Annual Report
Fiscal Year 2020

Table of Contents

About the Office of Children's Ombudsman......………..………..………………3-4

Committee Participation……..........…………………………..………...…………5

Message from the Children's Ombudsman………..………..……...……………………6

A Year In Review........………………………………………..…………...……………7-8

Overview of the Intake Process.....……………………..……………...……………..9

Overview of the Investigation Process..………………..........………………………..10

Fiscal Year Highlights.......…………………….........……………………………11-12

How We Help .....……………………………………………..…………………13-14

Annual Report FY 2019 Updates ....………………………………………...15-16

Annual Report Findings and Recommendations ....…..………………………17-26

About the Office of Children’s Ombudsman

The Office of Children's Ombudsman (OCO) is an 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 and Human Services (MDHHS), child placing agencies, and/or child caring institutions. To be autonomous from MDHHS, the OCO was placed under the Michigan Department of Technology, Management & Budget (DTMB).

Authority

The Children's Ombudsman has the authority to investigate administrative actions of child protective services, foster care programs and agencies, adoption services, and juvenile justice programs.

After an investigation, the Children's Ombudsman may make a finding and a recommendation to the agency it investigated. The goal of the ombudsman is to formally or informally influence policy and rule changes for the betterment of all children involved with the child welfare system.

As required by law the ombudsman provides the agency it investigated the opportunity to respond to the findings and recommendations. The responding agency has the ability to agree or disagree with the findings and recommendations.

Key Goals

⇒ To conduct independent, impartial investigations.

⇒ To make impactful recommendations in order to change and/or update statute, policy, or administrative rules that have a positive impact on the child welfare system.

⇒ To 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 a system-wide issue or deficiency or can be used as a case sample to improve the child welfare system as a whole, 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

Phone: 517-241-0400
1-800-642-4326
Website: www.michigan.gov/oco

The OCO is made up of 12 staff members with experience in the child welfare system, the legal system, and law enforcement.

Ryan Speidel– Interim Children's Ombudsman

Suzanna Shkreli– Interim Deputy Director

Tobin Miller– Chief Investigator

Brooke Brantley-Gilbert– Investigator

Tiffany Jackson– Investigator

Paula Cunningham– Investigator

Scott Clements– Investigator

Toni Dennis– Investigator

Chris Kilmer– Investigator

Pamela Bryant– Analyst

Michelle Brandel– Lead Analyst

Becky Taylor– Senior Executive Management Assistant

OCO Committee Participation

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

Scott Clements participates in the **Child Death State Advisory Team, Child Safety Forward Advisory Panel and the Policy Structure/CPS Main Topics/Supervision CPS redesign workgroup**. Scott plays a role as an advisor in each of these committees by providing feedback on policy and statutory changes and offering annual recommendations that are presented to the governor and Legislature. He participates in all committee meetings and other tasks as assigned.

Pam Bryant and **Michelle Brandel** were a part of the **Safe Sleep Advisory Committee**. The committee has not met in person since January 2020 as they have been working to reconfigure the committee. While working remote through COVID-19, committee members participated in a few virtual meetings via Zoom. These meetings covered ways to promote safe sleep during Safe Sleep Awareness Month. From this, ideas were used to promote and provide education to the public on safe sleep during the month of October.

Tobin Miller participates in the **Court Improvement Program Task Force** and **Safe Delivery of Newborns Steering Committee**. Tobin is an active member in both committees, participating in special projects, such as online training for lawyer-guardians ad litem, videos of mock-court hearings for training purposes; and presenting during online training for courts regarding the intersection of the safe delivery of newborns and drug-positive newborns.

Pam and **Toni Dennis** participate in the **DTMB Diversity and Inclusion Committee**. The role of the committee is to educate, promote awareness, provide training, show recognition and promote advancement within the DTMB workplace. Both are a part of the awareness theme subcommittee.

Toni also participates in the **Adoption Oversight Committee**. She participates in monthly meetings to discuss best practices, updates in MDHHS policy and programs, statewide adoption events, and training opportunities. Subcommittees meet every other month to develop toolkits, best practice guides, update policy, and discuss areas for improvement. Toni is involved with the Legal, Policy, and Service Provision Subcommittee.

Chris Kilmer participates in the **PIP Training Redesign Steering Committee and Pre-service Institute Redesign Workgroup.** The workgroup was established to form a partnership based on analyzing and enhancing child-welfare recruitment, training, and retention to benefit all involved agencies and university partners. A steering committee and three work groups were created to develop a comprehensive list of recommendations to reform child welfare recruitment, training, and retention in Michigan. Chris sat on the steering committee and co-chaired the workgroup focused on child welfare training. In June 2020, 21 recommendations were submitted to the MDHHS Children's Services Agency leadership for consideration and initial implementation of those recommendations began in December 2020.

Brooke Brantley-Gilbert is an active participant in the **Citizen Review Panel for Child Fatalities**. The panel reviews child deaths that have occurred in the state of Michigan and provides recommendations for systemic change to various stakeholders, including but not limited to the MDHHS, the court, hospitals, and law enforcement. These reviews help improve understanding of how and why children die, with an overarching goal of providing additional protection and safety to prevent other child deaths.

Message from the Children's Ombudsman

Fiscal year 2020 saw a host of changes for the OCO. We delivered a new records management system, began a new approach to the way we conduct investigations, and continued our critical work amid the global COVID-19 pandemic. The shift to working remotely from our homes was nearly seamless, and I am proud of the fact that we were one of the first state agencies to allow its employees to work remotely in an effort to keep our staff safe.

