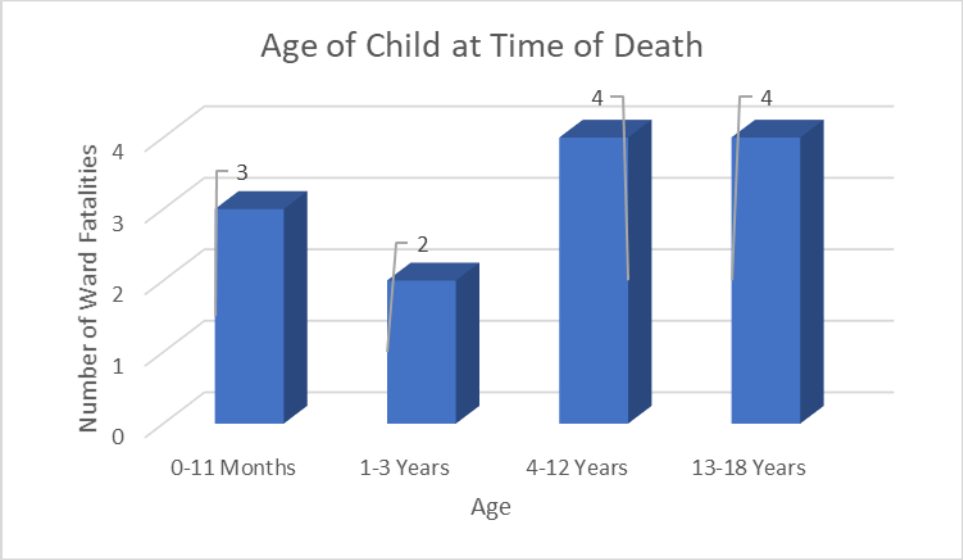
Each OFA fatality review involved on-site inspection of the original case file, remote inspection of exact copies of case files, or a review of the information available on the Michigan State Automated Child Welfare Information System (MiSACWIS). Each review contained a summary of the case facts, practice strengths identified during the review, and, when applicable, findings and corresponding recommendations. Office of Family Advocate 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 some cases, Office of Family Advocate 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.

The following chart displays the number of children who died between 2010 and 2017 while under court jurisdiction and in the care and custody of MDHHS:

DEMOGRAPHICS

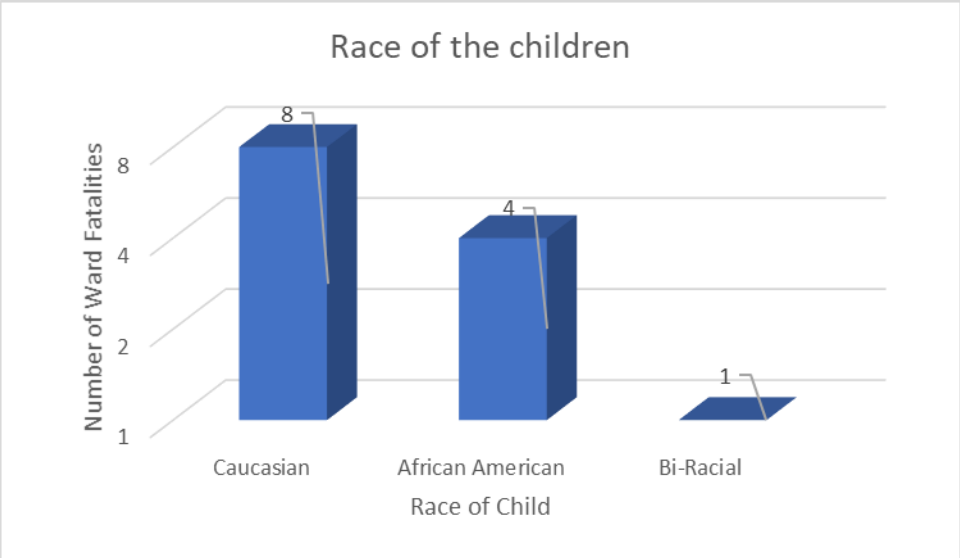
The following data was compiled using the thirteen fatality reviews completed during 2017.





The range of the children's age was birth to 18 years old.

Four of the thirteen children (31%) were teenagers with two of those youth being 18 years old. Two of the teens died by homicide, one was a medically fragile youth who came into foster care with severe injuries, and the fourth died from suicide.



