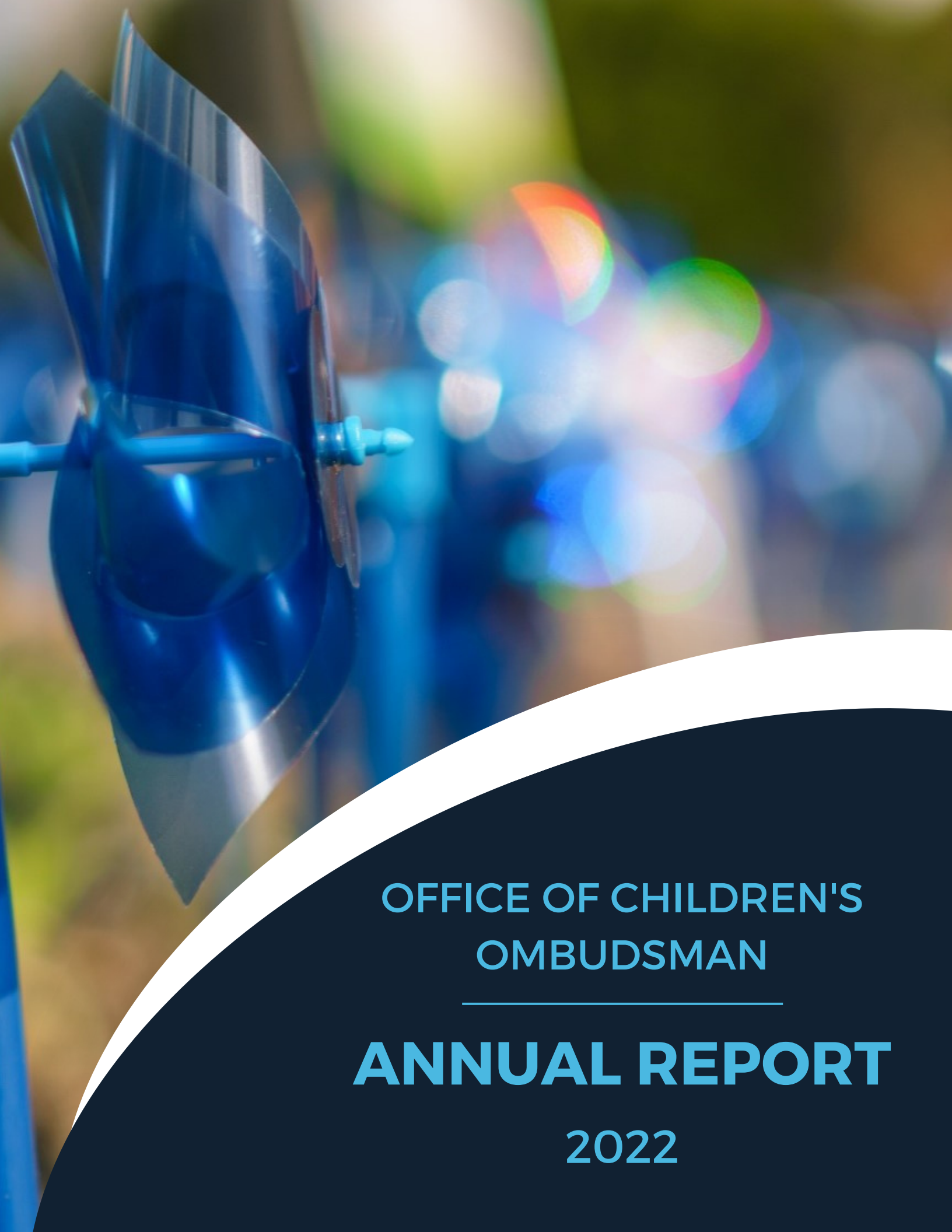

OFFICE OF CHILDREN'S OMBUDSMAN

ANNUAL REPORT

2022

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Message from the Children's Ombudsman

The Office of Children's Ombudsman's mission is to help improve Michigan's child welfare system through awareness, advocacy, public education, review, and recommendation. We accomplish this through independently investigating complaints, advocating for children, and recommending changes to improve law, policy, and practice for the benefit of current and future children involved in the child welfare system.

In accordance with my statutory obligation, I am pleased to submit to the governor, Legislature, and the Michigan Department of Health & Human Services, my annual report detailing the functions and operations of our office for the 2022 calendar year. In 2022, the OCO came in full compliance with a material finding from a previous audit, and we welcomed a new chief investigator to our team. In addition, I was appointed to serve on the Governor's Task Force on Child Abuse and Neglect and chair the subcommittee on training and protocol, where we will focus on updating the statewide child fatality protocol.

It is a privilege to serve as Michigan's Children's Ombudsman. My staff and I are deeply dedicated to the mission of this office. We are especially encouraged by the positive changes made by the department as a result of our recommendations but know that there is much work that lies ahead to strengthen our system to better protect our children. We will continue that work every single day and hope that you'll join us in cultivating positive change.

Sincerely,

Suzanna Shkreli
Children's Ombudsman

VISION

The Office of Children's Ombudsman (OCO) is a type one autonomous agency created to advocate for effective change in policy, procedure, and legislation; to educate the public; and to review the actions of the Michigan Department of Health & Human Services (MDHHS), child placing agencies, and child caring institutions. The OCO is housed under the Michigan Department of Technology, Management & Budget (DTMB).

AUTHORITY

The OCO can investigate administrative actions of child protective services, foster care programs and agencies, adoption services, and some juvenile justice programs.

After an investigation, the OCO may report findings and recommendations to the agency it investigated. The goal of the ombudsman is to influence policy and rule changes for the betterment of all children involved with the child welfare system. The OCO also works informally in child welfare cases to ensure compliance with law.

As the law requires, the ombudsman provides the agency it investigated the opportunity to respond to the findings and recommendations. The responding agency can agree or disagree with the findings and recommendations.

OCO KEY GOALS

- **Conduct independent and impartial investigations.**
- **Make impactful recommendations to change and update statutes, policies, or administrative rules that positively impact the child welfare system.**
- **Promote transparency in the child welfare system.**

WHY CONTACT THE OCO

- **Empowerment through knowledge: If you have general questions about the child welfare system in Michigan, we may be able to assist you in providing insight.**

- **If you believe that your experience with Michigan's child welfare system (child protective services, foster care, adoption, and/or juvenile justice) can highlight an issue, please contact our office or file an online complaint.**

- **The OCO may be able to use your experience to highlight areas where the ombudsman can make recommendations for change to improve the child welfare system.**

Office of Children's Ombudsman
PO BOX 30026
Lansing, MI 48909

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1-800-642-4326
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2022 OFFICE OF AUDITOR GENERAL (OAG) PROJECT

In 2019, the OAG released its findings of a 2018 audit of OCO activities. The OAG found that MDHHS did not send 206 death alerts to the OCO as required. In its finding, the OAG stated that the OCO was not doing enough to independently identify children who died, which would cause an OCO investigation.

In response to the audit's finding, the OCO successfully implemented a corrective action plan (CAP) by creating a system that identifies all children who have death certificates recorded in state vital records. These records are electronically cross-referenced to child welfare data. These batches of data are considered secondary death alerts. Each secondary death alert receives at minimum, a preliminary investigation.

The OAG conducted a follow-up review of the OCO's CAP in May 2022. The review evaluated the CAP to determine if it effectively mitigated the material finding from the 2019 audit. The OCO worked with the OAG through December 2022 to aid them in their research and auditing. The OCO is proud to announce that, after an extensive audit of our CAP, it has fully complied and has mitigated the 2019 material finding. The OCO appreciates the OAG's partnership and dedication to factual findings in its 2022 audit project.

GOVERNOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT

In 2021, OCO Deputy Director Ryan Speidel was asked to serve as a subject matter expert on the task force's training committee. Ryan, and approximately 12 other individuals recognized as subject matter experts, helped develop an 8-part training series on investigating child sexual assaults. This eight-part training series culminated in 2022 and provided experts from around the world who trained upwards of 781 child welfare professionals. Members of professions, such as defense attorneys, protective services specialists, police officers, other states' ombudsmen, prosecuting attorneys, and medical professionals attended the training. The series culminated in a 2-day live training event hosted by the governor's task force in 2022. The event brought all the trainers together on stage to answer questions that attendees provided in advance.

In 2022, the Children's Ombudsman, Suzanna Shkreli was appointed by Gov. Gretchen Whitmer to serve a three-year term on the governor's task force. Shortly after joining the task force, Suzanna was selected to chair the training committee. Suzanna brought together a committee of subject matter experts including child protective services, judges, prosecutors, criminal defense attorneys, law enforcement, medical professionals, and other child welfare experts to begin the work of updating Michigan's child fatality protocol which has not been updated since 2008. Upon completion of the protocol, the training committee in conjunction with the State Court Administrative Office will develop and organize training modules around this protocol in 2024 which will benefit the our child welfare partners statewide and nationally.

UNITED STATES OMBUDSMAN ASSOCIATION (USOA) CONFERENCE

The OCO sent eight staff members to the annual USOA conference in Portsmouth, NH in 2022.

Children's Ombudsman Shkreli and Deputy Director Speidel are active USOA Children and Families Chapter members. Staff who attended the conference were brought up to speed on nationally recognized processes of the ombudsman and received specialized training in diversity, equity, and inclusion, authoring reports of findings and recommendations, how to navigate conflicts with agencies an ombudsman may criticize, interacting with the media, and justifying findings. The OCO was introduced to a new investigation tool by the Edmonton, Canada, ombudsman. This tool, called S.T.A.R., is used by Edmonton's ombudsman to determine whether an investigation should be conducted. S.T.A.R. stands for Significance, Timing, Attention and Recommendation. The OCO modified the S.T.A.R. tool to aid investigators in making case closure recommendations to the OCO administration. OCO staff will implement the S.T.A.R. analysis in 2023.

