

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND
HUMAN SERVICES

CHILD FATALITY REVIEWS: JAN.-DEC., 2016
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 where a child has 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 policy and practice as it relates to both Children's Protective Services, Foster Care, Adoption and Licensing in the state of Michigan.

OFA REVIEW PROCESS

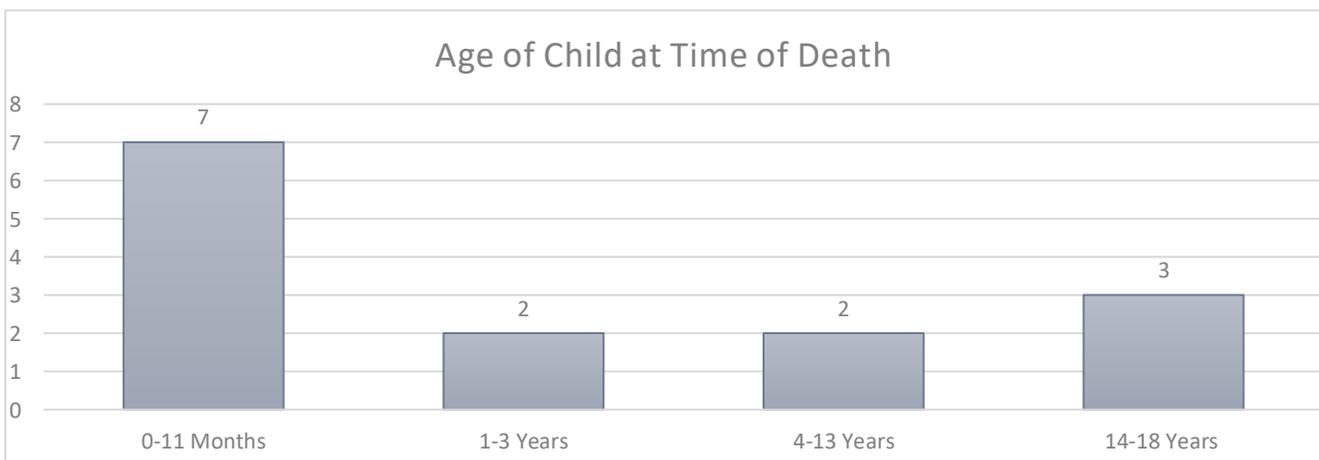
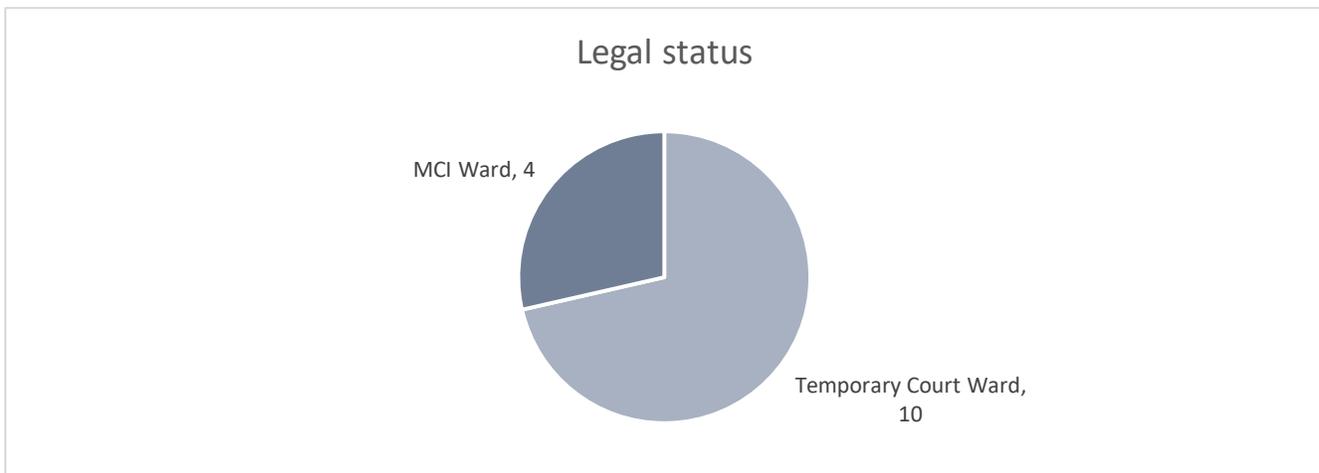
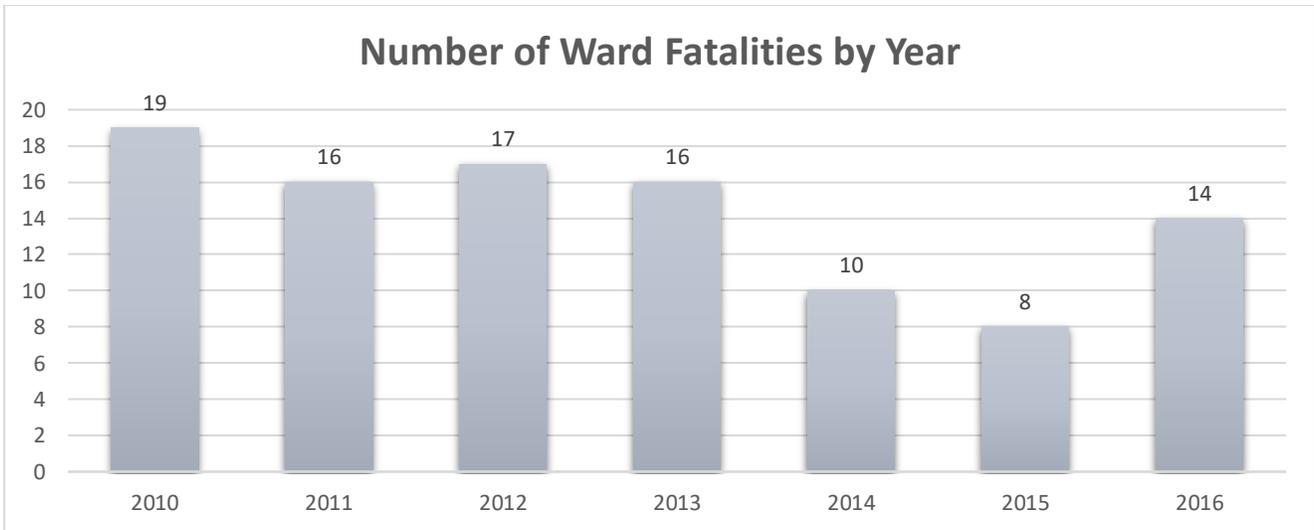
The OFA developed guidelines to ensure that fatality reviews are consistently independent and comprehensive. Each review is completed by the OFA director or departmental specialist.

