STATE OF MICHIGAN
GRETCHEN WHITMER
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LANSING
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Report of Findings and Recommendations Preamble

May 12, 2023

Office of Children's Ombudsman (OCO) Case No: 2020-0225 and 2021-0416

The attached report of findings and recommendations is being made public pursuant to the Children's Ombudsman Act. The report has been redacted as required by Michigan law.

Two OCO investigations found similar evidence and circumstances in two separate children's protective services cases. All personal identifying information has been redacted. Initials were not redacted to allow the reader a better understanding of the separate investigations.

The OCO investigation was conducted during my tenure as the OCO deputy director. The report of findings and recommendations was authored by a multidisciplinary team at the OCO. As acting children's ombudsman, I support the findings and recommendations made in this document.

Ryan J. Speidel
Acting Children's Ombudsman

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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 is exempt from disclosure under the Freedom of Information Act.

Date: January 30, 2023

Case No: 2020-0225, 2021-0416

Summary:

The Office of Children's Ombudsman (OCO) effects changes in policy, procedure, and legislation by investigating and reviewing actions of the Michigan Department of Health and Human Services (DHHS), child placing agencies, or child caring institutions. The OCO ensures laws, rules, and policies pertaining to children's protective services, foster care, and adoption are being followed. *The Children's Ombudsman Act*, Public Act 204 of 1994. The OCO is an autonomous entity, separate from the DHHS.

The OCO review included reading confidential records and information in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), service reports, medical records, social work contacts, court documents, photographs, text messages, drug screens, and law enforcement reports. The OCO also interviewed complainants, DHHS staff, guardians, lawyer-guardian ad litem (LGAL), foster parents, prosecutors, medical personnel, and law enforcement personnel. Due to the confidentiality of OCO investigations, the OCO cannot disclose the identity or sources of statements and evidence.

The objective of this review is to identify areas for improvement in the child welfare system by looking at how the families' cases were handled by Marquette County CPS (CPS), and the involvement of staff, court personnel, physicians, and law enforcement. This review reinforces that 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 the investigations; inform policy, procedure, and practice of DHHS; and advocate for changes in the child welfare system on behalf of similarly situated children.

The OCO opened investigations of Marquette County CPS on June 11, 2020, and May 21, 2021, based on allegations that the agency failed to protect children and families when the agency delayed filing petitions to remove children from their homes despite numerous reports of substance abuse, domestic violence, physical abuse, and neglect.

OCO Investigation #1: L[redacted] V[redacted]

Background and History

A[redacted] V[redacted] and D[redacted] V[redacted] are the parents of L[redacted] V[redacted] (DOB [redacted]) and K[redacted] V[redacted] (DOB [redacted]). The V[redacted]s also had an older daughter named K[redacted] to which their parental rights were voluntarily terminated in 2016 due to substance abuse. K[redacted] was later adopted by her paternal grandfather.

In 2017, L[redacted] was removed from D[redacted] and A[redacted]'s care because they did not cooperate with services after it was determined the V[redacted] home was not a safe place for L[redacted] due to drug use and the condition of the home. L[redacted] was reunified with her parents one year later, after they successfully completed and benefitted from reunification services.

From 2014 to 2020, Child Protective Services Centralized Intake (Centralized Intake) received numerous complaints concerning A[redacted] and D[redacted]'s substance abuse and related issues. The following history is meant to inform the reader of the pattern of drug use that the OCO uncovered during the investigation. Although the history from 2014 to 2020 is not the basis for this OCO investigation, it is important to provide a full picture of the V[redacted] family's history and frequent interactions with CPS. The OCO did not investigate the cases from 2014 to 2020 and therefore issues no findings relating to the CPS investigations completed during that timeframe.

2014

- December 30, 2014. A complaint was made to CPS alleging that K[redacted] was born with Subutex and Neurontin in her system and was receiving methadone to treat her withdrawal from these drugs. After investigating this complaint, CPS found that no preponderance of evidence of child abuse and/or neglect existed because A[redacted] was prescribed the drugs K[redacted] was born with in her system.

