

State of Michigan
Department of Human Services

Child Fatality Reviews: 4/1/09 - 12/15/09
Quality Assurance Report

Introduction

The Michigan Department of Human Services (DHS) is responsible for administering the state's child welfare program. The DHS mission includes a commitment to ensure that children and youths are safe; to sustain a higher quality of life; and to give children in DHS permanent and stable family lives. The DHS Children's Services Administration is responsible for planning, directing and coordinating statewide child welfare programs, including social services provided directly by DHS via statewide local offices and services provided by private child-placing agencies.

A settlement agreement was signed July 3, 2008 and a final consent decree was entered on October 28, 2008. Since then, DHS has made significant strides to improve the quality of service to children and families in the child welfare system by reducing caseloads for its workers, moving more children to permanency, reducing the number of children in out-of-home care, launching a continuous quality improvement system, increasing oversight of contracted providers, and developing extensive data reporting capabilities.

The consent decree requires DHS 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 in the foster care custody of DHS. The fatality review process is overseen by the Office of Family Advocate.

The Child Welfare Quality Assurance (QA) Unit is responsible for analyzing results and incorporating the findings and recommendations from the reviews into relevant QA activities. The QA Unit has been established as a division of the Child Welfare Improvement Bureau in the Children's Services Administration to ensure the provision of service in accordance with DHS philosophy. The goal of the QA Unit is to ensure that children receive high quality services and achieve positive outcomes through improved service delivery, regular monitoring of case records and data trends, and improved implementation of policy.

This report is a summary of the child fatalities between 4/1/09 and 12/15/09 concerning 19 children who died while in the foster care custody of DHS.

Process

The Office of Family Advocate (OFA) has developed guidelines to assure fatality reviews are consistently independent and comprehensive. The reviews are completed by qualified DHS staff, independent from the county or agency in which the fatality occurred. In most cases, the review is completed by the OFA director or an OFA department 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 other information related to the child death. Reviewers utilized existing DHS policy, Michigan Child Protection Law, licensing rules, DHS L-letters, and BCAL Child Placing Agency Letters as reference material to determine case compliance and best practice.

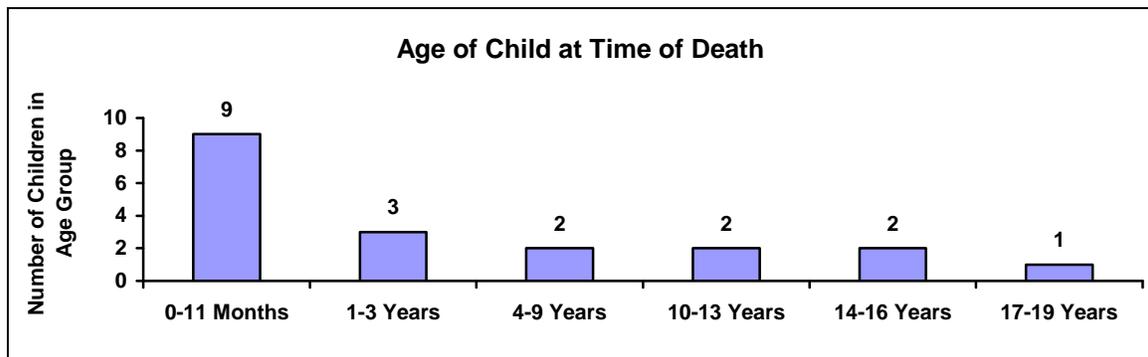
Each review was completed within six months of the fatality and involved on-site inspection of the original case file or remote inspection of exact copies of case files. Each review included specific findings and corresponding recommendations in the areas of safety, permanency and well-being. Each completed review is sent to the involved agency and/or program office to review and respond.

The Office of Family Advocate sent completed summaries to the QA Unit, who reviewed the individual reports for each of the 19 child fatalities. Information from these reports was compiled and used for analysis. The QA Unit used the Services Worker Support System (SWSS) to expand the information from the fatality review summaries. Specific demographic data, such as the child's age, race, gender, and living arrangement was derived from SWSS data.

