STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR
OFFICE OF CHILDREN'S OMBUDSMAN
LANSING
SUZANNA SHKRELI
DIRECTOR

Findings and Recommendations

Under state law a record of the Office of Children's Ombudsman's is confidential, 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: September 21, 2021

Child's Name: [redacted]

Date of Birth: [redacted]

Date of Death: June 28, 2020 (11 years of age)

Case No.: 2020-0044

Summary:

[redacted] died on June 28, 2020. Pursuant to MCL 722.627k, the Michigan Department of Health and Human Services (MDHHS) notified the Office of Children's Ombudsman (OCO) of the child fatality. On July 9, 2020, and pursuant to its statutory duties, the OCO opened an investigation into the handling of this matter by Kent County DHHS.

The OCO reviewed confidential records and information in the Michigan, Statewide Automated Child Welfare Information System (MiSACWIS), which includes but is not limited to: Children's Protective Services (CPS) complaints and investigation reports, court documents, police reports, and mental health records. The OCO also interviewed DHHS staff, mental health providers, and a reporting source.

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 Kent County DHHS, 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. This report 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:

[redacted] and her family came to the attention of the OCO after she murdered her son, [redacted] and then committed suicide on June 28, 2020. Prior to [redacted] death, [redacted] had one investigated CPS complaint within the 24 months preceding [redacted] death, and an open CPS investigation at the time of their deaths. Based on this and pursuant to MCL 722.926(2)(a), the OCO opened a full investigation in accordance with our statutory responsibilities on July 9, 2020.

Family History:

According to mental health records gathered from [redacted] mental health provider, Network 180, [redacted] had a history of receiving counseling services prior to October 2019. Network 180's records do not reflect when she sought counseling services or what they entailed. In October 2019, [redacted] self-reported to a Licensed Master of Social Work (LMSW) at Network 180, that she began to experience higher than normal levels of anxiety, began having sleep problems, disruptive ruminations, and frequent panic attacks. Consequently, and at the advice of her father, [redacted] and boyfriend, [redacted] sought out mental health services through Network 180 on October 23, 2019.

[redacted] had her initial assessment at Network 180 on November 5, 2019. Her symptoms were identified in those records as obsessing, depression, anxiety, panic attacks and some delusions and paranoia. She was also making quasi-suicidal and fatalistic statements. The OCO found no specific details about the actual statements made by [redacted] She agreed to a psychiatric evaluation for a medication assessment and accepted a referral for outpatient therapy in Network 180's crisis intervention program. She completed the psychiatric evaluation on November 6, 2019. She was diagnosed with major depressive disorder with anxiety and prescribed Abilify and Ativan.

[redacted] mental health records indicate she never took her medication as prescribed. She took the Ativan more often than the Abilify. When she did take the Abilify she only took half of the prescribed dose. To achieve more symptom relief, her psychiatrist added Zoloft to her medication regimen. [redacted] never took the Zoloft. [redacted] commonly expressed opposition to being dependent on medication.

[redacted] completed the crisis intervention program at Network 180 in December 2019. She continued to be seen by the psychiatrist there after this, but her condition was reported to continue to deteriorate. By January 13, 2020, she had stopped taking the Abilify and was beginning to express suicidal ideations. She, however, did not make any suicide attempts because she expressed concern about who would take care of her son if she were gone.

By January 21, 2020, [redacted] condition deteriorated to such an extent that the mental health professionals treating her wanted her to enter a partial hospitalization program. Ultimately, she refused even though two such programs had been identified for her. She did, however, continue to see her psychiatrist for her medication reviews, although she was still not complying with her medication regimen.

There is documentation in [redacted] records from Network 180 that on February 11, 2020, [redacted] mother contacted Network 180. [redacted] mother told Network 180 that [redacted] had expressed suicidal thoughts to her, and that [redacted] said she was [redacted] It is also documented in the Network 180 records that [redacted] mother contacted CPS for advice about [redacted] comments, but did not make a formal report to CPS. The Network 180 records do not specify who [redacted] mother called at CPS or what she told them. There is no record of [redacted] mother's call to CPS in the MDHHS internal database, MiSACWIS.