In addition to a work-from-home adjustment, the OCO staff has met new demands placed on us, both statutorily and with internal policies. One of those changes included the OCO releasing its first ever finding and recommendation. Prior to recent changes in law that took place in October 2020, the OCO lacked the ability to share with the public the good work our staff does. The OCO's records have always been and remain very confidential in nature. We now have the responsibility of publishing the ombudsman's findings and recommendations. Findings and recommendations are the ombudsman's instrument, a flag to raise, if you will, shining a light on areas the ombudsman believes requires change. These findings and recommendations are often the culmination of a thorough, fact-driven investigation and team work. We are hopeful that our published reports can start discussions on systemic trends, issues, and barriers that remain in place, which slow the progress of Michigan's child welfare system and to also highlight areas where MDHHS does great work.

I have met with many of our complainants over the past year and consider this one of the most important aspects of the Children's Ombudsman. It is vital that members of the public who reach out to the OCO are heard, so that our office can do whatever necessary to be a voice for children from within state government. Our staff and I could not be prouder to be that voice for our most vulnerable population. This past year has been the honor of my lifetime to serve as your Children's Ombudsman.

A Year in Review

New Complaint & Records Management System

OCO staff rolled up their sleeves and got to work on the development of a new complaint management system this past year. The new system, coined the Michigan Child Advocate Investigation System (MiCAIS) went live for OCO staff on June 30, 2020. MiCAIS includes an online complaint portal, where anyone can file an online complaint or inquiry.

MiCAIS will allow the OCO to use data to identify systemic issues and trends that our staff can further investigate. This same data can be used to produce statistics for feedback to the MDHHS regarding OCO cases and investigations. The reporting functionality of MiCAIS is extremely robust, and we have only scratched the surface of its potential.

FY 2020 statistics: Due to the transition to MiCAIS just before the fourth quarter, the OCO's statistics for this year's annual report are a blend from our old case new case management systems.

COVID-19

Due to the nature of the OCO's work, our staff has always been nimble. To keep staff safe and COVID-19 free, we transitioned in early March 2020 to 100% telecommuting. Because of this, COVID-19 has had a very minimal impact on the actual work we do at the OCO.

COVID-19 has caused the OCO to change some practices. Our analysts and investigators conduct interviews every day. Often these interviews, pre-COVID-19, were done in person. The OCO has used technology to its advantage, and with the state of Michigan's adoption of virtual meeting platforms, we have not skipped a beat. Our investigative staff conducts interviews, the OCO holds investigative meetings and case discussions, and the ombudsman still meets with the public, now all in a virtual setting.

COVID-19 affected the OCO's ability to roll out MiCAIS. The state of Michigan's IT support for assistance with development of the MiCAIS application was transitioned to support the IT response to the pandemic. COVID-19 also delayed the OCO's corrective action plan for its response to the Office of Auditor General's 2018 material findings.

Through our lens, we see that COVID-19 has had a negative impact on the child welfare system. Our office has fielded complaints about communication issues, foster care and adoption assessments being delayed, and individuals not being able to have human contact with children in their families due to state intervention. We have worked formally and informally to address these issues where we can, and this work will not stop. The impact COVID-19 has had on the child welfare system may still be felt for years after the pandemic has subsided.

Changes in Policy, Changes in Law

As described in the OCO's FY 2019 annual report, the OCO fully implemented a host of new of internal policies that affect the way the office investigates cases. Our concentration has shifted to looking for trends or emerging issues and if there is anything the ombudsman can speak to that will help improve the child welfare system as a whole. To be transparent, the OCO has published its policies online at www.michigan.gov/oco.

FY 2020 saw two bills that amended the Children's Ombudsman Act come to fruition. Gov. Whitmer signed House Bills 5248 and 5249 into law. The changes in law define preliminary investigation, full investigation, and investigation for the purposes of the act. The ombudsman is now required to conduct a preliminary investigation on all child fatalities that occurred or are alleged to have occurred because of child abuse or neglect. After completing a preliminary investigation, the act requires the ombudsman to determine whether a full investigation is necessary, and if so, requires the ombudsman to open a full investigation.

Additionally, if the ombudsman makes a formal finding and recommendation that criticizes an agency, the ombudsman is now required to release those findings, recommendations, and the agency's response. The OCO has already released two finding and recommendation documents. The finding and recommendation documents can be found online at www.michigan.gov/oco.

2018 Office of the Auditor General Audit Progress

In April 2019, the OCO received the Auditor General's audit findings. The Auditor General noted that the OCO relied on child death notifications from MDHHS and did not independently identify child fatalities. From 2014-2017, the OCO was unaware of 206 child fatalities that it was required to review. The OCO reviewed all of these child fatalities, and safeguards have been put in place to provide the OCO with the necessary information. In addition, the OCO continues to work with information technology support at DTMB and MDHHS to develop an independent means for receiving child fatality information separately from MDHHS.

In December 2019, the OCO had a path forward and began to act. The material finding safeguards that were planned were placed on hold in March 2020 as the state of Michigan's IT resources were drawn to support the state's response to COVID-19. As we move forward, the OCO will comply with the path forward so we can begin to independently identify child fatality cases that the OCO is statutorily required to review.

Overview of the Intake Process

The OCO receives inquiries and complaints from the general public by phone and through an online complaint system. An OCO intake analyst speaks to each complainant by phone to obtain a detailed understanding of the complainant's concerns. The analyst may refer a complainant to another agency that is better able to address some or all of the complainant's concerns.