STAFFING CHANGES

There were several important staff changes at the OCO in 2022. For the first time since its inception in 2021, the Public Education and Intake (PEI) unit was fully staffed. The OCO received funding to hire our third PEI analyst, as well as a technician position that had been vacant since approximately 2006. Our new analyst, Roger Smith, is the PEI unit's lead analyst and is responsible for our secondary death alert reviews, more complex intakes, the organization of our annual report, and a host of other projects. Our new technician, Jessica Carls, ensures members of the public receive a timely response after contacting the OCO and various other tasks related to intake and public education..

The OCO's long-time chief investigator, Tobin Miller, retired from state service. Our newest member, Erin House, took his place and has made a dramatic impact from the start. Erin is responsible for drafting and organizing the ombudsman's findings and recommendations, aiding the deputy director with investigation management and oversite, conducting OCO systemic investigations, and managing a host of other projects. Currently, Erin co-chairs the Governor's Task Force on Child Abuse and Neglect Training and Child Death Protocol Subcommittee with Children's Ombudsman Shkreli. Erin came to the OCO from the State Court Administrative Office Child Welfare Services office. As an attorney, Erin has previously represented parents who were involved in the court system due to child welfare issues.

RETURNING TO THE PHYSICAL OFFICE

Up until May 2022, the OCO was working fully remotely due to the COVID-19 pandemic. After nearly two years of successfully fulfilling our duties while working remotely, the OCO adopted a hybrid work model allowing its staff to work remotely up to 60% per week while maintaining a physical office presence 40% of the week.

With hybrid work, the OCO has taken advantage of its investment in teleconferencing equipment to meet with staff, members of the public, and other state departments. The OCO can hold hybrid meetings with some in attendance virtually and some physically present for the meeting. This has allowed OCO staff to communicate more effectively between Lansing and Detroit offices and attend trainings virtually.

PROCESS OVERVIEW AND 2022 STATISTICS

OCO INTAKE PROCESS

The OCO intake process starts with either an inquiry/complaint from a member of the public or when the OCO receives a child's death alert from MDHHS or vital records. The child death alert system is an automated process in which the OCO receives notifications of a child's death from MDHHS's Statewide Automated Child Welfare Information System (MiSACWIS).

All OCO complaints are initiated in the OCO PEI unit. The PEI unit addresses concerns from the public by providing education and referral information or conducting a preliminary investigation. The PEI unit is staffed with three PEI analysts, a departmental technician/intake coordinator, and the unit manager.

If an inquiry is made to the OCO that does not meet guidelines for investigation, the PEI unit staff may be able to provide information on how an individual can resolve their concern. The PEI unit staff share a wealth of information regarding the complexity of the child welfare system and often assist customers in finding the appropriate department or resource to address a concern.

The PEI analysts conduct preliminary investigations. The analysts review case file information documented in MiSACWIS, conduct interviews, and examine other evidence found or provided.

At the conclusion of the preliminary investigation, the analyst uses the facts and evidence to make a recommendation to the ombudsman. The recommendation is either opening a full investigation into the complaint or death alert or closing the case after the preliminary investigation has been completed.

2022 saw an increase in overall intakes, with the total number at 1,055. The number of inquiries/ complaints and child death alerts increased in 2022, while there was a slight decrease in the number of information referrals. (See statistics page 10 to page 12)

STATISTICS

Figure 1 below shows the year-to-year comparison separated by intake type:

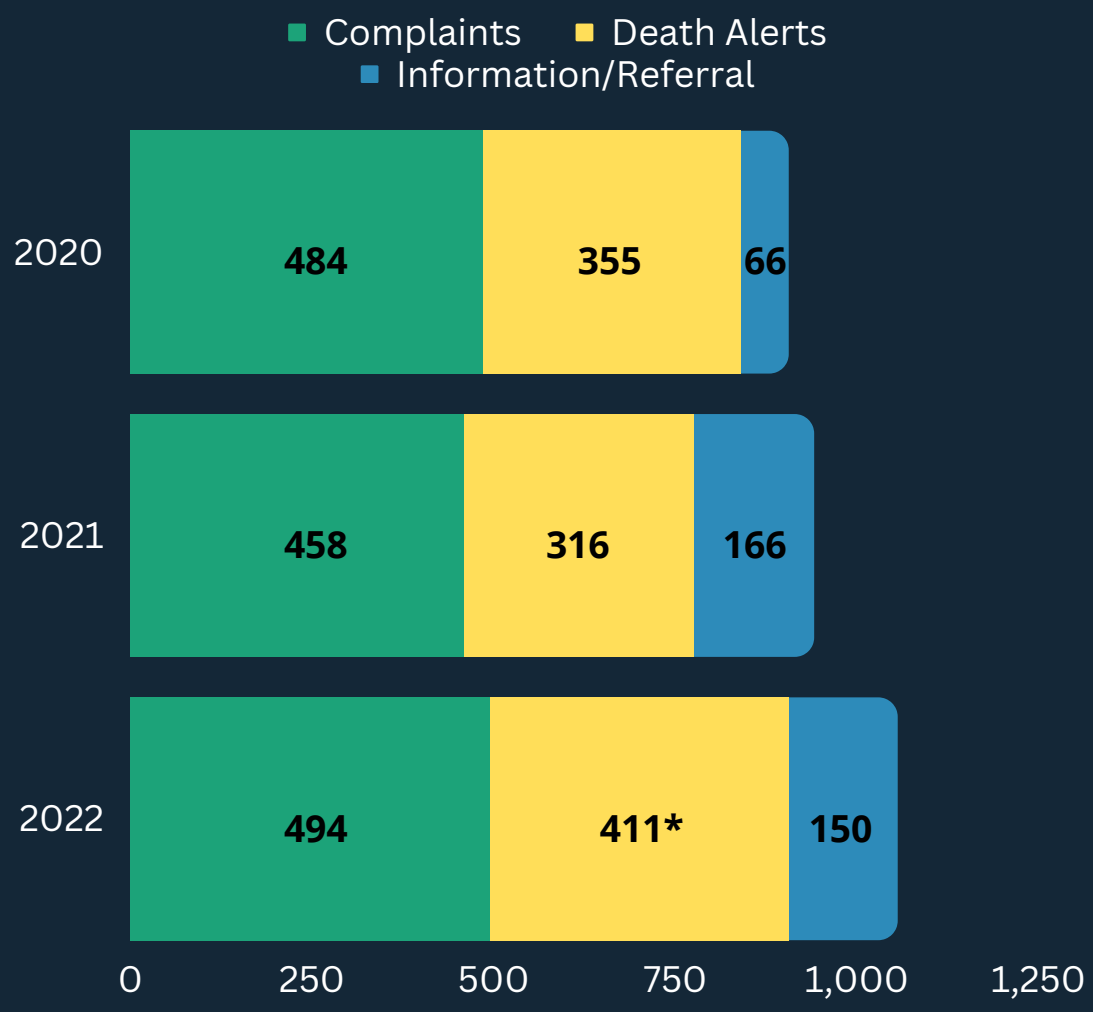
The OCO breaks these intakes into two categories;

- **Child death alerts**
- **Complainant Cases**

All child death alerts receive a preliminary investigation.

Complaints can result in preliminary investigations or can be closed after information or a referral is provided.

Figure 1



*The OCO started receiving secondary death alerts in 2022 for the first time. The 411 death alerts in 2022 contain the results of the secondary death alert system in addition to the primary death alerts.