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.

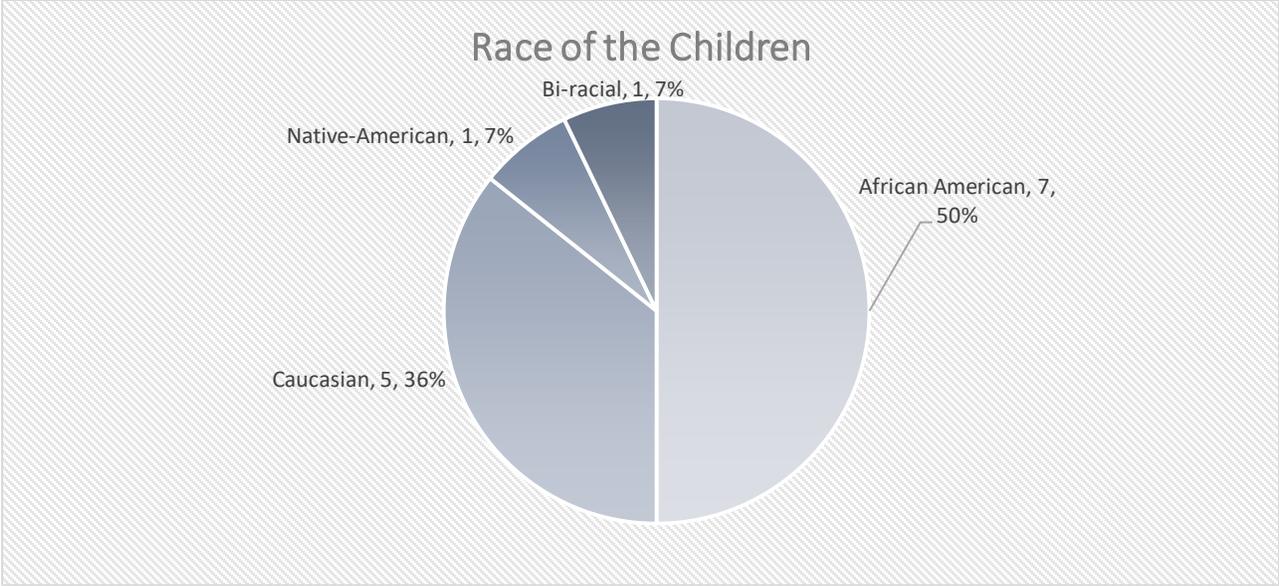
OFA staff completed each fatality review within six months after the child's death which involved on-site inspection of the original case file, remote inspection of exact copies of case files, or a review of the information available on the Michigan State Automated Child Welfare Information System (MiSACWIS). Each review contained a summary of 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 many 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.