2015

- January 12, 2015. A complaint was made to CPS alleging that A[redacted] and D[redacted] were addicted to opioids which impacted their ability to safely care for K[redacted], because it was alleged when they get high, they are "extremely high." This complaint was not investigated because the December 30, 2014, complaint was still open and alleged similar allegations.
- February 2, 2015. A complaint was made to CPS alleging that A[redacted] and D[redacted] were found intravenously injecting drugs in a car with K[redacted] where needles were

strewn about the car. When this happened, police took K[redacted] into protective custody. After investigating this complaint, CPS found that a preponderance of evidence existed that A[redacted] and D[redacted] improperly supervised and placed K[redacted] in a situation of threatened harm. K[redacted] was subsequently removed from their care and placed into relative foster care. While K[redacted] was in relative foster care, A[redacted] and D[redacted] failed to participate in services to address their substance abuse issues. Subsequently, A[redacted] and D[redacted] released their parental rights to K[redacted] and she was later adopted by her paternal grandfather.

2017

- January 28, 2017, and February 3, 11, and 13, 2017, complaints were made to CPS alleging A[redacted] and D[redacted] had another child, L[redacted], and that they were struggling with drug addiction and maintaining stable housing. L[redacted] was also born with prescription medications in her system and was going through withdrawals. After investigating these complaints, CPS found that there was a preponderance of evidence that both A[redacted] and D[redacted] improperly supervised and placed L[redacted] in a situation of threatened harm because they did not have suitable housing for themselves and L[redacted].
- March 9, 2017. A complaint was made to CPS alleging that L[redacted] was born with drugs in her system and that her respiratory rate was too high. An in-home nurse told A[redacted] to take L[redacted] to the emergency room, but A[redacted] refused. After investigating this complaint, CPS found a preponderance of evidence existed that A[redacted] medically neglected L[redacted] after A[redacted] failed to follow medical advice to take L[redacted] to the emergency room. This case was closed because the January 28, 2017 complaint was still open, and the family was working with service providers.
- June 7, 2017. A complaint was made to CPS made alleging that L[redacted] presented with a yeast infection and dirt all over her body, including in the folds of her skin and under her toes and fingernails. After investigating this complaint, CPS found that no preponderance of evidence of child abuse and/or neglect existed that A[redacted] or D[redacted] physically neglected L[redacted] because each time CPS visited the home, including two unannounced visits, the caseworker observed that L[redacted] appeared to be healthy and clean.
- July 14, 2017. A complaint was made to CPS alleging that D[redacted] drove L[redacted] to the doctor's office and was high or intoxicated to the extent that he could not stand straight and was slurring his speech. After investigating this complaint, CPS found a preponderance of evidence existed that A[redacted] and D[redacted] physically neglected, improperly supervised, and placed L[redacted] in a situation of threatened harm because D[redacted] admitted to driving L[redacted] to the doctor's office while high or intoxicated and was unable to appropriately care for her. The parents also failed to comply with CPS's safety plan to clean up their home which had needles throughout, follow safe sleep practices, and work with service providers. Consequently, L[redacted] was removed from her parents' care and placed into foster care.

- September 3, 2017. A complaint was made to CPS alleging that A[redacted] and D[redacted]'s substance use had gotten worse since L[redacted] entered foster care. It was also alleged that A[redacted] once shook L[redacted] and D[redacted] had to hit A[redacted] to get her to stop shaking L[redacted]. The foster care staff were notified of this complaint. Over the course of the foster care case, A[redacted] and D[redacted] gradually complied with services and L[redacted] was returned to their care on June 7, 2018, with family reunification services in place.

2018

- June 28, 2018. A complaint was made to CPS alleging that needles were observed in the V[redacted] home, and it was suspected that A[redacted] and D[redacted] were using drugs again even though L[redacted] had just been returned to their care. There were also concerns with the cleanliness of the home, as it was reported there was clothing and garbage all over. The foster care staff were notified of this complaint.
- The court dismissed jurisdiction over L[redacted] in September 2018 due to A[redacted] and D[redacted] complying with services.