Primary death alert: 389 **Secondary death alert: 24**

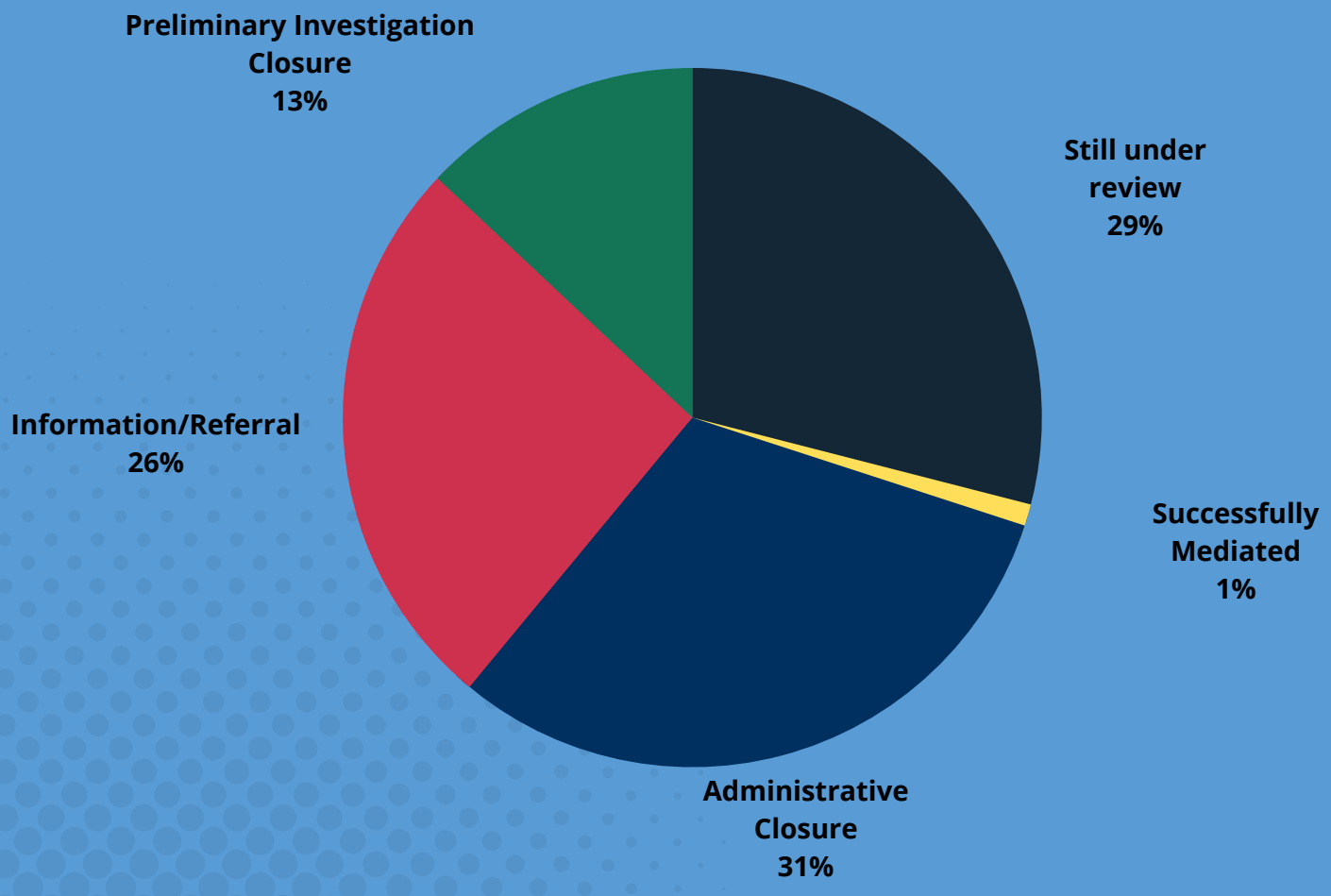
COMPLAINT CASES

Complaints from the public can be made to the OCO by phone, fax, handwritten letter, or through an online complaint system. Each complainant is contacted and interviewed by phone to obtain a detailed understanding of the complainant's concerns.

During the preliminary investigation involving a complainant, the PEI unit analyst will attempt to determine the truth or falsity of the allegations. The PEI unit analyst is first trying to determine if the complaint is based in fact. The analyst is also looking for agency missteps, whether a solution may be mediated with the agency, whether the agency missteps are likely to recur in future cases, and/or if missteps occurred, whether they negatively impacted the child(ren).

Figure 2 shows the disposition of all the preliminary investigations from inquiries/complaints in 2022.

Figure 2



DEATH ALERTS

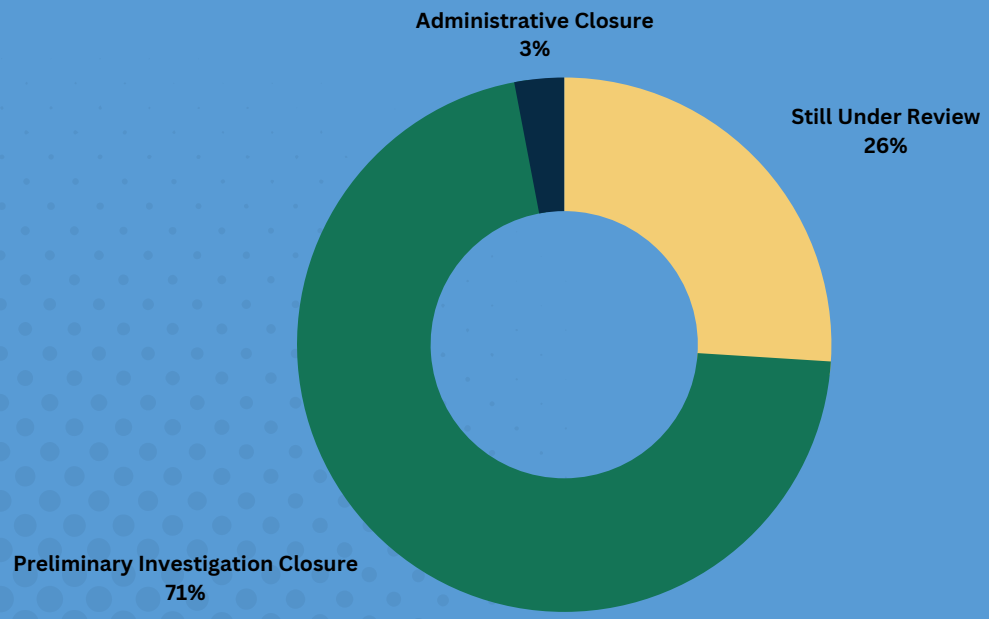
The OCO receives an automated alert whenever CPS Centralized Intake processes a complaint involving a deceased child. The alert is an email that is automatically generated by the MiSACWIS.

The OCO also receives data batches from MDHHS Vital Records. These records are sent to the OCO on a daily basis and contain information on any child under 18 that dies while matching one of several criteria in the Children's Ombudsman Act. The OCO refers to vital record data batches as secondary child death alerts.

The OCO conducts preliminary investigations for all child death alerts. The PEI unit attempts to determine if the child's death involved child abuse or neglect and if the child's family was involved in the child welfare system during the two years preceding the child's death. If child abuse or neglect is present in the death, the PEI unit analyst will review it under the Children's Ombudsman Act and OCO policy and make a recommendation for case closure or a full investigation by the OCO.

Figure 3 shows the disposition of all preliminary investigations stemming from child death alerts in 2022.

Figure 3



PRELIMINARY INVESTIGATION REVIEW

The OCO has several layers of review depending on the facts presented or found during the preliminary investigation. The PEI unit manager and deputy director both review the preliminary investigations, each making their own recommendation to the ombudsman about case closure or a recommendation for a full OCO investigation. In some instances, the ombudsman may ask the chief investigator to review a preliminary investigation and offer a recommendation.

FULL INVESTIGATIONS

Full investigations are conducted by OCO investigators. The OCO investigators are specialist-level employees with expertise in child welfare and conducting administrative investigations. Full investigations are far more detailed than preliminary investigations.

In 2022, OCO investigators conducted 86 full investigations. Thirty-nine of those investigations stemmed from complaints made to the ombudsman, while 47 full investigations resulted from child death alerts. On a case-by-case basis, the assigned OCO investigator may interview MDHHS staff, complainants, police officers, physicians, and other witnesses; obtain and examine evidence, such as documents, police reports, medical records, photographs, court reports and orders, autopsy reports, and medical examiner reports. The 86 full investigations conducted in 2022 included 259 interviews.

Throughout all OCO investigations, the assigned investigator remains alert to emerging threats to child safety. If a child safety issue is observed during an OCO investigation, immediate action is taken to alert MDHHS or local law enforcement to ensure the safety of the child.

OCO investigators are also tasked with attempting to mediate a complaint and advocate for the child or children within the complaint. The OCO investigators have over a century of combined child welfare experience and are willing to share their expertise with those they interact with.

FULL INVESTIGATIONS
(CONTINUED)

Full investigations may result in a formal document known as the report of findings and recommendations. A formal report of findings and recommendations contains factual findings concerning the agency's handling of a case and recommendations to improve the agency's handling of similar cases in the future. The findings and recommendations report is authored by multiple team members and is a true multi-disciplinary approach to problem resolution.

Based on the OCO investigation, the ombudsman may make a formal finding when one or more of the following is present.

- **A matter should be further considered by the department or the child-placing agency.**
- **An administrative act or omission should be modified, canceled, or corrected.**
- **Reasons should be given for an administrative act or omission.**
- **Other action should be taken by the department or the child-placing agency.**

Michigan law requires the OCO to issue a draft report of findings and recommendations to MDHHS prior to any public release. MDHHS has 60 days to respond to the draft report. The MDHHS response must be in writing.

Once the MDHHS response(s) are received, or 60 days have passed, the OCO case can move to case closure. The OCO is required to publish redacted reports of findings and recommendations within 30 days of case closure. These reports are published on the OCO's website.

In 2022, the OCO published three findings and recommendations, which can be found in the published reports section of the OCO website.

SYSTEMIC INVESTIGATIONS

Investigations may uncover issues that impact children and families across the state's entire child welfare system. These are considered systemic investigations and examine the child welfare system as a whole.

These investigations examine how multiple agencies interacted within the system to identify gaps or similar deficiencies. The OCO may use evidence from these investigations to make recommendations to child welfare partners outside of MDHHS. These investigations uncover evidence of similar issues negatively affecting children.

The OCO's focus on recommendations in systemic investigations is to identify solutions to improve the child welfare system. These investigations typically culminate with recommendations in the OCO's annual report. Some of the larger systemic investigations may take several years to complete.

The OCO chief investigator is the lead on all systemic investigations performed at the OCO. In 2022, the office began a review to determine if there is a correlation between substance-positive births and subsequent unsafe-sleep deaths. A substance-positive birth is when a newborn is born with an illegal narcotic or alcohol in their system. The OCO determined this is an issue ripe for systemic review after an increased number of investigations presented similar concerns.

HOW THE OCO HELPS

The Children's Ombudsman Act requires the OCO to ensure the MDHHS complies with applicable laws, policies, and/or administrative rules. This can only be done in real-time during child welfare case reviews. To achieve this goal, the OCO staff builds and maintains a close working relationship with all levels of staff at MDHHS. In addition, OCO analysts and investigators are empowered to provide corrections as soon as they arise rather than waiting until the end of the review. This is particularly important if an analyst or investigator is reviewing a case and sees actions or inactions that appear unsuitable for the children involved. In the OCO's experience, when laws, policies, and rules are followed, they almost always lead to better outcomes for children. The five cases outlined below are just a small sample of the work the OCO does every day.