DEMOGRAPHICS

The following data was completed for the 14 fatality reviews completed during the review period.



The range of children’s ages was 5 weeks to 18 years old. Seven out of 14 children (50%) were less than 6 months old at the time of death.

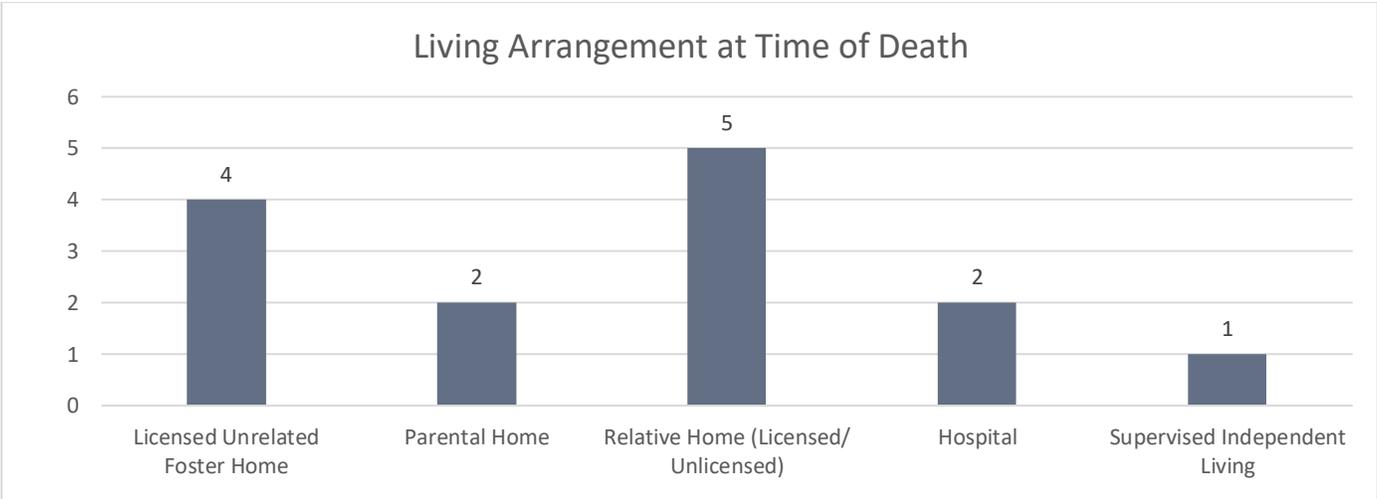


Ward Death Localities

County	Number of 2016 Ward Deaths
Wayne	5
Oakland	2
Marquette	1
Berrien	1
Kalamazoo	1
Washtenaw	1
Ingham	1
Muskegon	1
Monroe	1

The Office of Family Advocate reviewed 14 ward fatalities that involved nine different counties. Seven of the 14 deaths (50%) occurred in the one of the five urban counties (Wayne, Oakland, Genesee, Kent, or Macomb).