2019

- On February 26, 2019. A complaint was made to CPS alleging A[redacted] and D[redacted] are regularly using drugs while caring for L[redacted]. There were also concerns with the condition of the home. After investigating this complaint, CPS found no preponderance of evidence existed because A[redacted] and D[redacted] denied using substances they were not prescribed, their drug screens came back positive only for their prescribed medications, and they cleaned up the home.
- May 2, 2019. A complaint was made to CPS alleging that A[redacted] and D[redacted] were drug users, were selling drugs out of their home, and using them in front of L[redacted]. Centralized Intake rejected the complaint after their preliminary investigation revealed that law enforcement did not receive any calls about the V[redacted] home for drug related issues.
- May 28, 2019. A complaint was made to CPS alleging A[redacted] and D[redacted] were drug users and were selling drugs out of the home. There was also frequent traffic in and out of the home. This complaint was not investigated by CPS because the allegations were documented to be "vague and speculative."
- June 24, 2019. A complaint was made to CPS alleging that A[redacted] and D[redacted] were using methamphetamine and Suboxone with L[redacted] present. It was also alleged that there were needles, cigarettes, and garbage throughout the home. After investigating this complaint, CPS found that no preponderance of evidence existed because when CPS visited the home there were no safety hazards observed. L[redacted] appeared to be adequately cared for, the parents denied using drugs that were not prescribed to them, and only tested positive for marijuana and drugs they were prescribed.
- December 13, 2019. A complaint was made to CPS alleging that D[redacted] appeared to be under the influence of some substance while caring for L[redacted], including driving

with her in the car. This complaint was not investigated because the allegations were "vague" and there were two recent investigations of the parents regarding substance abuse that were denied.

2020

- October 22, 2020. A complaint was made to CPS alleging that A[redacted] had given birth to K[redacted] and K[redacted] had been started on methadone due to her Neonatal Abstinence Syndrome (NAS) scores. A[redacted] used Subutex and Neurontin while pregnant with K[redacted]. After investigating this complaint, CPS found that no preponderance of evidence existed that child abuse and/or neglect occurred because K[redacted] was only born positive for substances A[redacted] was prescribed and A[redacted] had all the necessary baby items to adequately care for K[redacted].

Summary of OCO Investigation into DHHS' Actions (V[redacted])

A complaint was made to the OCO alleging CPS received and failed to properly respond to a complaint involving the V[redacted] family on May 2, 2021. The OCO investigation centered around CPS's handling of the May 2, 2021 complaint, alleging that L[redacted], age 4, was observed crossing a street near a busy highway and went to a park unsupervised.

On May 2, L[redacted] was observed alone in a park by a bystander who called 911. Shortly after police arrived at the scene, A[redacted] called 911 because she could not find L[redacted]. The V[redacted]s were told that law enforcement was with L[redacted] at the park, and the V[redacted]s could meet there to pick L[redacted] up. Law enforcement noticed that there were needles on the floor of the V[redacted]'s car. Police reports note that the V[redacted]s did not appear to be under the influence of drugs or alcohol, and L[redacted] was returned to them. This incident was called into Centralized Intake and a complaint was assigned to CPS for investigation. As a result, CPS created a safety plan requiring A[redacted] and D[redacted] to install a dead bolt in the home so L[redacted] could not run loose and go to the park. CPS informed the family they would check the home in a few days to see if the lock was installed.

On May 7, 2021, law enforcement contacted CPS to request immediate assistance at the V[redacted] home. D[redacted] was arrested following a domestic altercation with A[redacted]. According to the CPS Investigation report, A[redacted] told CPS that she and D[redacted] fought over money, he trashed the home, and choked and hit her. D[redacted] appeared to be under the influence of an unknown substance and law enforcement had concerns that A[redacted] was unable to properly supervise L[redacted] and K[redacted]. The house had a foul odor, garbage bags were piled waist high around the house, there was a container full of needles in the bathroom, and the deadbolt was not yet installed on the front door as agreed upon in the safety plan.

On May 11, 2021, CPS received a second complaint about the same domestic altercation. The second complaint was rejected as already investigated. There is no indication that the CPS specialist investigating the allegations attempted to contact or interview the medical

professional who filed the complaint. This second complaint added more detail to the May 7, 2021, incident. The complainant informed Centralized Intake that A[redacted] disclosed that when she woke up on May 7, D[redacted] was "inside her" and started beating her. According to the complaint, D[redacted] was hitting A[redacted] while she was holding their one-year-old daughter, K[redacted]. Because of this, A[redacted] had to toss K[redacted] on the bed. After this occurrence, K[redacted] had a bruise on her head. A[redacted] was physically abused in the bedroom and living room, causing her pain and bruises. D[redacted] allegedly stole $4,000.00 out of A[redacted]'s bank account and smashed her phone. The children were not physically harmed; however, they may have witnessed some or all of the violence.