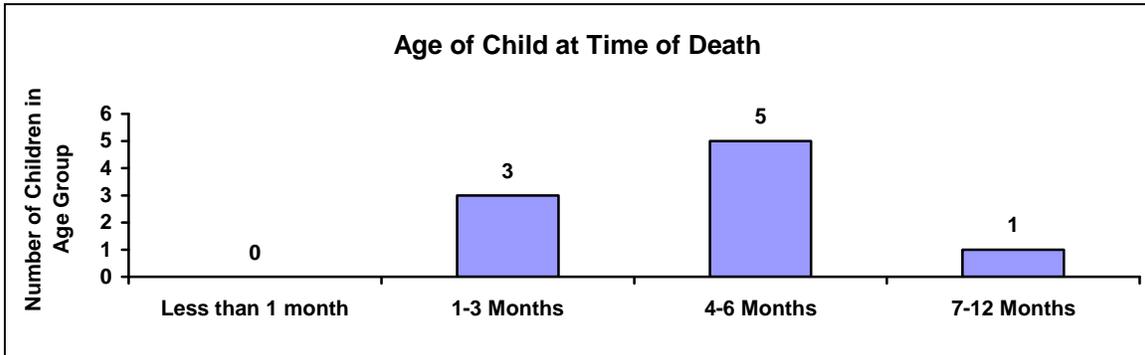
Results

The OFA completed 19 fatality reviews for this review period. Of the 19 cases reviewed, 14 (73.7%) of the cases were under the direct supervision of DHS and five (26.3%) were under the direct supervision of private child placing agencies (CPA). Ten of the children were male (52.6%) and nine were female (47.4%).

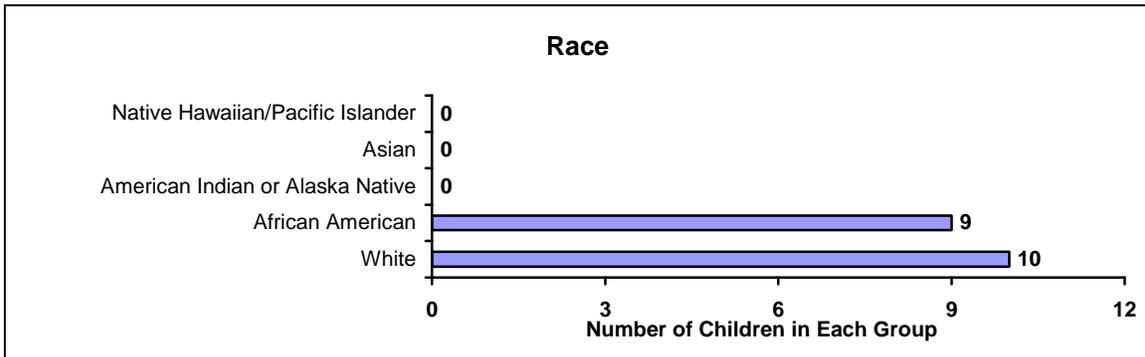
The average age of the children was five years at the time of death. Sixty-three percent of the children who died were three years old or younger. The graph below illustrates the age of the children.



Nine children were under the age of one, 47.4 percent. The graph below shows the age of these children in months.