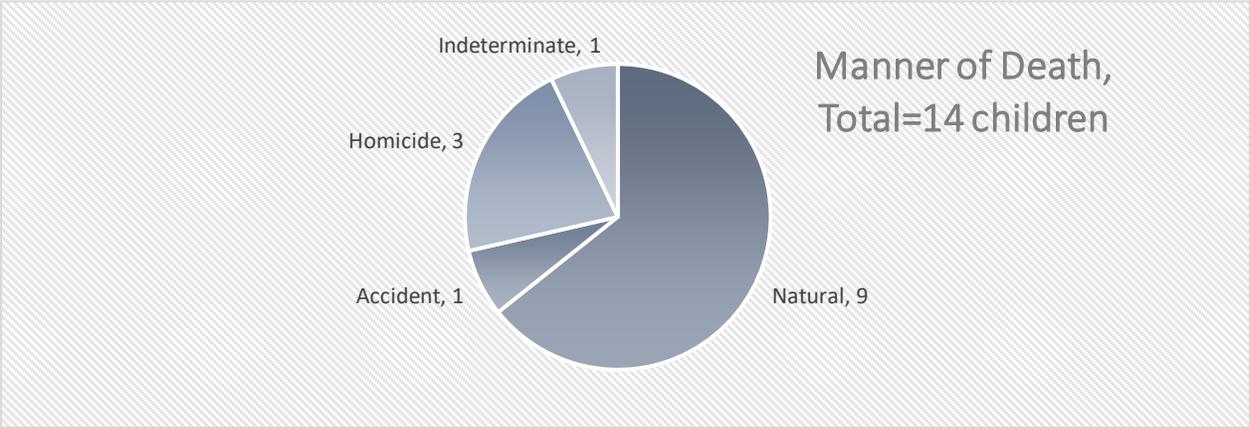
Two of the cases involved a family that lived in multiple counties where CPS and/or foster care were involved.



Four of the 14 children (29%) died while living in an unrelated foster home.

Two of the 14 children (14%) died while living with a biological parent.

Five of the 14 children (36%) died while living with a relative. Three of those children died because of chronic medical issues which existed prior to placement, one died from a gunshot wound to the head from an unknown suspect (unofficial cause), and one died from an accidental drug overdose.



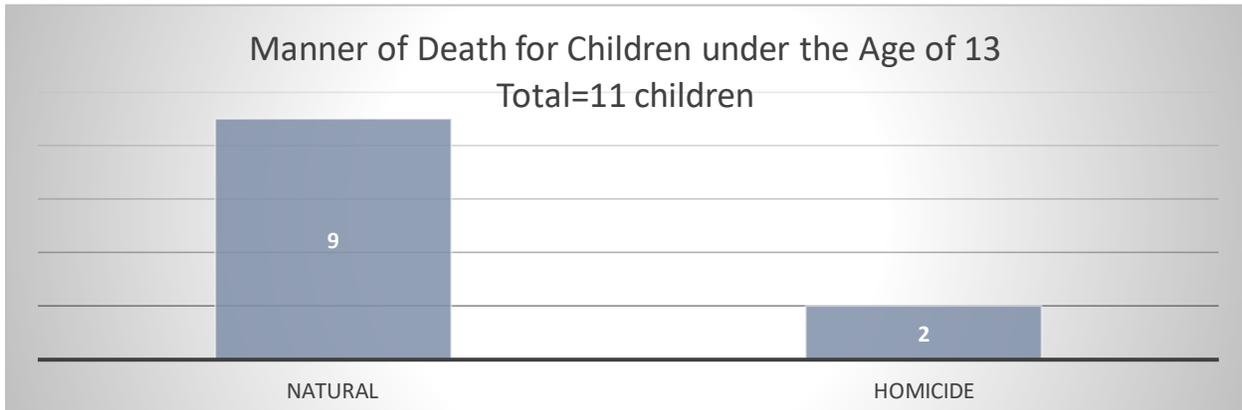
Individual autopsies were used to determine the manners of death.

Nine of the 14 children (64%) died from natural causes. Seven of those children died from various medical issues unrelated to neglect or abuse. The other two died from medical issues they suffered prior to entry into foster care.

Three of the 14 children (14%) died from homicide. Two children died because of physical abuse inflicted by a parent, the other died from a gunshot wound inflicted by an unknown suspect.