In case 2022-0337, the OCO recognized that, while the child's death may not have been due to child abuse or neglect, there was a high level of substance abuse presented by both parents.

The purpose of this OCO investigation was to monitor CPS's actions to ensure they were following law and policy when it came to the safety of the surviving siblings. The OCO investigator provided advice on filing a petition, which compelled the parents to comply with requests from CPS. After monitoring CPS actions for almost four months, the OCO observed that the continued actions of MDHHS helped guarantee the ongoing safety of the surviving children for the foreseeable future.

HOW THE OCO HELPS
(CONTINUED)

Case 2022-0317 was opened to determine whether maternal relatives of a child were unlawfully denied visitation while the child was placed in foster care. MDHHS policy requires that children have contact with their families while placed in foster care. The OCO investigator successfully garnered support from the private placing agency to allow the maternal relatives visitation with the children in foster care. The OCO advocacy helped facilitate visits for the child with relatives, per MDHHS policy. After following up on the case, the investigator learned that the agency is considering overnight visits between the children and maternal relatives. The OCO's advocacy was in the best interests of these children.

Case 2022-0662 was opened to determine why relative placement was not considered by the agency after the relatives requested an MDHHS assessment so they could serve as foster parents. When the OCO investigator reviewed the actions of MDHHS and the placing agency, the investigator realized that the relatives had not been properly assessed.

Additionally, the OCO investigator determined that MDHHS and the private agency did not do an appropriate relative search at the inception of the foster care case. With the OCO's guidance, the agencies responsible for the placement of the child assessed both relatives. Lessons learned from the case were relayed to both agencies involved to prevent similar situations from occurring in the future and to educate MDHHS and private agency staff involved.

HOW THE OCO HELPS
(CONTINUED)

Case 2022-0669 focused on the availability of counseling to children in foster care. The children had recently been moved to a new foster home, and the new foster parents did not see the need for counseling at the onset of caring for the children. While reviewing the case, the OCO investigator realized that the new foster parents were unaware of the trauma the children previously endured and their prior behavior. As a result of the foster parents' input and reports, the children involved did not qualify for counseling. The OCO investigator saw that the trauma sustained by the children was extensive. It was the investigator's professional opinion that counseling services were needed. In advocating for the children, the OCO investigator spoke with the foster care case manager and recommended facilitating another assessment for counseling services. The foster case manager agreed, and a new assessment was completed. The second assessment showed that one of the children was, in fact, in need of counseling services for the trauma he had endured. Without the OCO review, the child may not have received the counseling services he desperately needed.

The interventions and interactions highlighted in these cases demonstrate the vital role OCO serves in educating and guiding child welfare professionals to create more positive and safer outcomes for Michigan children and to ensure compliance with the laws, policies, and administrative rules applicable to Michigan's child welfare system.

THE POWER OF PARTNERSHIP

Image courtesy of Children Trust Michigan.

As one of the agencies charged with reviewing child death notifications in cases involving MDHHS, the OCO often sees worst-case scenarios. The OCO also receives complaints about potential violations of law and policy. Due to these responsibilities, the OCO often sees negative aspects of child welfare casework. However, this is not always the case and should not detract from the thousands of cases every year where MDHHS does what is needed for children and families in Michigan. The following case illustrates the work MDHHS is carrying out on behalf of Michigan's children. This is one of many great examples of what good can be accomplished when our child welfare partners work together to keep children safe.

Case 2022-0045 was initiated as a public complaint. The complainant's main concern was that MDHHS was not doing enough to ensure that the mother was properly caring for her son's diabetes. Due to extreme hyperglycemia (high blood sugar), the child was hospitalized for cardiac arrest attributed to diabetic ketoacidosis. Fortunately, the child survived. However, due to his young age, the mother's care of her child's diabetes was investigated by CPS, and an ongoing services case was opened. The ongoing CPS specialist did an outstanding job of interacting with all medical professionals and family members to ensure the child was well cared for by his mother before the CPS ongoing services case was closed. The OCO investigator stated that his investigation revealed that the county CPS office responded in accordance with law and policy as it pertained to the child's diabetes.

INTRODUCTION TO ANNUAL RECOMMENDATIONS

The OCO is uniquely positioned to view the actions of MDHHS and their respective child welfare partners during an investigation, allowing the OCO the ability to identify where law, policy, or procedure could be strengthened to positively impact the child welfare system. The ombudsman is required to submit to the governor, the director of MDHHS, and the legislature an annual report on the ombudsman's conduct, including any recommendations regarding the need for legislation or for change in rules or policies.

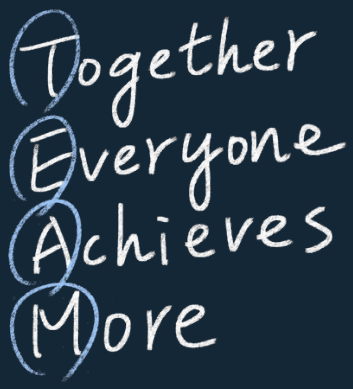
Through the OCO investigation and review process, the OCO has observed a considerable lack of communication and coordination within multidisciplinary teams (MDT) from around the state. In July 2022, the OCO began monitoring these instances in its case management system. Anecdotally, the breakdown of the MDT takes many forms, and after reviewing hundreds of cases each year, it is clear that when the MDT is effective, there are better results for children and families in Michigan. The annual report recommendations center around strengthening Michigan's MDTs.

What is the MDT?

Child abuse and neglect investigations are often complex and are always high stakes given the vulnerability of children. Recognizing these challenges, the MDT was created to increase communication and coordination of partners within child welfare, law enforcement, medical communities, and other child welfare partners to enhance and improve investigations and responses for children and families.

The Michigan Child Protection Law, Public Act 238 of 1975, codified the need for coordination during child abuse and neglect investigations. When child abuse and neglect occurs and is properly detected and reported, there is a domino effect of actions that child welfare partners must take in order to adequately investigate.

Under Michigan law, MCL 722.628(6), each county prosecuting attorney is to serve as the lead of the MDT, alongside an MDHHS designee. The law also provides that other child welfare partners may join the MDT on a case-by-case basis including, but not limited to, law enforcement officials, child advocacy center (CAC) personnel, and medical personnel. The MDT is also charged with adopting and implementing standard child abuse and neglect investigation protocols. These protocols streamline and coordinate efforts around interviews of victims of abuse or neglect, alleged suspects or witnesses, arranging medical examinations of the victim, and the timely collection and preservation of evidence.



ANNUAL RECOMMENDATIONS

The need for MDT coordination cannot be emphasized enough, especially in cases of physical and sexual abuse. In recent months have seen heartbreaking child fatalities where there was previous CPS involvement with the family. In those instances, the OCO focuses on the actions of the department leading up to the child's death and asks the critical question of what went wrong and how our recommendations to change law, policy, or practice can make all the difference for the next child. Every child who dies due to child abuse and/or neglect is one too many. Individuals and entities responsible for our children's welfare must do more to enhance communication and coordination in their child welfare investigations and better equip our investigators and medical professionals who come in contact with children, with the training necessary to detect injuries attributable to child abuse.

OCO's review of child fatalities helped inform the following recommendations to strengthen the work of the MDT across our state in child abuse and neglect investigations and better protect Michigan children.

1. OCO investigations reveal the unique application of the MDT process among Michigan counties. MDTs achieve positive results when actively involved in case-by-case decision-making to facilitate and support the work of its members, coordinate, share information, and provide oversight to increase awareness of, and compliance with, the law and best practices outlined in the child abuse and neglect protocol. MDT discussions benefit from a collective understanding of the roles and responsibilities of each child welfare partner when conducting investigations. The OCO recommends the following:
   - County prosecuting attorneys, or their designee, conduct regular MDT meetings to increase communication among members.
   - Each MDT require members of law enforcement, medical personnel, mental health personnel, and Child Advocacy Centers.
   - The Michigan Legislature fund and MDHHS hire liaisons to the MDT for each county. Liaison duties could include, but are not limited to, serving as a bridge between MDT members, assisting the MDT leader in facilitating monthly MDT case review meetings, collaboration with MDHHS central office on policy changes, and active participation in the investigation as an advisor to the MDT when the child presents with abnormal or suspicious bruising or injury, severe injury, sexual assault, or death.

ANNUAL REPORT RECOMMENDATIONS

2. The OCO recommends the Michigan Legislature amend Child Protection Law, MCL 722.628(3), to clarify that law enforcement lead the investigation in the following:
   - Child abuse or neglect is the suspected cause of a child's death.
   - The child is the victim of suspected sexual abuse or sexual exploitation.
   - Child abuse or child neglect resulting in serious physical harm to the child.
   - Law enforcement intervention is necessary for the protection of the child, a department employee, or another person involved in the investigation.
   - The alleged perpetrator of the child's injury is not a person responsible for the child's health or welfare.
   - The child has been exposed to or had contact with methamphetamine production.

3. The OCO recommends the Michigan Legislature amend Child Protection Law, MCL 722.628(6), to require that, as the lead criminal investigators, law enforcement be added to the MDT along with the prosecuting attorney and the department.

4. OCO investigations show that medical assessments of children in child abuse and neglect investigations are often the determining factor in the decision to substantiate or not substantiate child abuse and neglect. OCO investigations demonstrate the absolute necessity that all individuals in the medical field who may encounter children receive ongoing training to better detect injuries attributable to child abuse and neglect.