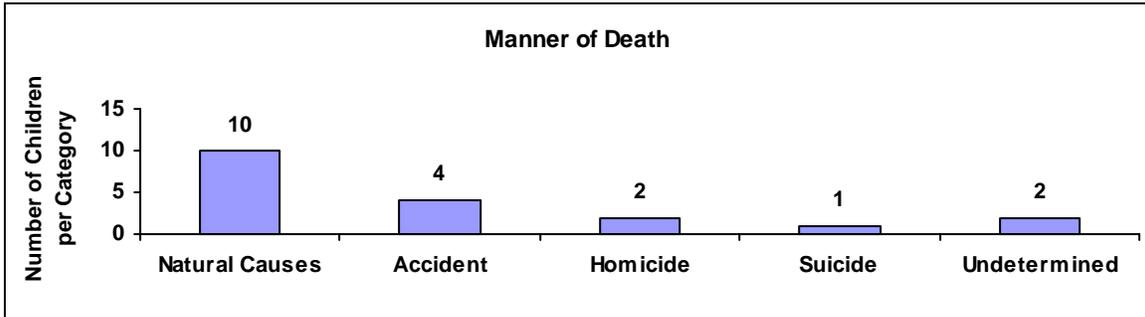
Nine of the children (47.4%) were African American and ten (52.7%) were white. The graph below shows the number of children in each racial group.



The manner of death for these children was as follows:

- Ten of the children died of natural causes, (52.6%). Nine of these deaths were a result of the child’s specific medical condition. The other natural death was from acute bronchopneumonia.
- Four of the deaths (21.1%) were ruled accidental: suffocation, injuries sustained in a motor vehicle accident, drug intoxication, and positional asphyxia.
- Two deaths (10.5%) were homicides. One teen was a victim of a gunshot. One young child died of severe head trauma sustained prior to placement in foster care.
- One of the cases reviewed involved suicide (5.3%). Official cause of death was asphyxia by hanging.
- Two cases had a cause of death that is classified as undetermined (10.5%). One child experienced sudden unexplained infant death (SUID). The other was due to complications related to a remote intracranial hemorrhage.

The manner of death for the 19 fatalities is illustrated in the graph below.

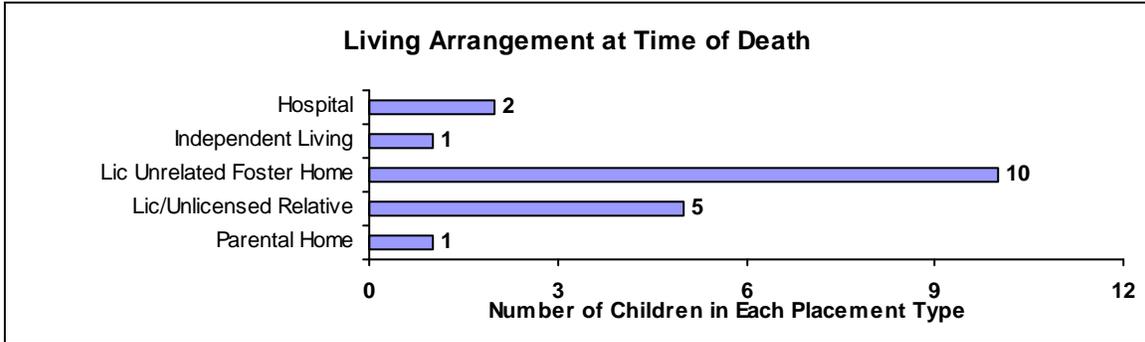


The children were under the supervision of nine different counties. The table below shows the number of fatalities that occurred per county, the number of active foster care cases on March 31, 2010, and the number of fatalities per 1,000 children in care.

The totals for children in care in the state are at the bottom of the table. Please note that counties with a small number of foster care cases will trend to a higher rate of fatalities per 1,000.

Children in Foster Care			
County Name	# of Fatalities	# of Active FC Cases (3/31/10)	Fatalities per 1000 Children
Berrien	1	414	2.4
Cheboygan	1	78	12.8
Genesee	2	1,205	1.7
Ingham	1	653	1.5
Kent	1	929	1.1
Macomb	1	1,196	0.8
Montcalm	1	60	16.7
Oakland	1	1,031	1.0
Wayne	10	4,835	2.1
Total for State	19	16,344	1.2

Five (26.3%) of the children were living with a relative when they died. Ten (52.6%) were in a licensed unrelated foster home. Two (10.5%) were placed at a hospital. One child (5.3%) was living in the parental home. One child was in independent living (5.3%). The graph below illustrates the living arrangement of these children.