One of the 14 children (7%) died from an accident. The accident involved a possible drug overdose (unofficial cause).

One of the 14 children (7%) died in an indeterminate manner. The cause involved a possible drug overdose (unofficial cause).



Nine of the 11 children (81%) under the age of 13 died from natural causes.

Two of the 11 children (18%) died from homicide, specifically by injuries inflicted by the parent.



The one indeterminate and one accidental death were both caused by drug overdose.

One of three teenagers (33%) died from homicide caused by a gunshot wound to the head.

OFA FATALITY REVIEWS: STRENGTHS, FINDINGS & RECOMMENDATIONS

In 2016, the OFA continued to identify strengths related to exceptional practice taken by child welfare staff. Strengths may include the worker or other staff member that went above and beyond general expectations or an exceptional practice that contributed to the child's well-being or safety.

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.

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

Though every child welfare case has practice that exceeds expectations, the OFA often identifies trends in exceptional practice within its fatality reviews. Reviewers identified exceptional practice in 13 of the 14 fatality reviews.

Excellent collaboration between numerous agencies and entities: Seven of the 14 cases (50%) involved MDHHS excellent collaboration efforts with numerous outside agencies.

Excellent effort to locate an appropriate placement: Five of the 14 cases (36%) involved MDHHS staff making extraordinary efforts to find placements for children with extreme medical needs or with a group of siblings.

Documented safe sleep education: three of the 14 cases (21%) involved MDHHS child welfare staff making special effort to review the tenets of safe sleep with the child's parent.

Support to the family: Three of the 13 cases (21%) 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 findings related to areas affecting the child's safety and/or well-being in nine of the 14 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. Five of the Fatality Reviews had no findings.

Insufficient contacts: In seven of the 14 Fatality Reviews (50%), a child welfare worker did not make sufficient contacts with children, family members, and/or collateral contacts while monitoring services. Most of the findings involved missed visitation with the child during their first 60 days of placement.

Inadequate documentation: In four of the 14 Fatality Reviews (29%), the Office of Family Advocate made a finding that the case lacked required documentation.

Incorrect risk assessment score: In three of the 14 Fatality Reviews (21%), 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 two of 14 Fatality Reviews (14%), the Office of Family Advocate made a finding that the agency did not develop a safety plan for a child in an unsafe situation.

Failure to document safe sleep education: In one of the 14 Fatality Reviews (7%), 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.

Premature closure of child protective services on-going case: In one of 14 Fatality Reviews (7%), the Office of Family Advocate made a finding that the county prematurely closed a Children's Protective Services on-going case without ensuring the family had participated or benefited from services.

RECOMMENDATIONS

The Office of Family Advocate made 13 recommendations for the nine Fatality Reviews with findings. Recommendations were directed towards the MDHHS local county offices, the private agencies involved, and the Children's Protective Services program office.

- Seven of the 13 recommendations (54%) required the MDHHS local or private agency to review policy or practice with workers and develop a plan to ensure consistent compliance. The policy most recommended for review was PSM 713-01—*CPS Investigation-General Instructions and Checklist*.
- Five of the 13 recommendations (38%) required the agency to complete a required form.
- One of the 13 recommendations (8%) requested the MDHHS local 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 local/agency to develop a plan to ensure future compliance with the related policy. None of the actions or decisions the Office of Family Advocate requested to be reviewed were directly involved in the death of a child.

OFFICE OF FAMILY ADVOCATE FATALITY ASSESSMENT

MDHHS provides protection and care for Michigan's most vulnerable children. When a child enters foster care, MDHHS assumes the responsibility to provide for the safety, well-being, and permanence of that child and often provides numerous services to them and their families.

Since the inception of the federal consent decree in 2008, MDHHS has made great strides in improving or exceeding compliance in areas that directly impact the care of children in the system. It is important to remember that cases involving fatalities are a very small subset of

overall cases and the trends identified in this report cannot be generalized to all practice or all counties across the state.

In many instances, the children died from tragic events that MDHHS could not have prevented. In 2016, nine of the 14 cases (64%) involved a child dying from chronic medical issues that existed prior to placement in out-of-home placement. One of the 14 cases (7%) involved a teenager dying from an accidental drug overdose. Two of the 14 cases (14%) the children died from homicide. Two of the 14 cases (14%) the children died from indeterminate causes.