   The OCO recommends the Department of Licensing and Regulatory Affairs (LARA) collaborate with the Michigan Boards of Medicine, Osteopathic Medicine and Surgery, and Nursing to promulgate rules to require continuing education for healthcare licensees on detection of injuries attributable to child abuse as a requirement of licensure.
   - LARA shares an annual message to all healthcare licensees providing training resources and information regarding the detection of child abuse injuries.

ANNUAL REPORT RECOMMENDATIONS

5 The OCO recommends that MDHHS require local county directors to:

- Work with their MDT to develop a working list of medical practitioners who are accessible to the community and who have specialized training in detecting child abuse and neglect, examining, and interviewing children in accordance with PSM 713-04.
- Maintain and update the list of statewide and local child abuse medical experts. Ensure CPS caseworkers and supervisors are aware of and have access to the updated list.
- Train CPS caseworkers and supervisors on the critical importance of using the child abuse medical expert list when scheduling initial and second opinion medical examinations.
- Instruct CPS caseworkers on which medical practitioners, in their respective communities, have specialized training in detecting child abuse and neglect.
    - Separately identify medical providers who are available to conduct medical assessments after hours within their respective communities.
- Invite the medical practitioners from the child abuse and neglect list to MDT meetings and case reviews.

6 The OCO recommends that DHHS require local county directors to:

- Develop processes in coordination with the local MDT to include detailed direction on how to request and access a second medical opinion.
- Develop a county-specific protocol on how to obtain a second medical opinion in accordance with PSM 713-04.
- Train CPS caseworkers on the county-specific protocols on how to obtain a second medical opinion in accordance with PSM 713-04.
- Stress the importance of obtaining a second medical opinion in a timely manner, so a child's injuries can be viewed by the medical practitioner before healing.

ANNUAL REPORT RECOMMENDATIONS

7. Child welfare investigations require that law enforcement and CPS caseworkers be proficient in detecting abuse and neglect. Physical abuse may be overlooked or misdiagnosed, especially in cases involving children under the age of 4 due to their vulnerable characteristics. Training enhancements to better equip child welfare investigators are critically needed to best protect Michigan children.
   - The OCO recommends MDHHS amend SRM-103 to mandate the annual in-service training, including objectives on the detection of injuries attributable to child abuse.
   - Incorporate TEN-4-FACESp in MDHHS' training.
     - TEN-4-FACESp stands for bruising to the torso, ears, neck, frenulum, angle of the jaw, cheeks, eyelids or subconjunctivae, “4” represents infants 4 months and younger with any bruise, anywhere, and “p” represents the presence of patterned bruising.
   - MDHHS is encouraged to make this training available to all law enforcement agencies in the state. This allows MDHHS and law enforcement, the two crucial investigative entities of the MDT, the opportunity to train together.

8. Currently, when MDHHS is required to notify law enforcement about child abuse and neglect, a system called the Law Enforcement Notification (LEN) is used. The LEN consists of a faxed piece of paper without acknowledgment of receipt. OCO investigations found that this system is ineffective and antiquated.
   - The OCO recommends that MDHHS restructure its LEN system, utilizing currently available technology for sending the LEN, which requires acknowledgment of receipt by the receiving law enforcement agency within 24 hours or an otherwise agreed upon and specified timeframe.

To read the MDHHS and LARA responses to the annual report recommendations, please refer to addendum A

Recommendations to the Legislature

In 2022, the OCO made recommendations to the Michigan Legislature. Those recommendations emerged from investigations conducted by the OCO (2021-0362 and 2022-0044) and were introduced during the last legislative session (House Bills 6076 and 6077), but did not become law. The OCO urges the Legislature to reconsider the following recommendations to strengthen the law to better protect Michigan children:

1. The OCO recommends the Legislature amend the Foster Care and Adoption Services Act, MCL 722.954a, to require a court to determine within 90 days of a child's removal from parental custody whether the supervising agency made diligent and timely efforts to identify, locate, notify, and consult with relatives interested in placement of or contact with a relative child.

2. The OCO recommends that the Legislature amend the Child Protection Law, MCL 722.629, so that it requires all mandated reporters receive training in child abuse and neglect detection and mandated reporting obligations on a regularly reoccurring basis as determined by the Legislature.

3. The OCO recommends that the Michigan Legislature amend the Mental Health Code, MCL 330.1748a, so pertinent mental health records are turned over to CPS within 7 calendar days of the request for such records. Currently, the Michigan Mental Health Code, MCL 330.1748a, states that mental health providers shall release pertinent mental health records to CPS workers involved in an investigation within 14 days after receipt of the request for such records. Given that these records are sometimes voluminous and the standard of promptness for completing a CPS investigation is 30 calendar days, a shorter window for mental health providers to comply with this requirement would allow more time for CPS case workers to review pertinent records and take action necessary in response to them.

OCO COMMITTEE PARTICIPATION

In 2022, the OCO had 13 staff members. OCO staff have professional experience in the child welfare system, the legal system, and law enforcement.

SUZANNA SHKRELI
Children's Ombudsman

ERIN HOUSE
Chief Investigator

DARSHELLA PIERCE
Senior Executive Management Asst.

RYAN SPEIDEL
Deputy Director

MICHELLE BRANDEL
Investigator

SCOTT CLEMENTS
Investigator

PAULA CUNNINGHAM
Investigator

TIFFANY JACKSON
Investigator

CHRISTOPHER KILMER
Investigator

KENYATTA LEWIS
PEI Unit Manager

ROGER SMITH
Lead Analyst

REBECCA TAYLOR
Intake Analyst

JESSICA CARLS
Intake Technician

OCO COMMITTEE PARTICIPATION

The OCO staff participates in several different committees surrounding the child welfare system.

Gov. Whitmer appointed Children's Ombudsman Suzanna Shkreli to the Governor's Task Force on Child Abuse and Neglect (GTFCAN). The GTFCAN is a multidisciplinary task force and consists of members with knowledge and experience relating to the criminal justice system and issues of child physical abuse, child neglect, child sexual abuse and exploitation, and child maltreatment-related fatalities. GTFCAN makes policy and training recommendations, reviews and evaluates state investigative, administrative, and civil and criminal judicial handling of cases of child abuse and neglect, as well as cases involving a potential combination of jurisdictions, such as intrastate, interstate, federal-state, and state- tribal. Children's Ombudsman Shkreli serves as the chair of the Training and Child Death Protocol Subcommittee, where she is helping lead the development of a statewide protocol on child fatality investigations.

Deputy Director Ryan Speidel sat on the MDHHS Pre-Service Steering Committee and concluded his time on the GTFCAN training subcommittee. This subcommittee's work culminated in 2022 with the creation of an eight-part virtual training on child sexual assault investigations. This training was attended by hundreds of professionals who are involved in child welfare cases as investigators, attorneys, and medical professionals. Child sexual assault training was viewed by professionals from all over North America.

Children's Ombudsman Shkreli and Deputy Director Speidel both serve on the Foster Care Board advisory committee and represent Michigan as voting members on USOA's Children and Families Chapter. Deputy Director Speidel also serves on the USOA's Diversity, Equity, and Inclusion committee.

OCO COMMITTEE PARTICIPATION

Chief Investigator Erin House serves as the co-chair of the GTFCAN Subcommittee on Training and Child Death Protocol. She also participates in the Court Improvement Program Tribal Court Relations Committee (TCR).

The Michigan Supreme Court's Court Improvement Program formed the Tribal Court Relations Committee to educate Michigan judges about the federal Indian Child Welfare Act of 1978. The TCR committee meets quarterly. Recent projects include a review of the anticipated Juvenile Court Data Dashboard – Tribal Affiliation View, upcoming trainings, discussions on the placement shortage crisis in Michigan, review of foster parent appeals under MCL 712A.13b, and discussions surrounding Brackeen v. Bernhardt. The committee consists of members from MDHHS, the Michigan State Supreme Court, attorneys, judges, federally recognized tribes, and child welfare professionals.

PEI Unit Manager Kenyatta Lewis is the OCO's equity inclusion officer. Kenyatta serves on several diversity equity and inclusion teams to ensure that OCO staff participate and benefit from statewide diversity trainings and department-centered equity and inclusion initiatives.

Investigator Michelle Brandel participates in the Infant Safe Sleep Action Committee. In 2022, this committee continued to work on ways to increase public education and awareness for infant safe sleep. The committee planned a virtual 5k Your Way for individuals across the entire state to assist in increasing safe sleep awareness. The event took place in October 2022 during Infant Safe Sleep Awareness Month. The first year brought 120 participants across 39 of the 83 counties in Michigan. The committee plans for this to be an annual event with goals to increase participation and awareness each year. The committee also began brainstorming ways to increase hospital certification on infant safe sleep. The goal of the Infant Safe Sleep Action Committee is to continue to increase public awareness of safe sleep practices in an effort to reduce sleep-related deaths in Michigan infants.

OCO COMMITTEE PARTICIPATION

Investigator Scott Clements participates on the Michigan Child Death State Advisory Team. The team was established to identify and make recommendations on policy and statutory changes pertaining to child fatalities and to guide statewide prevention, education, and training efforts. The team also provides support to local child death review teams, recommends improvements in protocols and procedures for the Michigan Child Death Review Program, and reviews Michigan's child mortality data, as well as local child death review team findings and recommendations, to identify causes, risk factors, and trends in child deaths. In his role as an advisor to the team, Scott provides feedback on policy and statutory changes and offers ideas for annual recommendations. The annual recommendations are presented to the governor and Legislature.