Reviewer Findings and Recommendations

The Office of Family Advocate evaluated 19 fatalities and made findings of non-compliance with specific policies, laws or best practices. Seventeen of the cases reviewed detailed a finding in regards to the child’s safety, permanency, or well-being.

Fourteen cases noted findings in regards to the child’s safety.

Foster Parent Training (Licensing rule 400.12312)

- Licensing file did not contain a foster parent training plan that specifically addressed safe sleep.
- CPA did not ensure that the licensed foster parent was adequately trained for the child’s special needs.

Safe Sleep (Licensing rule 400.9306)

- The licensed foster parent did not adhere to safe sleep practices.

Central Registry / Criminal Record Clearance (PSM 715-2 and FOM 722-3)

- The child’s placement was not thoroughly assessed. Assessments of adult household members were not documented.

Time Frame for Completion of Field Investigation (PSM 713-9)

- CPS did not meet the standard of promptness for completing an investigation. Investigation report, safety assessment and risk assessment were completed late. No extension was requested.

Services Worker Face-to-Face Contacts (FOM 722-6 and PSM 713-3)

- CPS did not meet standard of promptness for face-to-face contact.
- The CPA did not make required contacts with the child in the placement setting.
- CPS did not document adherence to proper service level and contact standards.

CPS Risk Assessment (PSM 713-11)

- CPS did not complete the risk assessment as required.

Relative Caregiver Home Study (FOM 722-3)

- The CPA did not complete the required Relative Home Study.

New CPS Complaint when Child is in Foster Care (PSM 716-9 and FOM 722-13)

- CPS did not inform or coordinate efforts with licensing agency when investigating foster home.
- Lack of communication / coordination among involved agencies.
- CPS did not conduct an independent investigation of the assigned complaint allegations.

Special Evaluation of Alleged Violations of Licensing rules (Licensing Rules 400.12314 and 400.12316 and FOM 922-2)

- Licensing agency did not conduct a special evaluation of alleged violations of licensing rules.
- Licensing special evaluation was insufficient to determine rule compliance.
- Licensing report did not reflect contact with CPS worker or any collateral contacts.
- Licensing agency did not implement meaningful corrective action plan.

Insufficient Investigation / Verification of Facts (PSM 713-1)

- CPS investigation was not thorough in that it lacked verification and/or follow up of asserted case facts.
- CPS investigative summary did not contain all relevant evidence to support the conclusion.
- CPS did not interview all necessary persons during the investigation.
- CPS did not obtain medical examination and/or include the results of medical examination in the file.
- CPS did not make sufficient collateral contacts to determine safety of the children.
- CPS investigation lacked thorough investigation or resolution of the injuries observed.

CPS Decision to Reject (PSM 712-7 and 713-8)

- CPS rejected a complaint that policy required be assigned for investigation.
- CPS improperly rejected a complaint as “already investigated,” but there was no evidence that CPS had previously investigated the allegation.

Two cases noted findings in regards to the child’s permanency. Specific examples of permanency findings and reviewer recommendations are listed below by category.

Placement (FOM 722-3)

- The child was not provided stability in placement or timely permanency.

Permanency Planning Conferences (L-Letter L-10-025-CW)

- The documented activity report for the permanency planning conference was not contained in the case file.

Twelve cases noted findings in regards to the child’s well-being. Specific examples of well-being findings and reviewer recommendations are listed below by category.

Placement with Siblings / Sibling Visitation (FOM 722-3 and FOM 722-6)

- Policies pertaining to sibling placement and sibling visitation were not followed.
- The CPA did not document a detailed plan for sibling visits and contact.
- Sibling visits did not occur monthly at minimum.