As outlined above, the OFA identified some common errors in these cases, though none of the errors directly led to the death of a child. Insufficient contacts, incomplete or incorrect documentation, and lack of safety planning continue to be challenges in cases involving a fatality. While there is no clear correlation between these errors and the death of a child, when they occur it could be an early warning sign of potential risk in the case.

FOLLOW-UP OF PAST FINDINGS AND RECOMMENDATIONS

The OFA recommended in its previous fatality report, *Child Fatality Reviews: 1/1/15 – 12/31/15 Office of Family Advocate Report* that the

“Foster Care Office Program, Child Welfare Operation management, and the Children’s Welfare Training Institute to consider strategies to improve field compliance, this may include additional training approaches, such as web training and podcasts, MiSACWIS Book of Business, and training on findings and trends identified in this report.”

Since that time, MDHHS started the initial implementation and training of the MiTEAM Enhancements that, if implemented as designed, would improve field compliance with standards of promptness and face-to-face contacts. MiTEAM competencies include Engagement, Teaming, Assessment, Case Planning, Case Plan Implementation, Placement Planning, and Mentoring. The skills and behaviors associated with the competencies stress the importance of quality face-to-face contacts, using caseworker visits to make case progress, partnering with families throughout a case, and integrating voice and choice of families and youth in decision-making.

Additionally, in January 2017, The Office of Workforce Development and Training’s child welfare Pre-Service Institute (PSI) was reformatted to allow trainees to receive more initial instruction in the classroom, be better prepared with program specific skills earlier in their trajectory and give adequate time to practice those early skills with support during field weeks. Increasing the number of days that new hires receive program specific training allows more emphasis on standards of promptness, face-to-face contacts, and other program requirements. This format also provides report writing training that is more program focused and incorporated into the program-specific portion of pre-service training. Further, the new format incorporates more extensive MISACWIS training into PSI and makes some previously optional

content now mandatory for all workers as part of their initial training. The enhanced MISACWIS content better prepares new workers to perform program specific job duties related to MISACWIS.

MDHHS conducted regional trainings in October and November 2017 for public and private supervisors and caseworkers focused on visitation requirements, how to document them properly in MiSACWIS, and how to utilize data reports to ensure compliance.

Lastly, foster care policy was updated to clearly reflect timeframes for case assignment (FOM 722-01. p7) and who is responsible for ensuring initial face-to-face visits are completed (FOM 722-01 p.11).

OFFICE OF FAMILY ADVOCATE UNIT RECOMMENDATIONS

STANDARD OF PROMPTNESS FOR FACE-TO-FACE VISITS

As noted in this report, MDHHS has implemented several strategies to increase the likelihood of overall policy compliance; however the Office of Family Advocate still made a finding in the majority of its 2016 Fatality Reviews regarding required face-to-face visits between the foster care workers and foster youth, most notably within the first 60 days of placement. As such, Office of Family Advocate recommends 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.

SAFE TALK

For the past several years, MDHHS has expanded the amount of resources and training available for Michigan child welfare staff concerning suicide awareness and prevention. In 2016, MDHHS hosted its second “Suicide Prevention conference” for child welfare staff statewide in which nearly 280 staff received safe TALK, a nationally recognized suicide-awareness training. More recently, MDHHS sponsored nine child welfare staff to become certified to train safe TALK and partnered with the University of Michigan to pilot a suicide lethality assessment for children ages 11 years or older entering into the foster care system. Though no foster children died by suicide in 2016, the OFA has reviewed youth suicides previously and recommends MDHHS sponsor an additional 10 child welfare staff in the upcoming year to be certified in safe TALK as well as continue in its efforts within the MDHHS and with the University of Michigan to provide child welfare staff additional resources and training regarding assessing and engaging those with mental health issues and/or suicidal ideation.

FUNERAL EXPENSES COMMUNICATION

Current policy allows for MCI wards to be buried at the state's expense but previously allowed reimbursement of up to \$725 for a funeral service complete with casket. Recently, MDHHS increased that reimbursement to \$6,000 with an exception process that could allow up to \$8,000 after a reasonable exploration of alternatives. The OFA recommends that 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 amounts.