Counties with Jurisdiction

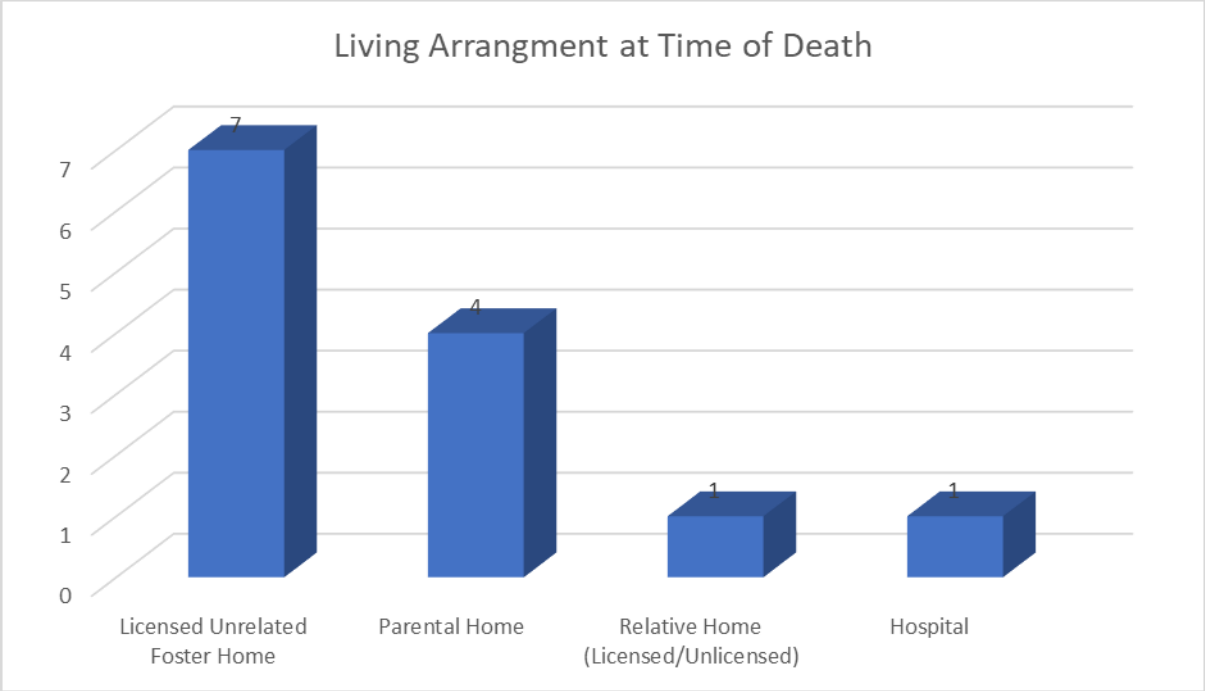
County	Number of Ward Fatalities
Allegan	1
Calhoun	1
Genesee	1
Ionia	1
Iosco	1
Jackson	1
Ken	1
Lenawee	1
Macomb	1
Oakland	1
Saginaw	1
St. Joseph	1
Wayne	1

The Office of Family Advocate reviewed thirteen ward fatalities that involved thirteen different counties.

Private Foster Care Agencies with Case Management Responsibility

Private Agency	Number of Ward Fatalities	County with jurisdiction
Catholic Charities of Western Michigan	1	Kent
Child & Family Services-Northeast Michigan	1	Iosco
D.A. Blodgett	1	Allegan
Ennis Center for Children	1	Oakland
Hands Across the Water	1	Lenawee
Wayne Center	1	Wayne