If the OCO has authority to address a complainant's concerns, an intake analyst conducts a preliminary investigation by analyzing case file information in MDHHS's computer database, the Michigan Statewide Automated Child Welfare Information System (MiSACWIS). If the preliminary investigation reveals that an agency involved in the case did not comply with applicable law or policy, or if it appears that OCO intervention may assist with keeping a child safe or improving their well-being, the OCO may open a full investigation of the complaint. If the complaint does not fall within these broad parameters, the OCO may close the complaint after the preliminary investigation. Complaint dispositions are reviewed by a chief investigator and deputy director and approved by the ombudsman. The ombudsman notifies all complainants in writing of the disposition of their complaint. Complainants identified in section 5 of the Children's Ombudsman Act may speak with the Ombudsman about the disposition of their complaint.

The OCO is also required to investigate child welfare cases involving a child who has died. The OCO receives an automated alert whenever Child Protective Services (CPS) centralized intake processes a complaint involving a deceased child. An OCO intake analyst conducts a preliminary investigation of all automated alerts. If the preliminary investigation reveals that the child's death may have involved child abuse or neglect, and the child's family was involved in the child welfare system during the preceding two years, the OCO must open a full investigation of the case. As with complaints from the general public, dispositions of automated alerts are reviewed by a chief investigator and deputy director and approved by the ombudsman.

Overview of the Investigation Process

The OCO conducts three types of investigations: complainant investigations, child death investigations, and systemic investigations. The goals of each type of investigation differ. Complainant investigations attempt to determine the truth or falsity of the allegations of agency missteps made by a public complainant, whether a solution may be mediated with the agency, and whether the agency missteps are likely to recur in future cases. Child death investigations examine agency handling of cases in the two years preceding a child's death to determine whether agency missteps affected case outcomes or contributed to the child's death and whether recommendations for improvement should be made to the involved agency or agencies. Systemic investigations examine agency handling of several cases involving the same issue, with the focus on recommendations to ameliorate the issues.

Basic investigative techniques are similar in each type of investigation. The assigned OCO investigator interviews caseworkers, complainants, and other witnesses; obtains and examines documents contained in the agency's case file or created by other agencies, such as a medical examiner's office, hospital, or law enforcement agency; reviews applicable law and policy; and consults with OCO staff and outside experts. Throughout all OCO investigations, the assigned investigator and others remain alert to emerging threats to child safety.

OCO investigations may be closed administratively or with the issuance of a formal report of findings and recommendations. The OCO may close an investigation administratively if the complainant's allegations are unfounded, the investigator mediated a solution with the agency to the complainant's concerns, or a change in case circumstances has rendered the continuation of the investigation unnecessary or unavailing. Child death investigations may be closed administratively if the investigator found no law or policy violations by an agency or any such violations did not affect case outcome or contribute to the child's death. Systemic investigations are typically closed through the issuance of a formal report of findings and recommendations.

A formal report of findings and recommendations contains factual findings concerning agency handling of a case and recommendations to improve agency handling of similar cases in the future. If there are no open law enforcement or CPS investigations open at the time, the OCO issues its formal report to the involved agencies, who have 60 days to respond to the report in writing. After personal and confidential information is redacted, the OCO publishes its reports and agency responses to those reports at www.michigan.gov/oco.

Each public complainant to the OCO receives a closing letter notifying them of the outcome of the OCO's investigations. As explained in the Children's Ombudsman Act, individuals with a personal or professional relationship to the child or children involved receive both the OCO factual findings and recommendations. Individuals with no personal or professional relationship to the child or children involved receive only the OCO's recommendations. The vast majority of OCO child death investigations have no public complainant. If the OCO closes a case administratively, the complainant is made aware of this outcome through the closing letter.

Fiscal Year Highlights

In FY 2020, the OCO received 839 total complaints between two databases.

These complaints included both child death alerts and complaints from the public.

Figure 1 shows a comparison of the complaints received from FYs 2020, 2019 and 2018.

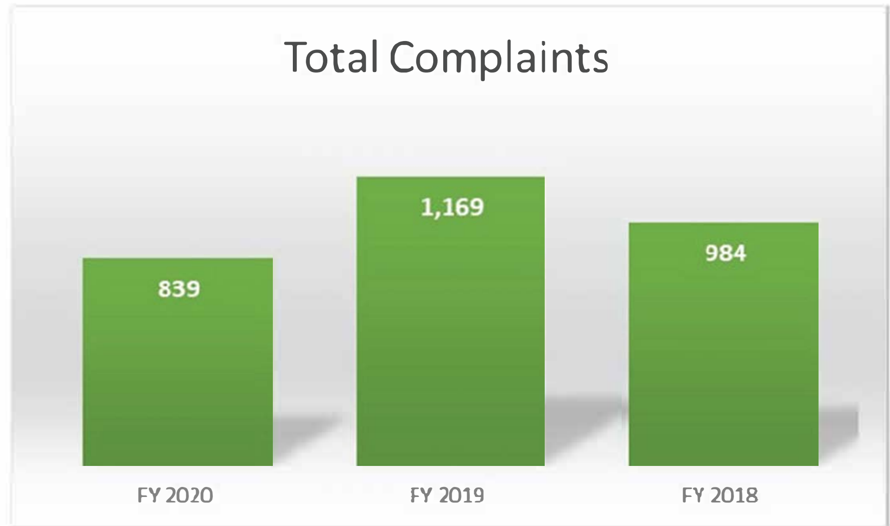

Figure 1

The OCO received a total of 484 complaints from the public that resulted in information referrals or preliminary investigations. The OCO provided information or referred a public complainant on 250 of the complaints. A preliminary investigation was completed on 234 of the complaints. The OCO opened 31 complaints for full investigation.

Figure 2 below shows the breakdown of the public complaints received by the OCO for FY 2020.