Investigator Paula Cunningham participates in the Citizen's Review Panel (CRP) for child fatalities. The panel reviews cases of child deaths where the family had previous interaction with the child protection system. Michigan's process of in-depth case review with a multidisciplinary team of experts has proven an effective way to gain insight into the state's child protection system and to make meaningful, data-driven recommendations. The panel is made up of volunteer experts representing law enforcement, child welfare, medical examiners, hospitals, the courts, and other children's advocates. The goal is to use the information found through the reviews to improve the child protection system and prevent future child fatalities. Once a year, CRP compiles their findings and recommendations in a report that is presented to MDHHS for systemic change to MDHHS, the court, hospitals, and law enforcement, with the goal of providing additional protection and safety to prevent other child deaths.

Investigator Christopher Kilmer participates in the Child Welfare Pre-Service Institute Redesign. The committee meets as needed and is steering the implementation of the Child Welfare Pre-Service Institute Redesign recommendations that were developed two years ago.

OCO COMMITTEE PARTICIPATION

Analyst Rebecca Taylor participates on the Adoption Oversight Committee (AOC). The AOC is comprised of representatives from MDHHS central and field offices, adoption contractors, the court, adoptive families, the Foster Care Review Board, and the Office of Children's Ombudsman. The committee's purpose is to examine adoption services in Michigan and make recommendations for improvement; to develop action plans to increase the number of child welfare adoptions and the recruitment of adoptive homes; to provide MDHHS with a long-term work group that represents a cross-section of partners in the adoption arena; act as ambassadors to the larger field, educating colleagues regarding system changes and obtaining input on areas of need. The work of the AOC has been instrumental in the review of pre-adoption training requirements; research and presentation of national post-adoption models; and making recommendations on adoption and adoption subsidy policy and form changes.

MDHHS UPDATE ON THE OCO'S RECOMMENDATIONS

The OCO sent a letter to MDHHS requesting an update regarding the recommendations the OCO made in 2022.

The OCO letter requesting updates and the MDHHS February 2023 letter responding to those update requests can be found in addendum B.

OCO

Office of Children's Ombudsman

CONTACT US

(517) 241-0400

Michigan.gov/OCO

111 S. Capitol Ave., Fifth Floor,
Lansing, MI 48933

Addendum A

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

June 5, 2023

Ryan Speidel, Director
Office of Children's Ombudsman
111 S. Capital Ave
5th Floor, OCO Suite
Lansing, MI 48933

Dear Mr. Speidel:

The following is the Michigan Department of Health and Human Services (MDHHS) response to the 2021-2022 Office of Children's Ombudsman (OCO) Annual Report Recommendations.

Annual Recommendation

1. OCO investigations reveal the unique application of the MDT process among Michigan counties. MDTs achieve positive results when actively involved in case-by-case decision-making to facilitate and support the work of its members, coordinate, share information, and provide oversight to increase awareness of, and compliance with, the law and best practices outlined in the child abuse and neglect protocol.[1] MDT discussions benefit from a collective understanding of the roles and responsibilities of each child welfare partner when conducting investigations. The OCO recommends that;

    - County prosecuting attorneys, or their designee, conduct regular MDT meetings to increase communication among members.
    - Each MDT require members of law enforcement, medical personnel, mental health personnel, and Child Advocacy Centers.
    - The OCO recommends the Michigan Legislature fund and DHHS hire liaisons to the MDT for each county. Liaison duties could include but are not limited to, serving as a bridge between MDT members, assisting the MDT leader in facilitating monthly MDT case review meetings, collaboration with DHHS central office on policy changes, and active participation in the investigation as an advisor to the MDT when the child presents with abnormal or suspicious bruising or injury, severe injury, sexual assault or death.

[1] DHS Pub 794, A Model Child Abuse Protocol (michigan.gov)

MDHHS Response to Recommendation 1: Agree. MDHHS has been supportive of MDTs (Multidisciplinary Teams) and believes this type of collaboration makes a difference when it comes to child safety.

2. The OCO recommends the Michigan Legislature amend Child Protection Law, MCL 722.628(3) to clarify that law enforcement leads the investigation in the following:

    - Child abuse or neglect is the suspected cause of a child's death;
    - The child is the victim of suspected sexual abuse or sexual exploitation;
    - Child abuse or child neglect resulting in serious physical harm to the child;
    - Law enforcement intervention is necessary for the protection of the child, a department employee, or another person involved in the investigation;
    - The alleged perpetrator of the child's injury is not a person responsible for the child's health or welfare;
    - The child has been exposed to or had contact with methamphetamine production.

    MDHHS Response to Recommendation 2: Law enforcement should not lead the CPS investigation. Child Protection Law should only require coordination between law enforcement's investigation and the assigned CPS investigator. Law enforcement and CPS have different requirements related to ensuring child safety and evidentiary standards; therefore, placing law enforcement as the lead could result in missed or delayed Child Protection Law and policy requirements.

3. The OCO recommends the Michigan Legislature amend Child Protection Law, MCL 722.628(6) to require that as the lead criminal investigators, law enforcement be added to the MDT along with the prosecuting attorney and the department.

    MDHHS Response to Recommendation 3: Local law enforcement are a part of MDTs. Local law enforcement agencies report to the local county prosecutors who serve as their lead and represent them at MDT meetings.

4. OCO investigations show that medical assessments of children in child abuse and neglect investigations are oftentimes the determining factor in the decision to substantiate or not substantiate child abuse and neglect. OCO investigations demonstrate the absolute necessity that all individuals in the medical field, who may encounter children, receive ongoing training to better detect injuries attributable to child abuse and neglect.

- The Department of Licensing and Regulatory Affairs (LARA) collaborate with the Michigan Boards of Medicine, Osteopathic Medicine and Surgery, and Nursing to promulgate rules to require continuing education for healthcare licensees on detection of injuries attributable to child abuse as a requirement of licensure.
- LARA share an annual message to all healthcare licensees providing training resources and information regarding the detection of child abuse injuries.

MDHHS Response to Recommendation 4: MDHHS agrees training provided through LARA to medical professionals would benefit and help enhance investigations involving child abuse and neglect.

5. The OCO recommends that DHHS require local county directors to:
   - Work with their MDT to develop a working list of medical practitioners who are accessible to the community, and who have specialized training in detecting child abuse and neglect, examining, and interviewing children in accordance with PSM 713-04.
   - Maintain and update the list of statewide and local child abuse medical experts. Ensure CPS caseworkers and supervisors are aware of and have access to the updated list.
   - Train CPS caseworkers and supervisors on the critical importance of using the child abuse medical expert list when scheduling initial and second opinion medical examinations.
   - Instruct CPS caseworkers on what medical practitioners, in their respective communities, have specialized training in detecting child abuse and neglect.
     - Separately identify medical providers who are available to conduct medical assessments after hours within their respective communities.
   - Invite the medical practitioners from the child abuse and neglect list to MDT meetings and case reviews.

MDHHS Response to Recommendation 5: MDHHS agrees with regional directors collaborating to determine what actions local county directors may take to address these opportunities.

6. The OCO recommends that DHHS require local county directors to:
   - Develop processes in coordination with the local MDT to include detailed direction on how to request and access a second medical opinion.
   - Develop a county specific protocol on how to obtain a second medical opinion in accordance with PSM 713-04.
   - Train CPS caseworkers on the county specific protocols on how to obtain a second medical opinion in accordance with PSM 713-04.

- Stress the importance of obtaining a second medical opinion in a timely manner so the injuries can be viewed by the medical practitioner before healing.

MDHHS Response to Recommendation 6: MDHHS agrees with regional directors collaborating to determine what actions local county directors may take to address these opportunities.

7. Child welfare investigations require that law enforcement and CPS caseworkers be proficient in detecting abuse and neglect. Physical abuse may be overlooked or misdiagnosed especially in cases involving children under the age of 4 due to their vulnerable characteristics. Training enhancements to better equip our investigators is critically needed to best protect Michigan's children.
   - The OCO recommends SRM-103 be amended to mandate the annual in-service training include objectives on the detection of injuries attributable to child abuse.
   - MDHHS is encouraged to make this training available to all law enforcement agencies in the state. This allows MDHHS and law enforcement, the two crucial investigative entities of the MDT, the opportunity to train together.

   MDHHS Response to Recommendation 7: MDHHS agrees to explore a mandate for annual in-service training to include objectives on the detection of injuries attributable to child abuse.

8. Currently, when MDHHS is required to notify law enforcement about child abuse and neglect, a system called the Law Enforcement Notification (LEN) is used. The LEN consists of a faxed piece of paper without acknowledgement of receipt of the LEN. Through the course of OCO investigations, we have found this system is ineffective and antiquated. The OCO recommends that DHHS restructure their LEN system, utilizing current available technology for sending the LEN, which requires acknowledgment of receipt by the receiving law enforcement agency within 24 hours or an otherwise agreed upon and specified timeframe.

   MDHHS Response to Recommendation 8: MDHHS will explore a technical solution during the development of the new Comprehensive Child Welfare Information System (CCWIS) to improve MDHHS' LEN process.

Recommendations to the Legislature

In 2022, the OCO made recommendations to the Michigan Legislature. Those recommendations emerged from investigations conducted by the OCO (2021-0362 and 2022-0044) and were introduced during the last legislative session, but did not become law (house bills 6076'22 and 6077'22). The OCO urges the legislature to reconsider the following recommendations to strengthen law to better protect Michigan children:

1. The OCO recommends the Michigan Legislature amend the Foster Care and Adoption Services Act, MCL 722.954a, to require a court to determine within 90 days of a child's removal from parental custody whether the supervising agency made diligent and timely efforts to identify, locate, notify, and consult with relatives interested in placement of or contact with a relative child.