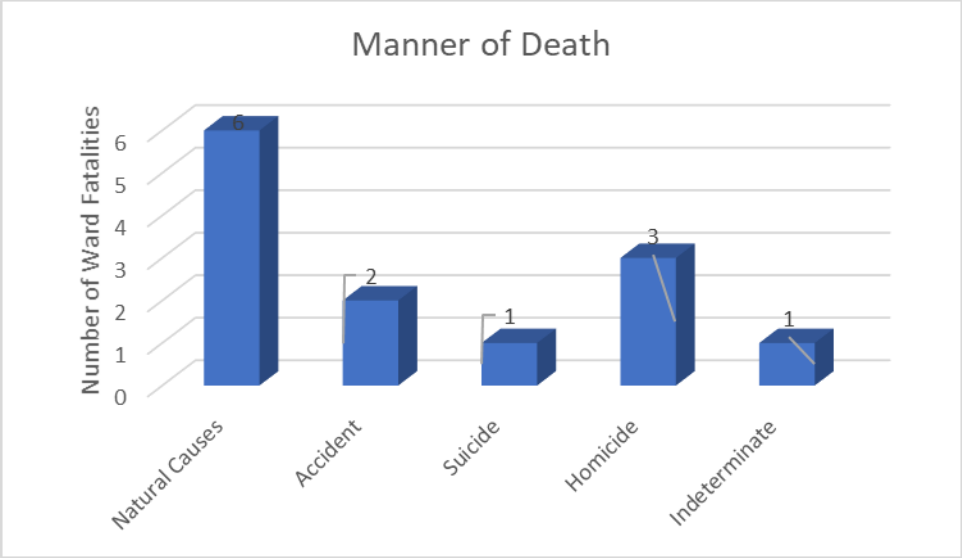
In 2017, 6 of the 13 cases where a ward died in foster care had a private agency with case management responsibility.



Seven of the thirteen children (53%) died while living in an unrelated foster home. Six of those children died because of a medical issue which existed prior to placement. The other child died from suicide.

Four of the thirteen children (31%) died while living with a biological parent. Two of those children died of medical issues which existed prior to placement. One child died after being placed in a compromised sleeping position by her parent. The fourth child died of carbon monoxide poisoning after her parent set up a generator in the home without proper ventilation.

One of the children died of a gunshot wound she received while AWOL from a relative placement. One child died in the hospital of injuries she sustained from her parent.

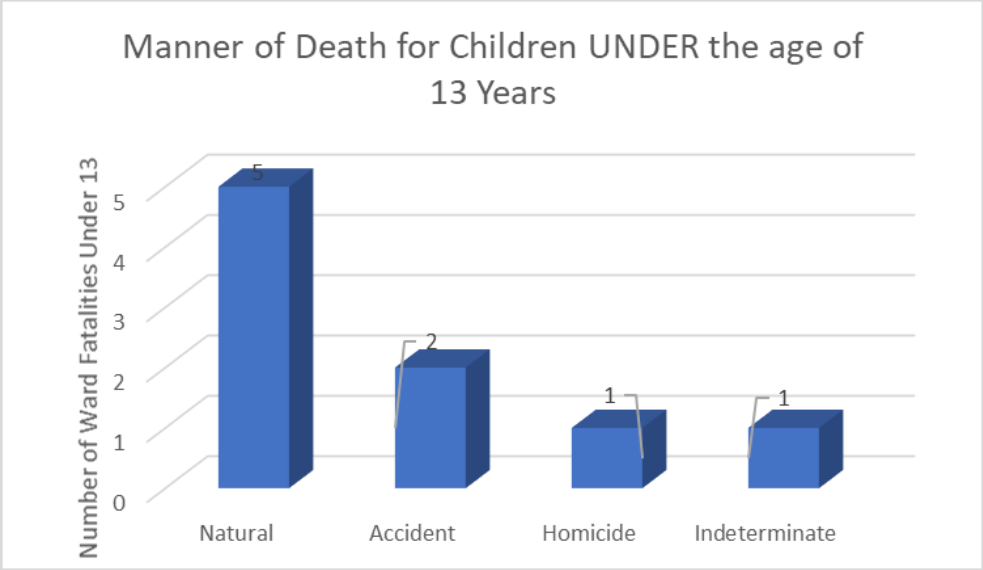


Individual autopsies were used to determine the manners of death for all thirteen children.

Six of the 13 children (46%) died from natural causes. Three children died from various medical issues unrelated to neglect or abuse that existed prior to their entry into foster care. One child died because of physical abuse inflicted by a parent/caregiver.

Other causes of death range from positional asphyxia (unsafe sleep of infants) in one case to accidental carbon monoxide poisoning in another. Three of the thirteen children (23%) died from homicide. Two of the homicides were caused by a parent prior to children entering foster care, the third occurred to a foster child who had run away from placement and who police later found after she had been shot.