Overview of Public Complaints

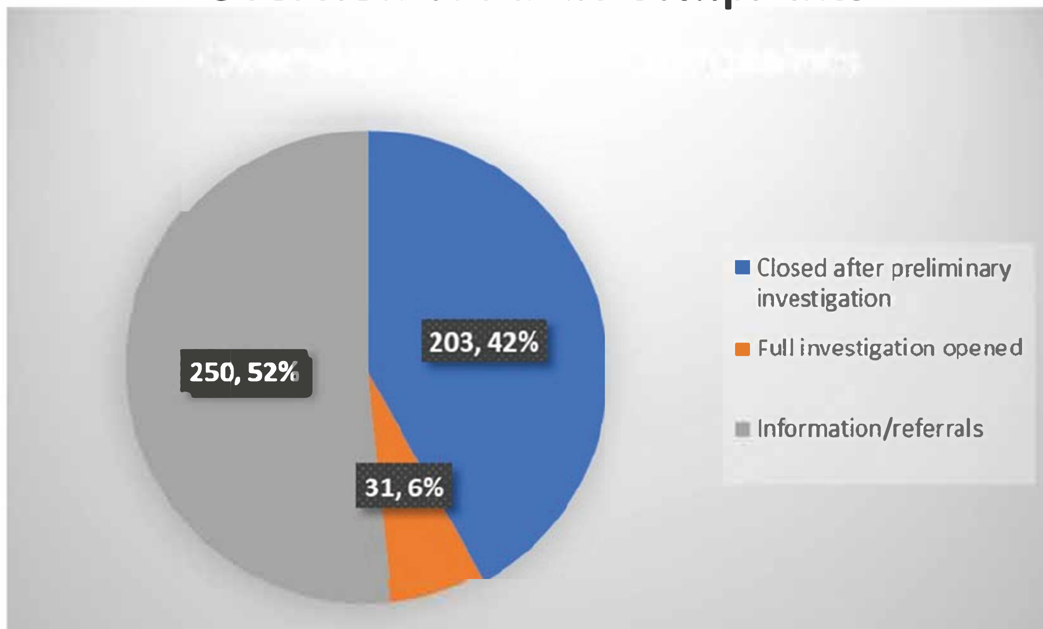

Figure 2

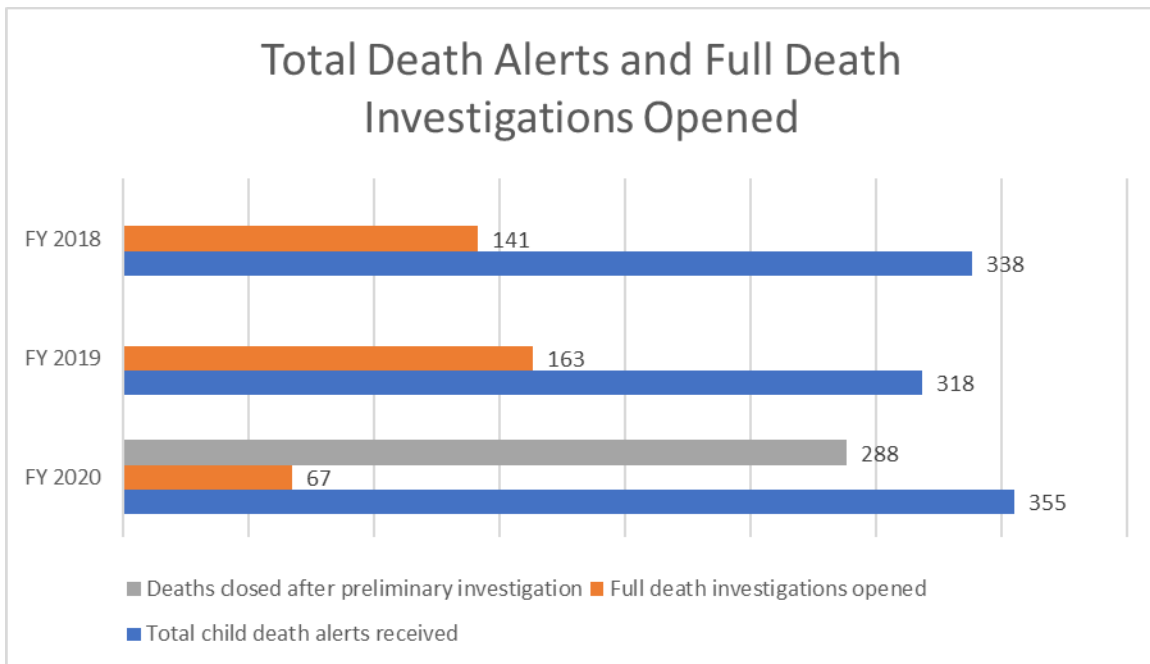

Figure 3

Figure 3 above shows the breakdown of child death alerts received over the last three fiscal years. In FY 2020, the OCO received 355 child death alerts from MDHHS.

A preliminary investigation was completed on all 355 death alerts received. 288 death alerts were closed by the Ombudsman after the preliminary investigation, and 67 were opened for full investigation.

As part of the changes to the OCO office previously mentioned, the OCO is tracking emerging trends through the new case management system, MiCAIS. Child deaths that involve unsafe sleep practices is one of the emerging trends that the OCO is currently monitoring. The OCO is taking a systemic look at child death cases where the child or a household member was born positive for any controlled substance.

How We Help

In some cases, the OCO can attempt to mediate resolutions through informal channels. Our intake staff and investigators are always looking for avenues in which we can efficiently communicate resolutions to keep children safe. The informal channels of resolution allow the OCO to be nimble and act in real time to help keep children safe.

Below are a few examples of what the OCO has done this past year to help resolve our complainant's concerns without a formal finding and recommendation from the ombudsman.