   MDHHS has no additional comments for Recommendation 1.

2. The OCO recommends that the Michigan Legislature amend the Child Protection Law, MCL 722.629, so that it requires all mandated reporters receive training in child abuse and neglect detection and mandated reporting obligations on a regularly reoccurring basis as determined by the legislature.

   MDHHS has no additional comments for Recommendation 2.

3. The OCO recommends that the Michigan Legislature amend the Mental Health Code, MCL 330.1748a, so pertinent mental health records are turned over to CPS within 7 calendar days of the request for such records. Currently, the Michigan Mental Health Code, MCL 330.1748a. states that mental health providers shall release pertinent mental health records to CPS workers involved in an investigation within 14 days after receipt of the request for such records. Given that these records are sometimes voluminous and the standard of promptness for completing a CPS investigation is 30 calendar days, a shorter window for mental health providers to comply with this requirement would allow more time for CPS case workers to review pertinent records and take whatever action necessary in response to them

   MDHHS has no additional comments for Recommendation 3.

Thank you for the opportunity to respond to these Annual Report Recommendations. If you have questions or concerns, please feel free to contact me.

Sincerely,

Demetrius Starling, Senior Deputy Director
Children's Services Administration

This OCO investigation shows that medical assessments of children in child abuse and neglect investigations are oftentimes the determining factor in the decision to substantiate or not substantiate child abuse and neglect. The facts presented in this case demonstrate the absolute necessity that all individuals in the medical field, who may encounter children in their practice receive ongoing training in order to better detect injuries attributable to child abuse and neglect. The OCO recommends that:

a. The Department of Licensing and Regulatory Affairs (LARA) collaborate with the Michigan Boards of Medicine, Osteopathic Medicine and Surgery, and Nursing to promulgate rules to require continuing education for healthcare licensees on detection of injuries attributable to child abuse as a requirement of licensure.
b. LARA share an annual message to all healthcare licensees providing training resources and information regarding the detection of child abuse injuries.

LARA Response to Recommendation:

a. The Department of Licensing and Regulatory Affairs (LARA) welcomes the opportunity to share information provided by the OCO with the Michigan Boards of Medicine, Osteopathic Medicine and Surgery, and Nursing regarding continuing education on detection of injuries attributable to child abuse. LARA encourages the OCO staff to participate in the rule promulgation process and attend relevant board meetings to share information directly. Board meetings, including rules subcommittee meetings, are open to the public.
b. LARA welcomes the opportunity to share a message with healthcare licensees regarding the detection of child abuse injuries on behalf of and crafted by the OCO.

Addendum B

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

OFFICE OF CHILDREN'S OMBUDSMAN
LANSING

SUZANNA SHKRELI
DIRECTOR

December 21, 2022

Seth Persky
Office of the Family Advocate
Department of Health and Human Services
Grand Tower, 15th Floor
Lansing, MI 48933

Mr. Persky,

Pursuant to MCL 722.930(7), the Office of Children's Ombudsman (OCO) is required to issue an Annual Report on the OCO's conduct, including reports and recommendations regarding the need for legislation or for changes to rules or policies.

In October 2020, changes to the Children's Ombudsman Act now require the OCO to publish our findings and recommendations with the department's responses. The OCO's 2022 Annual Report will include a section on the year's previous recommendations, the Michigan Department of Health and Human Services' (MDHHS) responses to our recommendations, and information on action the department has taken since the reports were published.

Additionally, you can find each of our published reports which includes MDHHS' complete responses at https://www.michigan.gov/oco under the "Published Reports" tab. Below you will see relevant excerpts of our recommendations and the department's responses. Under each recommendation and response, are questions about developments since the publication of these reports.

It is crucial for the governor, legislature, and general public to see what changes MDHHS has made to improve the child welfare system.

Sincerely,

Suzanna Shkreli
Children's Ombudsman

Cc: Demetrius Starling, Director, Children's Services Administration

Please provide written responses to these questions by close of business on Wednesday, February 22, 2023.

1. On January 11, 2022, the OCO published a findings and recommendation report, Case No. 2020-0044.

In this case, the OCO recommended:

> The MDHHS Children's Services Administration develop and implement a new training to be offered to all CPS staff and mental health workers statewide. This training should help ensure compliance with MCL 330.1748a, MCL 333.2640, and MCL 333.16281 regarding the sharing of clients' mental health records during an investigation of suspected child abuse or neglect, even without the client's consent. This training should focus on when these laws and policies are applicable, how to utilize and comply with their requirements, and what to do if CPS experiences resistance from mental health care providers.

MDHHS response:

> Though MDHHS does not have the capacity or mechanism to train all mental health professionals statewide, it does agree that providing information regarding the legal obligation of sharing mental health records during a CPS investigation is vital to assessing child safety. As such, the Child Welfare Medical and Behavioral Health (CWMBH) division within the Children's Services Agency (CSA) will develop a new webpage on the public MDHHS website which will include information on policy and procedure regarding the sharing of mental health records during a CPS investigation. CPS staff, mental health providers, and anyone in the public that has questions about the sharing of mental health information will be able to access the webpage. Additionally, CWMBH will work with the Behavioral Health and Developmental Disabilities Administration to ensure the webpage and information is shared with local community mental health partners.

What updates can you share about the development of a new webpage on the public MDHHS website including information on policy and procedure regarding mental health records during a CPS investigation? Has the webpage and information been shared with local community mental health partners as indicated?

In this case, the OCO also recommended:

> The MDHHS incorporate into their training of new and ongoing child welfare staff a portion dedicated to mental health and illness of clients. This aspect of training should focus on understanding the types, causes, and symptoms of mental illness, what treatment modalities are available to care for such individuals, and the impact a caregiver's mental illness can have on the child(ren) in their care. In doing so, an

emphasis should be placed on the assessment and response to a client's propensity to harm or neglect themselves or others, particularly the child(ren) the client is caring for. This training should occur for all new child welfare staff and be repeated on a regular basis, so workers are adequately prepared to assess and react to such situations should they arise in a case.

MDHHS response:

MDHHS agrees sound assessment of mental health factors is critical to assessing child safety and is currently working with multiple stakeholders to enhance its mental health training for child welfare staff. Current training for newly hired child welfare staff does include a mental health training module and the module can be updated to include policy and procedure enhancements as identified by Children's Services Agency (CSA) and can be offered annually to staff. MDHHS, along with a consortium of 16 Michigan universities, is updating the core competencies college students must learn to earn a child welfare certificate. The updated competencies include recognizing and assessing developmental delay and disability, understanding the characteristics, behavioral indicators, and preferred treatments for mood disorders, trauma and post-traumatic stress disorder, emotional disturbances, as well as how parental mental illness can affect parenting, and when/how to make a referral for additional mental health assessment. Additionally, CSA in partnership with the Office of Workforce Development and Training and the consortium of universities has begun a redesign of the Pre-Services Institute (PSI) for newly hired child welfare professionals in which mental health assessment is one of many areas to be updated. Input regarding the training redesign will involve numerous community partners including the Office of Children's Ombudsman.

How has MDHHS with its collaboration with multiple stakeholders and universities, enhanced its mental health training for child welfare staff since the issuance of this report? Have the core competencies been updated? What developments with the Office of Workforce Development and Training have happened with the redesign of the Pre-Services Institute?

In this case, the OCO also recommended:

The MDHHS Children's Services Administration consider amending the Children Protective Services Manual, PSM 713-08, Special Investigative Situations, to include a section that addresses how CPS should respond when a caregiver's mental health condition is potentially placing a child in harm's way. The Children's Ombudsman recommends this section could include the following items:

- An expedited timeframe for when to make collateral contacts, such as with mental health providers. Instead of a discretionary timeframe for making collateral contacts as in PSM 713-01, this section could prescribe that such contacts be made within 24 to 48 hours of receipt of the complaint when the

complaint alleges potential harm to a child due to a caregiver's mental health issues.

- Allow for extensions of the 30-calendar day standard of promptness to obtain and review mental health records of the client.

- Provide an assessment tool or other way to assess a caregiver's ability to continue to meet the needs of the child(ren) in their care. This could include questions like those in PSM 716-7, Decision Making for Cases Involving Substances, and include, but not be limited to, the following:

    - Is there evidence to demonstrate difficulty regulating emotions or controlling anger?
    - Does the caregiver's mental health condition reduce their capacity to respond to the child(ren)'s cues and needs?
    - Are there supports such as family and friends who can care for the child(ren) when the parents are not able to?
    - Are the parents willing to use their supports when necessary?
    - Is the caregiver taking their medications as prescribed? If not, does this present a possible harmful situation for the caregiver or others?
    - Has the caregiver's mental health condition caused substantial impairment of judgement or irrationality to the extent that the child(ren) was abused or neglected?

- A requirement to obtain and review all records from each mental health provider of the caregiver.

- Access to databases, such as the Judicial Data Warehouse (JDW), where CPS can check for any involuntary hospitalizations or commitments.

- An automatic referral to preventative services whether a preponderance of evidence is found or not.

MDHHS response:

MDHHS reviewed current policy and determined that an allowance for an extension to request and review mental health records currently exists in policy and that current time frames regarding completing collateral contacts and collecting mental health records are sufficient. Additionally, after consultation between the In-Home Bureau, Policy Unit, and the CPS Advisory, MDHHS determined enhancements to mental health training and the creation of a job aide/assessment tool would best address the issues highlighted in this case. The In-Home Bureau will develop the tool and CSA will notify the OCO when completed.