At this point in time, [redacted] mental health records indicate there is no contact between [redacted] Network 180, or any other mental health provider again until April 11, 2020. [redacted] failed to enroll in the Network 180 crisis intervention program on April 11, 2020. On April 12, 2020, [redacted] attempted suicide by overdosing on pills. [redacted] boyfriend at the time intervened, and [redacted] was unsuccessful in this suicide attempt. On April 13, 2020, [redacted] father) was with [redacted] when she stated that she was going to kill her son and then kill herself. During this incident [redacted] attempted to cut her wrists with keys and attempted to jump in front of moving traffic and then eventually from a moving vehicle. None of these suicide attempts were successful.

After these failed suicide attempts, [redacted] was admitted to Forest View Hospital on April 13, 2020. This occurred after her father and the Network 180 psychiatrist petitioned the court for involuntary hospitalization. The petition led to [redacted] accepting a deferral to the court hearing for her involuntary hospitalization. The deferral would last so long as she complied with treatment.

Because of the deferral of her hearing, [redacted] was at Forest View Hospital from April 13, 2020, to April 21, 2020. During her stay, on April 15, 2020, the first CPS complaint was made against [redacted] for the things she said to her father about killing herself and [redacted] It should be noted that [redacted] case manager at Forest View did not receive the suicidal statements directly from [redacted] and only knew of them because [redacted] father told the case manager.

[redacted] discharge from Forest View on April 21, 2020 occurred because she had a dental appointment. Forest View originally planned to allow her to go to the dentist appointment and then she was supposed to return but this did not happen. While she was at the dental appointment, she was told by Forest View that if she wanted to come back to inpatient, she would have to go through the intake screening process again at Network 180. At first, [redacted] attempted to do this but by the time she had completed the intake process she had changed her mind about hospitalization and left. Network 180 responded by completing a demand for hearing and notified the police to pick her up.

[redacted] was never picked up by the police and eventually showed up for an intake screening at Hope Network on April 27, 2020. This occurred because [redacted] ([redacted] boyfriend) discovered [redacted] researching ways to commit suicide on the internet. On this date, she entered Hope Network's Pivot Crisis Residential program. The Pivot Crisis Residential program is noted to be an alternative service to inpatient hospitalization for an individual in a mental health crisis. Hope Network's records indicate [redacted] was released from this program on May 1, 2020.

On May 4, 2020, CPS closed the April 15, 2020, investigation as a Category IV with a finding of no preponderance of evidence because [redacted] was actively receiving mental health care and [redacted] was in the care of [redacted] father.

Police reports indicate that on May 11, 2020, police did a welfare check on [redacted] because she was expressing suicidal ideations. On May 12, 2020, [redacted] her father, and her boyfriend went to Metro Health Hospital Emergency Department because of her suicidal ideations. According to the records, Metro Health Hospital petitioned the court for hospitalization since [redacted] was not being truthful about her mental health history or suicide attempts.

Due to the petition filed by Metro Health Hospital, [redacted] was involuntarily admitted to Forest Pine on May 12, 2020. During her stay there, she denied having a child, suicidal or homicidal ideations, intent or plans of suicide and minimized her symptoms. Her status was, however, changed to voluntary due to her willingness to cooperate with treatment. At this point, [redacted] medications were adjusted, and she was taken off Zoloft and placed on Cymbalta. She refused to allow anyone to contact her father without her present. She was to continue services through Hope Network upon discharge. [redacted] returned to Pine Forest Urgent Care via telehealth on June 17, 2020, due to concern over how her Cymbalta was making her feel. The decision was made during this meeting to keep her medication where it was even though [redacted] wanted to discontinue its use. [redacted] was discharged on May 15, 2020.

According to a police report dated June 21, 2020, [redacted] told her friend and neighbor, [redacted] that she had been researching ways to kill her son and herself, [redacted] called the police and [redacted] was taken to St. Mary's hospital because of this and her "history of suicidal threats and metal [sic] [mental] pick up orders…." After evaluation of [redacted] St. Mary's allowed her to leave because she denied ever making suicidal or homicidal comments about herself or her son to St. Mary's.

A second CPS complaint was made on June 22, 2020, alleging again that [redacted] was saying she was going to kill herself and her son. CPS made face-to-face contact with [redacted] and [redacted] and they all denied the allegations. CPS also concluded that since [redacted] was not hospitalized from the recent incident, she must not be a threat to herself of anyone else.