Case #1:

A relative contacted our office with concerns that the agency was not appropriately investigating allegations of both domestic violence and maltreatment. The relative stated they had contacted MDHHS Centralized Intake on two occasions, but one of the complaints was not assigned for investigation. The OCO preliminary investigation showed that the allegations of domestic violence had been assigned for investigation, but the allegations involving maltreatment were not supplied to the CPS investigator and were not addressed. The OCO contacted MDHHS Centralized Intake, making a complaint regarding the maltreatment allegations that were not addressed. In response, MDHHS assigned the maltreatment allegations to a CPS worker to conduct the investigation addressing our complainant's concerns.

Case #2:

Concerns were brought to the attention of the OCO that the medical needs of a medically fragile child were not being met and that these concerns were not being addressed in a current CPS investigation. The OCO investigated these concerns and spoke to the supervisor on the active CPS case. It was determined that even if the current CPS case was not assigned a CPS investigation per se, prevention services would be put in the home. This was done to ensure the child's medical needs were being met. As a result of the OCO intervention, services were placed in the home to assist the family with the needs of the medically fragile child.

Case #3:

The OCO received a complaint from an individual who said that a friend had related children removed from her care during a CPS investigation and did not know why. The OCO investigated this concern and discovered that some children had been placed in the care of the family member, but later a petition was filed and the children placed in foster care. Due to the confidential nature of an OCO investigation, the specific reasons for this action could not be discussed with the complainant or the family member. Instead, the OCO was able to bring individuals together involved in the CPS and foster care cases to discuss with the family member the reason for removal. In addition, the family member was given a path to be reconsidered for placement of the children in the future.

Case #4:

The OCO received concerns that a child involved in a CPS complaint had not been interviewed about some allegations of sexual abuse. After review of the case, the OCO investigator found that the complainant's concerns were correct, and an interview with the child about the sexual abuse allegations had not occurred. These types of interviews normally take place in a specialized setting with highly trained interviewers. The OCO investigator called in a new complaint to MDHHS Centralized Intake to initiate a new CPS investigation. As a result, the child was forensically interviewed in the appropriate venue.

Case #5:

The OCO reviewed a CPS case involving a parent who had allegedly physical abused their child. The parent contacted the OCO claiming that they did not. After a thorough review, which included the collection of additional evidence, the OCO determined that CPS appropriately determined that there was a preponderance of evidence in the case to show that physical abuse had occurred. The OCO followed up with the parent and explained portions of the Child Protection Law and MDHHS policy to the complainant. The parent was grateful for the work the OCO did, even though their denial of physical abuse was not supported by the OCO investigation.

The United States Ombudsman Association's (USOA) Governmental Ombudsman Standards recommend that a credible review process allow an ombudsman the discretion to act informally to resolve a complaint.

The cases above are examples of how the OCO has collaborated with MDHHS to develop an informal mediation process.

In these cases, the OCO acted informally to resolve public complaints thanks to trust and open dialogue with the agencies involved. The OCO will continue to support positive relationships with its partners to advance Michigan's child welfare system.

For more information about the USOA Governmental Ombudsman Standards, visit:
http://www.usombudsman.org/wp-content/uploads/USOA-STANDARDS1.pdf

Annual Report FY 2019 Updates

Each year, the OCO makes annual recommendations to MDHHS. In FY 2020, the OCO requested updates from MDHHS regarding any departmental changes as a result of the OCO annual recommendations from FY 2019. The recommendations and MDHHS responses can be found online in the OCO FY19 Annual Report. The current updates can be found below.

CSA update since submitting recommendation #1 response to the OCO:

CPS Program Office continues to work with the Medical Advisory Committee to provide the "Medical Issues Related to Child Abuse and Neglect Investigations." In 2020, the department originally planned for 10 trainings held regionally. Of the scheduled trainings:

- Six offices were provided training:
  - Wayne County: North and Central Districts - one training.
  - Wayne County: Western and South Central Districts - two trainings.
  - Kent County - one training.

These face-to-face trainings began in February 2020 and ended in March 2020 as a result of restrictions related to COVID-19. Due to the state emergency order, four trainings were cancelled in Kent and Wayne counties.

In 2021, virtual trainings (via Microsoft Teams) have been developed, scheduled, and are open for all counties for the following dates:

- February 17, 2021
- May 21, 2021
- September 15, 2021

CSA/CWTI-OFA update since submitting recommendation #2 response to the OCO:

In 2020, MDHHS's Office of Workforce Development and Training (OWDT) updated it's lesson plans to reflect the policy changes recommended by the OCO and collaborated with the CPS Centralized Intake to further improve lesson plans concerning CPS intake and investigation. OWDT also provided one-on-one support for field staff who could benefit from the additional training opportunities.

In 2020, MDHHS also Partnered with the newly formed Michigan University Consortium, led by Wayne State University, Michigan State University, University of Michigan and Western Michigan University, and made up of multiple other schools that offer curriculum related to child welfare. The partnership will work to redesign child welfare training for the state of Michigan.

Annual Report Findings and Recommendations

The Children's Ombudsman's annual recommendations stem from a systemic investigation the OCO conducted after being notified of the death of a teenager at a child caring institution (CCI) in Kalamazoo. During the investigation, it became apparent that the OCO could recommend systemic changes that will help prevent future deaths and may improve the quality of care at CCIs.

As required by the Children's Ombudsman Act, 1994 PA 204, the ombudsman submitted findings and recommendations to MDHHS and the Lakeside Academy for Children. MDHHS responded to these recommendations. You will find both the OCO's recommendations and MDHHS' response to those recommendations on page 22 of this annual report.