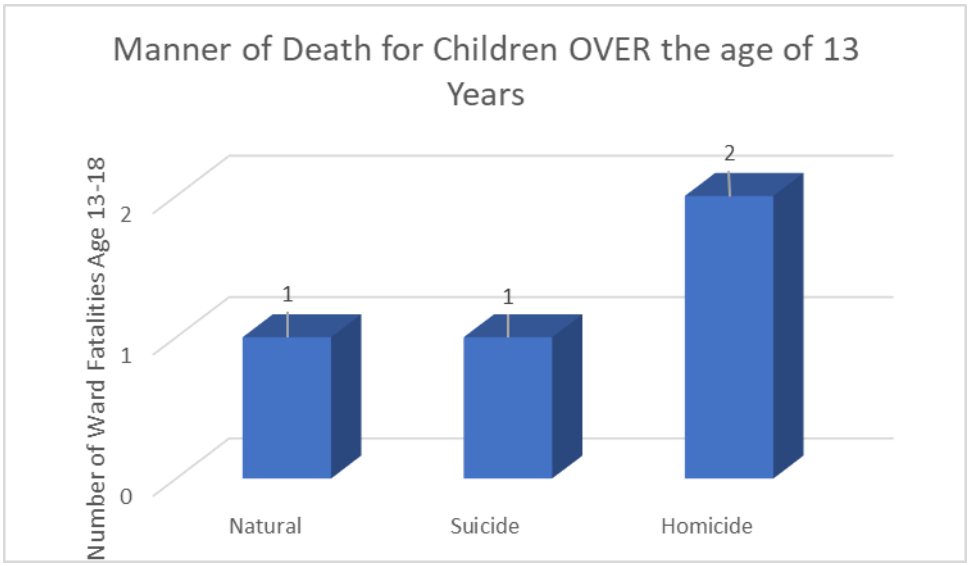
One of the 13 children (8%) died by suicide. One of the 13 children (8%) died in an indeterminate manner, however she had several medical issues stemming from the abuse she suffered from her parents.



Five of the nine children (55%) under the age of 13 died from natural causes.

One of the accidental deaths occurred after a child's parent placed their infant in a compromised sleeping position, the other accidental death was due to carbon monoxide poisoning.

One of the 9 children died from homicide, specifically from injuries inflicted by the parent prior to their entry into foster care. The child who died in an indeterminate manner also suffered medical complication stemming from abuse she suffered from her parent prior to foster care.



Two of the four children (50%) over the age of 13 died by homicide caused by a gunshot wound to the head. One of the children died naturally from medical issues that existed before the child entered care, and the other child died by suicide.

OFA FATALITY REVIEWS: STRENGTHS, FINDINGS & RECOMMENDATIONS

Consistent with prior years, the OFA continued to identify strengths related to exceptional practice taken by child welfare staff. Strengths included the worker or other staff member that went above and beyond general expectations and various exceptional practice that contributed to the child's well-being or safety in care.

Additionally, the OFA may identify findings or concerns that may have adversely impacted the child's safety or well-being at any stage 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. None of the findings identified in the 2017 Reviews contributed to or in any way impacted the child death.

It should be noted that the OFA looks at a very specific set of cases involving child fatality and the strengths and findings identified in those cases may not reflect statewide child welfare trends and should not be generalized to characterize practice statewide.

IDENTIFIED STRENGTHS

OFA reviewers identified exceptional practice in nine of the thirteen fatality reviews.

Excellent collaboration between numerous agencies and entities: Nine of the thirteen cases (69%) involved MDHHS and private agency staff going above and beyond the norm to collaborate efforts with numerous outside agencies, such as law enforcement, prosecutor's office, medical professionals, and foster parents.

Excellent effort to locate an appropriate placement: Five of the thirteen cases (38%) involved MDHHS staff making extraordinary efforts to find placements for children with extreme medical needs or for a group of siblings.

Support to the family: Five of the thirteen cases (38%) involved MDHHS staff providing extraordinary support to the family prior to or after the death of a child.

IDENTIFIED FINDINGS

The Office of Family Advocate issued twenty-three findings related to areas affecting the child's safety and/or well-being in the thirteen reviews completed.

For each finding, the Office of Family Advocate also made corresponding recommendations to the MDHHS local county, central office, and/or private foster care agencies regarding how to improve practice or correct an issue related to the case. No findings were made in three of the Fatality Reviews.

Insufficient contacts: In nine of the thirteen Fatality Reviews (39%), a child welfare worker did not document sufficient contacts with children, family members, and/or collateral contacts while monitoring services.

Inadequate documentation: In eight of the thirteen Fatality Reviews (35%), the Office of Family Advocate made a finding that the case lacked required documentation. Examples include in one case inadequate documentation recording when monthly supervisory consultations occurred. In another case, a worker did not properly document when they reviewed safe sleep information with the foster parent.