During the weekend of June 26, 2020, [redacted] and [redacted] went on a vacation to Mackinaw City with [redacted] and his two daughters. When [redacted] was checking out of the hotel on June 28, 2020, [redacted] and [redacted] went on a walk. They never returned from the walk. [redacted] looked for them and found them both dead in a storage shed in an apparent murder-suicide by [redacted] Records indicate [redacted] used [redacted] gun to shoot [redacted] and herself in the forehead.

[redacted] and [redacted] deaths were reported to CPS Centralized Intake on July 7, 2020, by the [redacted], which was still an open CPS investigation. As you will read below, the June 22, 2020 CPS investigation was concluded on July 30, 2020 with a finding of no preponderance of evidence. CPS stated the

reason for the no preponderance finding was because [redacted] was deceased, and she had no surviving children.

Scott Clements
Investigator

Finding(s):

Primary Agency of Focus:	Forest View Hospital
Secondary Agency(ies):	
MCL 330.1748a, MCL 333.2640, and MCL 333.16281 grant mental health professionals the legal authority and obligation to share their records with CPS during an investigation of suspected child abuse or neglect, even without the consent of a client. Despite this, CPS was denied access to mental health records pertaining to [redacted] by Forest View Hospital during the April 15, 2020 CPS investigation because [redacted] refused to sign a release of information.	

Primary Agency of Focus:	Kent County DHHS
Secondary Agency(ies):	
MCL 330.1748a, MCL 333.2640, MCL 333.16281 and form DHHS 1163-P, grant CPS the authority to obtain a client's mental health records without their consent. Kent County CPS did not utilize these laws, policies, or the relevant form to obtain [redacted] mental health records after they were denied access by Forest View Hospital during the April 15, 2020 CPS investigation.	

Primary Agency of Focus:	Kent County DHHS
Secondary Agency(ies):	Children's Services Administration
The OCO finds that for the better protection of children at risk of harm, CPS must secure mental health records in a timely manner and be given adequate time to review these records thoroughly and accurately. The OCO determined that [redacted] sought services from at least seven different providers within the six months preceding her and [redacted] deaths. The combined records exceeded 500 pages in length and took the OCO two to twenty-eight days to obtain.	

Primary Agency of Focus:	Children's Services Administration
Secondary Agency(ies):	
The OCO finds that current CPS policy is limited when providing instruction to CPS workers on what to do when allegations are received that a caregiver's mental health is placing a child in harm's way. Policy is limited to discussing the need to make collateral contacts with mental health professionals if needed, what constitutes threatened harm, how to request mental health records, and about the possibility of getting a psychiatric and/or psychological evaluation of a caregiver.	

CPS policy does not offer concrete ways to address a caregiver's mental health and its effects on a child's safety. Such clarification exists in policy when it comes to other similar situations like domestic violence, substance abuse, child deaths, and when a child is found home alone.

Primary Agency of Focus:	Kent County DHHS
Secondary Agency(ies):	
The OCO finds, given the facts and circumstances obtained by CPS, [redacted] death could not be prevented through CPS action. This case illustrates the need for policy and law enhancement as outlined in the OCO's recommendations to make similar deaths less likely in the future.	

Recommendation(s):

Primary Agency of Focus:	Michigan Legislature
Secondary Agency(ies):	
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.	

Primary Agency of Focus:	Children's Services Administration
Secondary Agency(ies):	
The OCO recommends that 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.	

Primary Agency of Focus:	Michigan Legislature
Secondary Agency(ies):	
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, 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.

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

The OCO recommends that 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.

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

The OCO recommends that 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?

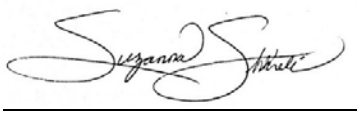
- Has the caregiver's mental health condition caused substantial impairment of judgement or irrationality to the extent that the child(ren) was abused or neglected?

- 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.

The OCO believes that policy addressing allegations that a caregiver's mental health is placing a child in harm's way could be expanded and enhanced to provide CPS workers with better guidance when handling such situations.