Report of:

Findings and Recommendations

Regarding the Michigan Department of Health and Human Services involvement with

DOB: DOD: 05/01/2020

Under state law a record of the Office of Children's Ombudsman's is confidential, shall only be used for purposes set forth in this act, is not subject to court subpoena, and is not discoverable in a legal proceeding. Additionally, a record of the Office of Children's Ombudsman's is exempt from disclosure under the Freedom of Information Act.

Date: 3-Dec-2020

Case No.: 2020-0036

Summary:

died on 05/01/2020. Pursuant to MCLA 722.627k, the Michigan Department of Health and Human Services (MDHHS) notified the Office of Children's Ombudsman (OCO) of the child fatality. On 05/06/2020, the OCO opened an investigation into the handling of this matter by Lakeside Academy for Children (Lakeside Academy) and MDHHS pursuant to our statutory responsibilities.

The OCO reviewed confidential records and information that was in MiSACWIS, which includes but is not limited to service reports, medical records, social work contacts, investigative reports, incident reports, video recordings, facility policies, facility training materials, and court orders. The OCO also spoke with ' foster care worker and the worker's supervisor, a maltreatment-in-care (MIC) worker and her supervisor, a licensing investigator and her supervisor, a Sequel Youth and Family Services employee, and numerous employees and managers of Michigan child caring institutions (CCI's).

*Sequel Youth and Family Services operated the Lakeside Academy facility in Kalamazoo.

The objective of this review was to identify areas for improvement in the child welfare system. By looking at how this family's case was handled by Lakeside Academy, and the involvement of staff, court personnel, physicians and law enforcement, this review reinforces the safety and well-being of a child is the shared responsibility of the family, community, and both law enforcement and medical personnel aiding children and families. It is not intended to place blame, but to highlight areas of concern regarding the handling of this case and advocate for changes in the child welfare system on behalf of similarly situated children.

Purpose, Scope & Summary of Investigation:

The purpose of this investigation was to determine whether [redacted] placement at Lakeside Academy was in his best interest; whether Lakeside Academy staff members complied with law, administrative rule, DHHS policy, internal facility policy, and internal facility procedure concerning a restraint of [redacted] on 4/29/20 that resulted in his death; whether the assigned MIC unit complied with applicable law and policy when investigating this restraint; and whether there are systemic issues necessitating recommendations to improve practice regarding CCI's and the use of restraint techniques in CCI's.

The scope of the OCO investigation included [redacted] foster care case, the MIC and licensing investigations concerning the 4/29/20 restraint, MIC and licensing investigations concerning Lakeside Academy resident discipline that occurred in the two years prior to [redacted] death, MIC and licensing investigations at other CCI's in the two years prior to [redacted] death, and the requirements for direct care workers in Michigan CCI's.

During this investigation, the OCO investigator:

- Obtained and reviewed [redacted] medical records from Bronson Methodist Hospital, which treated [redacted] immediately prior to his death
- Obtained and reviewed the report of an autopsy conducted on [redacted]
- Reviewed case file documentation in MiSACWIS concerning [redacted] foster care case, [redacted] adoption case, the MIC investigation concerning [redacted] death, and the licensing special investigation concerning [redacted] death and a previous restraint of [redacted] at Lakeside Academy
- Reviewed documentation in the Judicial Data Warehouse to confirm information describing the child protective proceeding involving [redacted] and his siblings and a delinquency proceeding involving [redacted]
- Interviewed [redacted] foster care worker and her supervisor, the assigned MIC worker and her supervisor, and the assigned licensing investigator and her supervisor
- Obtained and reviewed video recordings of the restraint leading to [redacted] death and a previous restraint of [redacted] at Lakeside Academy
- Obtained and reviewed internal Lakeside Academy policy concerning restraints and physical holds of residents at the facility and training materials used by Lakeside Academy to train staff on the use of restraints and physical holds
- Attempted to interview 11 former Lakeside Academy staff members involved in the 4/29/20 restraint of [redacted]

- Reviewed employment records of seven former Lakeside Academy staff members directly involved in the 4/29/20 restraint of [redacted]
- Reviewed law, policy, and documents describing restraint and positional asphyxia
- Reviewed 13 licensing special investigations and MIC investigations concerning Lakeside Academy staff that occurred in the two years prior to [redacted] death
- Tallied the number and general nature of licensing special investigations and MIC investigations that occurred in all Michigan non-secure CCI's during the two years prior to [redacted] death
- Obtained starting pay rates and education and experience requirements for direct care workers at a majority of Michigan non-secure CCI's.

Tobin Miller

Chief Investigator

Office of Children's Ombudsman

P.O. Box 30026

Lansing, MI 48909

Finding(s):

Primary Agency of Focus: **Lakeside for Children**
Secondary Agency(ies): **N/A**

The OCO finds that Lakeside Academy staff violated Michigan Administrative Rules 400.4159 and 400.4142 and Lakeside Academy's internal policy governing the use of holds and restraints when restraining [redacted] on 4/29/20. This restraint was unwarranted, improperly executed, conducted without appropriate supervisory approval or oversight, and inconsistent with [redacted] treatment plan. In addition, Lakeside Academy staff failed to obtain timely emergency medical care for [redacted] following the restraint.

Primary Agency of Focus: **Lakeside for Children**
Secondary Agency(ies): **Children's Services Administration**

The OCO finds that a review of MIC substantiations and administrative rule violations concerning Lakeside Academy staff maltreatment of residents in the two years prior to [redacted] death indicates a pattern of inappropriate use of restraint and assault to manage non-threatening behaviors.

For example, the OCO reviewed confirmed allegations of Lakeside Academy staff members restraining a resident for over 30 minutes; dragging a resident across the floor for failing to respond to staff requests; challenging a resident to fight; pushing a resident into a brick wall because the staff member believed the resident was about to spit on him; yelling directly in a resident's face; and "backhanding" a resident in the face, in the presence of the resident's therapist, for calling the staff member a name.