What enhancements to mental health training has occurred since the issuance of this report and has the In-Home Bureau created and deployed a job aide/assessment tool as of present day?

2. On February 16, 2022, the OCO published a findings and recommendation report, Case No. 2021-0108.

In that case, the OCO recommended:

> This case presents an opportunity for the three key child welfare partners, Children's Protective Services, law enforcement, and the courts in Mason and Manistee counties, to revise their protocols to align with Michigan law governing emergency removal of children from parental custody. Law enforcement's role differs from CPS' role in these situations. Child welfare partners in Mason and Manistee counties should discuss those differences. The courts in these jurisdictions play a critical role as well, and the parties may wish to review Michigan Court Rule (MCR) 3.963 and revise their protocols consistent with that court rule. Thus, the OCO recommends that these partners come together to review this case and discuss it in the context of guiding law, policies, and protocols. The OCO also recommends that MDHHS Children's Services Agency review this case and consider providing guidance to all county offices on their legal responsibilities after a law enforcement officer has removed a child from parental custody.

MDHHS response:

> Mason County administration has reached out to their local partners to discuss the situation to determine how law enforcement and the local office can better partner. Although MDHHS believes the county acted appropriately, we recognize practices regarding partnering with local law enforcement may vary and the department will review the case to identify if any statewide communication is necessary.

What information can MDHHS share regarding Mason County MDHHS' interaction with their local law enforcement? Have any additional practices been implemented to better the relationship and understanding of roles between MDHHS and Mason County law enforcement?

Has MDHHS reviewed this case and identify if any statewide communication was necessary regarding collaboration with law enforcement?

3. On July 15, 2022, the OCO published a findings and recommendation report, Case No. 2021-0362.

In that case, the OCO recommended:

> MDHHS Children's Services Agency amend FOM 722-03B to emphasize that adherence to deadlines and documentation requirements are crucial to fully

implementing the preference for relative foster care placement in effect during the 90 days following removal of a child from parental custody.

MDHHS response:

MDHHS will updated FOM 722-03B, Relative Engagement and Placement Policy, to include a note under "Diligent Search and Notification Process" that emphasizes adherence to deadlines documentation requirements are crucial to fully implementing the preference for relative foster care placement in effect during the 90 days following removal of a child from parental custody.

Has MDHHS Children's Services Agency amended FOM 722-03B as indicated above? If so, when was the change implemented? If not, what is the anticipated date of implementation of the amended form?

The OCO also recommended:

The OCO recommends that MDHHS Children's Services Agency develop an internal review, oversight, or quality assurance mechanism regarding contracted entities' compliance with law and policy on relative placement processes. Timely adherence to law and policy regarding relative placement is in the best interest of the child, and to that end, achieving greater compliance is necessary. Furthermore, the OCO strongly recommends that MDHHS finds meaningful ways, including provisional licensing, to hold these contracted agencies accountable when relatives are routinely disregarded when seeking placement of children.

MDHHS response:

The Children's Services Agency (CSA) recognizes the importance of implementing internal review, oversight, and quality assurance mechanisms for contracted agencies compliance with law and policy in all areas including relative placement processes. Currently, the Division of Child Welfare Licensing (DCWL) audits for compliance with Rule 400.12404 Placement and 400.12404 Change of Placement, specific to relative placement. The rules require that agencies consistently consider relatives for placement and replacement. They also audit for compliance with policy FOM 722 03B, Relative Placement and Engagement. Policy is more specific about timeframes and the specific requirement needed to fully engage relatives.

Provisional license recommendations are outlined in Act 116 as only being used for willful and substantial non-compliance with the act or rules. The Division of Child Welfare Licensing cannot make a license recommendation based on policy or contract violations.

Additionally, CSA is beginning a new quality improvement process called Sustaining Performance Improvement (SPI). SPI will improve outcomes for children and families by bringing CSA and agency leaders together regularly to review key data trends, identify and problem solve challenges before they magnify, and strengthen partnerships through improved communication, transparency, and collaboration.

What updates can MDHHS provide regarding the development and launch of SPI?

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

February 22, 2023

Ms. Suzanna Shkreli
Office of Children's Ombudsman
401 S. Washington Square
Lansing, MI 48933

Dear Ms. Shkreli:

The following are Michigan Department of Health and Human Services' (MDHHS) updates regarding developments since the publication of previous Office of Children's Ombudsman (OCO) Reports of Findings and Recommendations.

1. Regarding the 1/11/22 OCO Findings and Recommendations Report:

   A. What updates can you share about the development of a new webpage on the public MDHHS website including information on policy and procedure regarding mental health records during a CPS investigation? Has the webpage and information been shared with local community mental health partners as indicated?

   MDHHS Response: The Child Welfare Medical and Behavioral Health Resources webpage is active on the public MDHHS website at Child Welfare Medical and Behavioral Health Resources (michigan.gov). The Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) has shared the webpage with partners who are currently vetting an educational PowerPoint, which MDHHS will upload to the site by 2/28/23. The PowerPoint aligns with materials presented to new workers regarding resources for mental health during Pre-Service Institute (PSI) training.

   B. How has MDHHS with its collaboration with multiple stakeholders and universities, enhanced its mental health training for child welfare staff since the issuance of this report? Have the core competencies been updated? What developments with the Office of Workforce Development and Training have happened with the redesign of the Pre-Services Institute?

MDHHS Response: In 2022, staff from Children's Services Administration (CSA), Office of Workforce Development and Training (OWDT), and Michigan's Child Welfare University Consortium updated the core competencies for the Child Welfare Certificate (CWC). Four of the 63 newly updated competencies specifically focus on mental health and require schools that receive the CWC endorsement to include instruction on identifying characteristics of common mental health disorders, understanding how trauma impacts children and families, the potential impact that parental mental health disorders have on child development, and how to make referrals for additional assessment.

Currently, PSI covers multiple topics related to mental health including engaging those with mental health issues, safety planning, Children's Protective Services (CPS) legal authority to obtain records, how to request information from providers, procedures for when a provider denies a request, and an overview of with whom CPS may share information. In 2022, OWDT contracted with the Child Welfare University Consortium, led by Wayne State University, to redesign the PSI. To date, they have completed a national scan of similar trainings, led a dozen focus groups with child welfare stakeholders, reviewed topics covered in the current PSI, and held several planning sessions with CSA and OWDT staff. The OWDT and CSA will pilot the new PSI in mid-2023.

C. What enhancements to mental health training has occurred since the issuance of this report and has the In-Home Bureau created and deployed a job aide/assessment tool as of present day?

MDHHS Response: Because MDHHS and its stakeholder developed multiple new resources and educational opportunities regarding mental health in 2022, the In-Home Bureau did not create an additional job aide. Those new resources include updates to the CWC and PSI competencies; the educational PowerPoint uploaded to the new BCCHPS public webpage accessible by the public; and online study guides, available to all child welfare staff, which contain resources, guidance, and training documents related to mental health and obtaining records.

2. Regarding the 2/16/22 Report of Findings and Recommendations Report:

A. What information can MDHHS share regarding Mason County MDHHS' interaction with their local law enforcement? Have any additional practices been implemented to better the relationship and understanding of roles between MDHHS and Mason County law enforcement?

MDHHS Response: Mason County MDHHS shares a positive relationship with the local law enforcement. The police chief has the Mason MDHHS director's direct phone number and can make contact at any time with concerns. Mason staff ride with law enforcement for on-call and after-hours face to face contacts. Additionally, Mason County MDHHS administration has plans to meet with the two new/interim chiefs in the city of Mason and Scottville and the local prosecutor this month. In addition, MDHHS administrators shared the OCO findings with their courts last year and recently updated their child safety protocol.

B. Has MDHHS reviewed this case and identify if any statewide communication was necessary regarding collaboration with law enforcement?

MDHHS Response: Both CSA and the Office of Family Advocate (OFA) reviewed this case and communicated with both local law enforcement and local MDHHS administration regarding the case concerns.

3. Regarding the 7/15/22 Report of Findings and Recommendations Report:

A. Has MDHHS Children's Services Agency amended FOM 722-03B as indicated above? If so, when was the change implemented? If not, what is the anticipated date of implementation of the amended form?

MDHHS Response: The updated FOM 722-03B, *Relative Engagement and Placement*, policy does include new language under the "*Diligent Search and Notification Process*" heading which emphasizes adherence to deadlines and documentation requirements within the first 90 days following removal of a child. The updated policy draft is in the first stage of review/approval and will need to go through Final Draft Review (FDR) and approval before publication. The target date for release is March 2023.

B. What updates can MDHHS provide regarding the development and launch of SPI?

MDHHS Response: In March 2022, CSA's Division of Continuous Quality Improvement (DCQI), in coordination with CSA's Bureau of Out of Home services, launched the Sustaining Performance Improvement (SPI) initiative for Child Placing Agencies (CPAs). The initiative included sending monthly data dashboards to all county and private agency CPAs, holding quarterly partnership meetings, and providing ongoing technical assistance.

Later in 2022, the newly formed Child Safety and Program Compliance (CSPC) Division joined the endeavor. The team has been working closely since that time to identify key metrics of focus for each quarterly partnership meeting. The meetings include data presentations by DCQI, as well as presentations by selected CPAs on improved compliance and best practices. The DCQI and CSCP continue to work together to develop procedures for data tracking and technical assistance for identified metrics of concern, all under the umbrella of SPI.

Thank you for the opportunity to respond to your questions. If you have questions or concerns, please feel free to contact me via email at starlingd@michigan.gov.

Sincerely,

Demetrius Starling
Senior Deputy Director
Children's Services Administration