Incorrect risk assessment score: In four of the thirteen Fatality Reviews (17%), the Office of Family Advocate made a finding that CPS incorrectly scored the Risk Assessment, leading to an incorrect disposition category.

Lack of safety planning: In one of thirteen Fatality Reviews (8%), the Office of Family Advocate made a finding that the agency did not adequately document the safety plan regarding a child with a medical condition.

RECOMMENDATIONS

The Office of Family Advocate made twenty-four recommendations for the thirteen Fatality Reviews with findings. Recommendations were directed towards the MDHHS local county offices, the private agencies involved, and the child protective services program office.

- Ten of the 24 recommendations (42%) requested the local MDHHS or private agency to review an action or decision they made during a case to determine if it was correct. If not, the Office of Family Advocate requested the agency develop a plan to ensure future compliance with the related policy. None of the actions or decisions reviewed had an impact on the child fatality.
- Nine of the 24 recommendations (38%) required the agency to complete paperwork such as a form.
- Five of the 24 recommendations (21%) required the local MDHHS or private agency to review policy or practice with workers and develop a plan to ensure consistent compliance. The policy most often recommended for review was PSM 713-01—*CPS Investigation- General Instructions and Checklist*.

FOLLOW-UP OF PAST FINDINGS AND RECOMMENDATIONS

The OFA made two recommendations in its previous fatality report, *Child Fatality Reviews: 1/1/16 – 12/31/16 Office of Family Advocate Report*. They were:

> 1—"*Foster Care Program Office, Child Welfare Field Operations management, and the Children's Welfare Training Institute continue to implement strategies to increase the likelihood of field compliance to standards of promptness and completion of required documentation. Additional strategies to consider include additional training approaches, such as web training and podcasts, MiSACWIS Book of Business, and training on findings and trends identified in this report."*
>
> 2—*"The Children's Services Agency issue a Communication Issuance to the field explaining this change as well as update FOM 903-10, FUNERAL PAYMENTS, to reflect these [increased] amounts."*

Since that time, MDHHS Foster Care Program Office began to make updates to policy to highlight the requirements of visits with a child in the first 60 days of placement as well as all subsequent months. They also worked with the MDHHS Data Warehouse to develop reports which track the contacts required with youth in shelter placement. Additionally, MDHHS's Child Welfare Training Institute has incorporated additional training regarding the timeliness of foster care face to face visits into new Program Specific In-Services Reviews being conducted statewide.

Also, since the OFA made its recommendations, MDHHS has continued to partner with the University of Michigan to enhance resources related to suicide prevention for child welfare workers. In 2018, MDHHS sent an additional 9 child welfare staff for certification in safe TALK suicide awareness training. MDHHS also worked with University of Michigan to author a research paper that examines the need of child welfare staff to receive suicide prevention training.

Lastly, the Children's Services Agency has begun to make updates to FOM 903-10, FUNERAL PAYMENT to reflect the new amounts allowed for funeral expenses. Additionally, when SRM 172, CHILD/WARD DEATH ALERT PROCEDURES AND TIMEFRAMES is updated, it will refer to the updated policy as well.

OFFICE OF FAMILY ADVOCATE UNIT RECOMMENDATIONS

1. **The OFA recommends the Children's Services Agency consider creating additional SCPs and expand the CRT to include CPS Ongoing cases, the Foster Care and Adoption programs, as well as Licensing to increase compliance in those program areas.**

In 2019, as a result of the Office of Auditor General's review of Michigan's CPS program, the Children's Services Agency created the Supervisory Control Protocol (SCP), a checklist used by supervisors to ensure complete investigations, and the Compliance Review Team (CRT), a unit which reviews completed CPS investigations to ensure consistent policy compliance. Since the creation of these two monitoring mechanisms, the OFA has seen a substantial increase in CPS worker compliance with investigation requirements.

2. **The OFA recommends Foster Care Program Office, Adoption Program Office, and the Department of Child Welfare Licensing also develop and issue specific policy in their respective policy manuals which provide guidance to the field regarding when and how to develop safety plans along with where to document them within the system.**

   In 2019, CPS Program Office issued policy which gave direction as to when and how the field should be developing safety plans during a CPS investigation and where they should be documented in the system. It was the first program to create such a specific policy.