Suzanna Shkreli
Children's Ombudsman

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

November 24, 2021

Suzanna Shkreli
Office of Children's Ombudsman
401 S Washington Sq Ste 103
Lansing, MI 48933

Dear Ms. Shkreli:

The following is the Michigan Department of Health and Human Services (MDHHS) response to the findings and recommendations from the Office of Children's Ombudsman (OCO) Report of Findings and Recommendations regarding [redacted]

This report contains confidential information from a Children's Protective Services file. The Michigan Child Protection Law [MCL 722.627, section 7(3)] prohibits the release of this information to any individual/entity not authorized under Section 7(2) of the law. Pursuant to Section 13(3), release of this confidential information to an unauthorized individual/entity may subject you to criminal and/or civil penalties.

Finding(s):

Primary Agency of Focus:	Forest View Hospital
Secondary Agency(ies):	
MCL 330.1748a, MCL 333.2640, and MCL 333.16281 grant mental health professionals the legal authority and obligation to share their records with CPS during an investigation of suspected child abuse or neglect, even without the consent of a client. Despite this, CPS was denied access to mental health records pertaining to [redacted] by Forest View Hospital during the April 15, 2020 CPS investigation because [redacted] refused to sign a release of information.	

Primary Agency of Focus:	Kent County DHHS
MCL 330.1748a, MCL 333.2640, MCL 333.16281 and form DHHS 1163-P, grant CPS the authority to obtain a client's mental health records without their consent. Kent County CPS did not utilize these laws, policies, or the relevant form to obtain [redacted] mental	

health records after they were denied access by Forest View Hospital during the April 15, 2020 CPS investigation.

Primary Agency of Focus:	Kent County DHHS
Secondary Agency(ies):	Children's Services Agency
The OCO finds that for the better protection of children at risk of harm, CPS must secure mental health records in a timely manner and be given adequate time to review these records thoroughly and accurately. The OCO determined that [redacted] sought services from at least seven different providers within the six months preceding her and [redacted] deaths. The combined records exceeded 500 pages in length and took the OCO two to twenty-eight days to obtain.	

Primary Agency of Focus:	Children's Services Agency
Secondary Agency(ies):	
The OCO finds that current CPS policy is limited when providing instruction to CPS workers on what to do when allegations are received that a caregiver's mental health is placing a child in harm's way. Policy is limited to discussing the need to make collateral contacts with mental health professionals if needed, what constitutes threatened harm, how to request mental health records, and about the possibility of getting a psychiatric and/or psychological evaluation of a caregiver. CPS policy does not offer concrete ways to address a caregivers' mental health and its effects on a child's safety. Such clarification exists in policy when it comes to other similar situations like domestic violence, substance abuse, child deaths, and when a child is found home alone.	

Primary Agency of Focus:	Kent County DHHS
Secondary Agency(ies):	
The OCO finds, given the facts and circumstances obtained by CPS, [redacted] death could not be prevented through CPS action. This case illustrates the need for policy and law enhancement as outlined in the OCO's recommendations to make similar deaths less likely in the future.	

Recommendation(s):

Primary Agency of Focus:	Michigan Legislature
Secondary Agency(ies):	
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 Response to Recommendation: MDHHS supports this recommendation to the legislature and is pursuing a contract to review the existing mandated reporter training curriculum and develop new and enhanced materials with a specific focus on addressing implicit bias and disproportionality. Should the Legislature support this recommendation, MDHHS may need additional funding to ensure all mandated reporters receive the updated curriculum on a regular and reoccurring basis.

Primary Agency of Focus:	Children's Services Agency
Secondary Agency(ies):	

The OCO recommends that MDHHS Children's Services Agency 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 to Recommendation: 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.

Primary Agency of Focus:	Michigan Legislature
Secondary Agency(ies):	

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, 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.

MDHHS Response to Recommendation: MDHHS supports the recommendation requiring release of mental health records to CPS within 7 calendar days of the request.

Primary Agency of Focus:	Children's Services Agency
Secondary Agency(ies):	

The OCO recommends that 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 to Recommendation: 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.

Primary Agency of Focus:	Children's Services Agency
Secondary Agency(ies):	

The OCO recommends that the MDHHS Children's Services Agency 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.

The OCO believes that policy addressing allegations that a caregiver's mental health is placing a child in harm's way could be expanded and enhanced to provide CPS workers with better guidance when handling such situations.

MDHHS Response to Recommendation: 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.

Thank you for the opportunity to respond to this Report of Findings and Recommendations. If you have questions or concerns, please feel free to contact me.

Sincerely,

Demetrius Starling
Executive Director
Children's Services Agency