The OCO also finds that despite multiple rule violations concerning these and other incidents at Lakeside Academy, and despite the imposition of numerous corrective action plans as a result of the rule violations, the facility was still on regular license status at the time of [redacted] death.

Primary Agency of Focus: **Lakeside for Children**
Secondary Agency(ies): **N/A**

The Michigan Administrative Code for Child Care Institutions (CCIs) defines qualifications for direct care workers in Rule 121 (R 400.4120). The minimum qualification for a CCI direct care worker is "A direct care worker shall have completed high school or obtained a general equivalency diploma (GED)."

The OCO finds that of the seven employees most directly involved in the 4/29/20 restraint of [redacted], none had child welfare experience prior to being employed by Lakeside Academy. One of the seven employees holds a bachelor's degree in criminal justice, sociology, and anthropology; one has an associate's degree in business and accounting; and five have high school diplomas.

Employment records from Lakeside Academy also show that the average number of months the seven employees had been employed by Lakeside Academy prior to 4/29/20 was approximately 12.

Primary Agency of Focus: **Children's Services Administration**
Secondary Agency(ies): **N/A**

The OCO finds that among 36 private non-secure CCI's that receive children under a Michigan court's jurisdiction for child abuse or neglect, the starting hourly pay rate for direct care workers ranges from a low of $9.50 per hour to a high of $18.77 per hour.

In addition, the OCO finds that among these 36 CCI's, the average starting rate of pay for direct care workers, including pay differentials for education and relevant experience, is approximately $15.60 per hour.

Primary Agency of Focus: **Children's Services Administration**
Secondary Agency(ies): **N/A**

The OCO finds that MDHHS commissioned the Annie E. Casey Foundation's Child Welfare Strategy Group to review MDHHS' oversight of the safety and quality of Michigan CCI's. One of the recommendations from this review was to limit the number of residents at CCI's to 16.

The OCO reviewed publicly available licensing special investigations and confidential MIC investigations occurring at non-secure CCI's within the two years preceding [redacted] death. Based on this review, the OCO finds a correlation between the number of children housed within a non-secure CCI and the likelihood that the CCI was found responsible for a rule violation or a CCI employee was substantiated for staff assault of a resident or an improper restraint. Those CCI's with a violation or substantiation for a staff assault or improper restraint in the last two years (21 total CCI's) have an average of 40 residents. Those CCI's without such a violation within the last two years (31 total CCI's) have an average of 19 residents.

Recommendation(s):

Primary Agency of Focus: **Children's Services Administration**
Secondary Agency(ies): **N/A**

The OCO recommends that MDHHS require a heightened response by DCWL to statutory or administrative rule violations regarding restraint, staff physical abuse of a resident, or failure to comply with the mandated reporting provisions of the Child Protection Law (CPL) by a CCI. This heightened response could include the following:

- For a second or subsequent violation of law or administrative rule concerning restraint, staff physical abuse of a resident, or failure to report, issuing a provisional license to the CCI; and

- For any violation of law or administrative rule concerning restraint, physical abuse of a resident, or failure to report, requiring DCWL to notify local DHHS offices of its findings to permit local offices to decide whether to seek re-placement of children under their care and supervision.

MDHHS Response to Recommendation: MDHHS intensified its response to rule violations by requiring the MDHHS Division of Child Welfare Licensing, prior to determining adverse action, to conduct a comprehensive review of a Child Caring Institution's serious and safety-related violations for the previous twenty-four months. The goal is to identify patterns and trends that may necessitate a corrective action plan or other intervention to address concerns that impact child safety and wellbeing.

Effective 7/16/20, MDHHS issued Emergency Rules for Child Caring Institutions restricting dangerous types of restraints and limiting use of restraints when necessary to prevent serious injury to the child or injury to others.

Effective 7/24/20, MDHHS licensing consultants began making unannounced visits to Child Caring Institutions – quarterly to all Child Caring Institutions, monthly when a first provisional license is recommended, and weekly when a second provisional license is recommended.

Additionally, the Department implemented weekly Child Caring Institution status meetings to identify concerns that impact child safety and require immediate action, such as caseworker verification of safety and wellbeing, implementation of safety plans, review of staffing sufficiency, additional investigation by Children's Protective Services Maltreatment in Care unit or licensing, technical assistance by licensing and/or program offices, and temporary suspension of new referrals to the facility. Participation at the weekly meetings includes, among others, the Bureau of Out-of-Home Services director, the Division of Child Welfare Licensing director or designee, the Maltreatment in Care director, the Juvenile Justice Programs director, the manager of the Regional Placement Unit, and the respective managers of foster care and juvenile justice program offices. The Division of Child Welfare Licensing also holds conference calls with the caseworker in the local office after every restraint of a child on their caseload. The Division of Child Welfare Licensing seriously considers issuing a provisional license to Child Caring Institutions that have more than one serious restraint violation.

After the tragedy at Lakeside, MDHHS asked national experts to help guide reform of its use of residential services and improve safety for children receiving residential services. National experts issued a report containing recommendations to improve oversight of safety and quality of care to children receiving residential services and their families, including moving towards restraint-free programs. In September 2020, Michigan convened a 6-month steering committee to implement the recommendations in the report. The steering committee is set to conclude its work at the end of March 2021.

Finally, MDHHS has implemented a series of trainings for Child Caring Institutions focused on implementation of best practices to prevent and safely reduce the use of restraints; additional technical assistance is planned in 2021.