Placement with Relatives (FOM 722-3)

- Insufficient efforts were made to place children with relatives.
- Relatives were not identified or considered for placement.
- The CPA did not take sufficient action to facilitate relative licensure.

Educational Needs (L-Letter L-09-128 and FOM 722-6)

- The child was not provided with educational stability while in care. Child was enrolled in 12 different schools and was two grade levels behind.
- The child was not provided services to address educational and therapeutic needs while under DHS care and supervision.
- Child’s progress in school was not monitored or tracked consistently.

Medical Record Maintenance / Medical Passports (FOM 722-6)

- The child’s pertinent medical information was not documented on the medical passport or foster care ISP.
- The child was not provided services to address medical needs while under DHS care and supervision.
- The CPA did not maintain updated medical documentation as required.

Referral to *Early On* (PSM 714-1)

- CPS did not make the required referral to *Early On* services.
- CPS and the CPA did not ensure timely provision of required services to the child.

Updated Service Plan Content and Completion Requirements (FOM 722-9 and licensing rule 400.12418)

- CPA service plans were not completed in accordance with licensing rules and departmental policy.

Foster Care Case Closing (FOM 722-15 and 722-9C)

- The CPA did not follow foster care case closure process. As a result, social work contacts from the time of the last USP to case closure were not reflected on SWSS or in the case file.

Contact with Treatment and Service Providers (FOM 722-6)

- The CPA did not independently verify that the child's medical needs were consistently met in the foster home.
- Collateral contact to verify the child's progress and well-being were inadequate.

Protecting Intervention (FOM 722-9B and PSM 711-2)

- The CPA missed opportunities for meaningful therapeutic intervention.
- CPS missed opportunities to provide meaningful intervention.
- The CPA did not ensure the child received needed services.

Quality Assurance Assessment

The reviewers' findings primarily focused on non-compliance with existing policies that either impacted or had the potential to impact child safety and well-being. The non-compliances listed above and corresponding recommendations indicate a need for improvement in oversight / monitoring of the foster care case by the DHS foster care worker and supervisor. Untimely reports, lack of required case contacts, and lack of adherence to policy are issues that continue to be cited by reviewers.

Many cases reviewed this period involved medically fragile children whose deaths were unrelated to the intervention provided by DHS. Children born with terminal medical conditions were likely to experience premature death regardless of protective custody or placement status. Similarly, tragic events such as an automobile or shooting accident were unlikely to have been prevented by DHS intervention. Policy non-compliances in these cases are noted, but cannot be assessed as contributing factors.

Implementing recommendations made by the OFA to address safe sleep practices, providing training for foster parents, improving documentation of medical needs/treatments, and ensuring meaningful and timely interventions will likely result in improved quality of care and outcomes for children. Medically fragile and very young children are especially vulnerable. Four of the infant deaths involved suffocation, respiratory failure, asphyxia, and sudden unexplained infant death. Proper training for foster parents and accurate, complete documentation and application of medical treatments are vital to promoting a child's quality of care, overall health and well being. One youth's death was ruled suicide by hanging. In the months and weeks leading up to his death, he displayed significant anxiety and depression. Another child's death was accidental and due to multiple drug intoxication. The youth had a documented history of substance use and delinquent behaviors. Multiple interventions were provided to these youths, but did not prevent their deaths.

Recommendations

At the conclusion of each fatality review, the OFA issues case specific recommendations to the local DHS office and private child placing agency, if applicable. The most prevalent recommendation involved strategies to strengthen agency compliance with existing policies. The QA Unit makes recommendations based on overall trends observed as reports are compiled. The recommendations below involve four different administrative units.

Foster Care Program Office:

- Issue policy clarification regarding documentation requirements for collateral contacts with treatment and service providers (FOM 722-6).
- Ensure that the risk assessments are being completed on the youth, specific needs are being identified, and efforts are made to ensure that services being provided are meeting those specific needs identified.
- Develop requirements for documenting the medical treatment needs of a medically fragile child and developing a specialized case plan.
- Develop policy regarding safe sleep requirements for children 12 months or younger that reflects licensing rule 400.9306 (3).