Primary Agency of Focus: **Children's Services Administration**
Secondary Agency(ies): **N/A**

The OCO recommends that MDHHS amend R 400.4121 to require either

a) A bachelor's degree in social sciences, human services, or a related field, or

b) A minimum number of years of experience working with children before being employed in a CCI as a direct care worker.

This would encourage persons who plan a career working with children to apply for such jobs, reorient the nature of the position toward effective interaction with traumatized children and away from physical management of such children, and bring staff qualifications in line with the required qualifications for staff in other child welfare program areas.

MDHHS Response to Recommendation: MDHHS recognizes the important role Child Caring Institution direct care staff have in working with children who have experienced trauma and their families. Draft revisions to the licensing rules, that are expected to take effect in Fall 2021, enhance the amount and types of training newly hired and existing staff will receive when employed at a Child Caring Institution. Under the draft revised rules, staff are required to complete 50 hours of training in their first year of hire, and 25 hours annually thereafter. Staff will select from over 30 annual training topics as identified in Michigan Administrative Code R400.4128 and the Child Protection Law including, but not limited to, topics related to working as part of a team, understanding and defusing challenging behaviors, relationship building with the family, crisis intervention, suicide prevention, grief and loss for foster children, and other topics which will enhance staff skill and ability to deliver effective services and intervention with youth and their families.

Primary Agency of Focus: **Children's Services Administration**
Secondary Agency(ies): **N/A**

The OCO recommends that MDHHS identify jobs within the state civil service that are substantially similar to the position of direct care worker at a private non-secure CCI. MDHHS should require by contract that pay rates for direct care workers within private non-secure CCI's be commensurate with the department's pay rates for substantially similar positions within the state civil service and include pay differentials for employees with relevant child welfare experience.

MDHHS Response to Recommendation: Beginning in December 2020, MDHHS began working with Public Consulting Group and residential service providers to identify comparable market rates for similar positions and identify salary benchmarks commensurate with job duties and expectations. The next meeting among MDHHS, Public Sector Consulting Group and residential providers is scheduled for March 17, with additional meetings scheduled to occur in April and May. This work will be factored into actuarily sound rate recommendations for Child Caring Institutions.

Primary Agency of Focus: **Children's Services Administration**
Secondary Agency(ies): **N/A**

The OCO recommends that MDHHS add a requirement to Michigan Administrative Rule 400.4128; Rule 128, to require all direct care workers in CCI's, similar to the first aid training requirement, to take Parent Resources for Information, Development, and Education (PRIDE) training as required for foster parents.

MDHHS Response to Recommendation: While Parent Resources for Information, Development, and Education (PRIDE) training is geared toward the placement of children with foster parents and relatives, Child Caring Institution contracts require orientation for all new staff that include topics identified in Michigan Administrative Code R400.4128 and the Child Protection Law. Current draft rule revisions will require additional annual training in over 30 areas related to staff providing effective treatment for children and families involved at Child Caring Institutions.

Additionally, all staff will receive annual trauma-focused program training to maintain a trauma-informed milieu and treatment environment. In 2020 and 2021, all Child Caring Institutions were invited to participate in the Six Core Strategies training, delivered by national experts in congregate care system reform. The training included five three-hour training sessions on strategies they should take to reduce the use of restraints, seclusion, and other coercive practices. The training focused on ways that Child Caring Institutions can promote permanency, family-driven, youth-guided and trauma-informed care, cultural and linguistic competence, strength/resiliency-based and individualized care.

A workgroup has drafted rule revisions that will require all Child Caring Institutions to develop agency-based and child specific crisis prevention and intervention strategies that are strength-based and non-coercive. These plans will be used to support staff and assist children in self-regulation, social skills, and healing.

Primary Agency of Focus: **Michigan Legislature**
Secondary Agency(ies): **N/A**

The OCO recommends that the Michigan Legislature amend the Child Care Organizations Act, MCL 722.111 et seq., to limit the number of children that a CCI may house within a self-contained unit of a facility to 19 residents or less.

MDHHS Response to Recommendation: As part of the Child Caring Institution Steering Committee convened from September 2020 through March 2021, a workgroup analyzed and carefully considered modifying the Licensing Rules for Child Caring Institutions to limit residential program size to a capacity of 16 youth or less. The workgroup recommended updates be made to licensing rules, contracts, programs, and oversight focus on factors that improve safety and positive outcomes for children and their families such as engagement with families, reducing lengths of stay, prevention of restraint/seclusion use, workforce support and development, urgency toward permanency, use of data for program improvement, post-discharge supports, trauma-responsive interventions and organizational oversight.

The workgroup recommended, and the Steering Committee agreed, not to modify the licensing rules, or contracts, for residential services to limit bed capacity. The decision was based on the following: 1) insufficient data, research, or consistent approach in other locations, 2) current Michigan data does not support this recommendation and 3) evidence to establish a correlation between bed capacity and safety/outcomes research suggests that positive outcomes are linked to factors such as family engagement, staff training, and adherence to evidence-based practices.

As MDHHS implements Qualified Residential Treatment Programs under the Family First Prevention Services Act, its contractual requirements and residential treatment programs will implement trauma-informed treatment models, staff professional competencies, licensed nursing, and intensive aftercare support to sustain each youth and family success in the community.

Primary Agency of Focus: **Michigan Legislature**
Secondary Agency(ies): **N/A**

The OCO recommends that the Michigan Legislature appropriate sufficient funds to support the establishment, monitoring, and administrative costs of CCI's with smaller resident populations as recommended in this document.

Ryan Speidel, Acting Ombudsman

Office of Children's Ombudsman

P.O. Box 30026

Lansing, MI 48909

P.O. BOX 30026 ● LANSING, MICHIGAN 48909 www.michigan.gov/oco

517-241-0400 ● Toll Free 800-642-4326