Child Welfare Contract Compliance Unit:

- Develop requirements for a CPA that is licensed to place special needs children to include specialized training for the foster care workers and foster parents responsible for the specialized care.
- Develop requirements that the Foster PRIDE (Parent Resources for Information, Development, and Education)/Adopt PRIDE training to include infant safe sleep practices as part of the curriculum for foster parents.

Bureau of Children and Adult Licensing:

- Licensing rules should be amended to require all foster parents receive training on infant safe sleep practices in accordance with existing licensing rule 400.9306 (3).

Child Welfare Training Institute:

- Develop training curriculum in conjunction with the new DHS medical director for workers assigned to cases involving medically fragile children.
- Review existing training materials regarding medical documentation to ensure that it addresses the policy and procedures for the specialists.
- Develop continuing education curriculum for specialists and supervisors in regards to documenting medical information.
- Develop continuing education curriculum for CPS, foster care, and licensing workers in regards to CPS complaints involving a foster home.

Follow Up

DHS is committed to improving the quality of service to children and families in the child welfare system. Since issuing the previous fatality report, *Child Fatality Reviews: 4/1/08-3/31/09, Quality Assurance Report*, DHS has taken the following steps to improve practice.

- By November 25, 2009 local offices must assure all foster care, juvenile justice, and adoption case contacts are entered on SWSS-FAJ for the 2009 fiscal year. In addition, effective February 23, 2010, DHS direct workers must enter face to face case contacts on SWSS-FAJ/CPS within 5 calendar days.
- Counseling Services contract standards were issued on November 9, 2009. Timeframes for service delivery, guidelines for monitoring, and consequences for not meeting contract requirements were defined.
- DHS updated its medical passport policy on December 1, 2009 to emphasize mandated requirements. Policy on required immunizations was added with verification and documentation process outlined. Further on March 10, 2010, DHS began to require every initial and yearly medical and dental examination completed back to October 1, 2007 be entered on all currently open cases.
- Effective April 10, 2010, quarterly tracking sheets are now required from each county showing compliance with initial and yearly physical and dental exams, informed consent for all psychotropic medications, and

documentation that the foster care provider is in receipt of a Medicaid card or number within 30 days of placement.

- On January 6, 2010 a new medical and mental health training series was offered to assist child welfare workers and supervisors more effectively identify and meet the medical and mental health needs of children.
- DHS announced that in the summer of 2010 training on child welfare caseworker visitation will be offered to foster care, juvenile justice, CPS and adoption workers and supervisors in DHS and private agency child placing agencies. Training objectives include: recognizing the relationship between visits on child safety, placement stability and permanency; reviewing policy requirements and the use of structured decision making tools for assessing child safety and affecting permanency and well-being; planning visits; and documenting the quality of the visits in services plans and SWSS.

Conclusion

The Michigan Department of Human Services provides protection and care for Michigan's most vulnerable children. Children enter foster care for a variety of reasons and face numerous challenges. Based upon the 19 fatalities reviewed between April 2009 and March 2010, child fatalities were most prevalent among children under three years old who were diagnosed with a medical condition at birth. Three older youths also died this year from medical problems they had since infancy. Three teenagers died this year due to drug intoxication, suicide, and homicide. Teenage males in foster care have unique social, environmental, and mental health concerns. These may be associated with past victimization and other stressors exacerbated by being in foster care. More must be done to respond to the immediate risk factors and long-term treatment needs of these children.

Information gathered from these reviews indicates an ongoing need for improved case management, training, and supervisory oversight. Many of the findings and recommendations involve non-compliances with existing policies and improvements can be made with more vigilant attention to program requirements. The results of this analysis will be shared with the DHS Quality Council and Children's Cabinet and utilized in the CQI process.