In its response to the domestic violence incident, CPS created a safety plan requiring A[redacted] to change the locks on the door to prevent D[redacted] from returning. The agency and law enforcement recommended that A[redacted], L[redacted], and K[redacted] move in with A[redacted]'s mother, and not return until the house is clean, there were new locks installed, and CPS verified compliance with this safety plan.

CPS had a case conference on May 12, 2021. According to the conference report, the caseworker was supposed to go to the home that day, however the OCO was unable to find any record in MiSACWIS showing the visit happened.

On May 17, 2021, L[redacted] was found alone a block and a half from her home. Law enforcement was called and responded to retrieve L[redacted] and return her home. Law Enforcement again reported this to CPS. According to law enforcement and CPS reports, A[redacted] was home, lethargic, and had slurred speech. A[redacted] was not aware that L[redacted] was missing. Reports show that L[redacted] wandered off because she was hungry and searching for food as there was no food in the home. A[redacted] was not in compliance with the safety plan created on May 3, 2021, because she had not yet installed the dead bolt that would prevent L[redacted] from wandering off.

CPS made a home visit on May 18, 2021. During this visit, CPS provided the V[redacted] family with a lock for the door and asked A[redacted] to install it by the end of the day. The caseworker asked A[redacted] why she wasn't following the safety plan, which included installation of the lock and staying with maternal grandmother until the house was cleaned. A[redacted] said that she was only in the house to clean, she fell asleep, and L[redacted] wandered off again. It was noted that there was dirty laundry lying around the house.

On May 21, 2021, the agency received D[redacted]'s drug screen results from his May 14, 2021, drug screen. The drug screen was positive for amphetamine and Buprenorphine. D[redacted] told CPS he had a prescription for both drugs.

A CPS complaint was made on May 21, 2021, stating that law enforcement was dispatched to the V[redacted] family's residence on May 20, 2021, for a well-being check regarding rumors that A[redacted] was under the influence while caring for the children. Both children appeared unharmed, but there were two syringes observed in the home that were accessible to the

children. A[redacted] appeared "slightly" under the influence but capable enough to care for the children. The syringes were disposed of. This complaint was rejected for investigation because the earlier complaints assigned in May 2021 dealt with similar issues. CPS visited the home on May 21, 2021. CPS created another safety plan with A[redacted] because of the concerns that were reported by law enforcement the previous day. The safety plan stated that A[redacted] was not to use drugs, not leave her children unsupervised, and they were not to return to the home with the children before the case is closed and CPS verifies it for habitability and cleanliness. During this visit, CPS found the house was still unsanitary and the dead bolt, that was agreed upon in the safety plan created on May 7, 2021, and provided to A[redacted] on May 18, 2021, was still not installed.

The OCO received a complaint on May 21, 2021, due to unaddressed safety concerns regarding the V[redacted] children.

On May 28, 2021, the OCO was made aware the children had a routine medical wellness examination on May 26, 2021. The Children's Ombudsman contacted the health care provider on May 28, 2021. The provider stated that during this examination, they observed new injuries on K[redacted]'s head. One injury was a grape-sized red contusion on the left side of her head, between the ear and forehead. During the two-hour long exam, the contusion changed color and got darker. The provider also discovered a baseball-sized contusion on the right side of K[redacted]'s head. The provider stated she had been a pediatric nurse for over a decade and had never seen anything like this injury before. The provider believed that the contusion on the left side of the K[redacted]'s head was consistent with A[redacted]'s explanation that L[redacted] hit K[redacted] with a buckle. The provider said that the contusion on the right side of K[redacted]'s head was not consistent with being hit by a buckle. The provider ordered x-rays and bone scans. The medical provider explained they were aware of the domestic violence incident from May 7, 2021, and the contusions discovered during this examination were more recent than that. The provider told the Children's Ombudsman that the current injuries were quite urgent. The provider shared concerns about A[redacted]'s follow through regarding the children's medical appointments because it took her 16 days to bring the children to the emergency room after the May 7, 2021 domestic violence incident.

The OCO became aware of the head contusions because the Children's Ombudsman contacted the medical provider and asked questions. There was no information in MiSACWIS regarding these injuries. At the completion of this investigation, the only documentation of the head contusions in MiSACWIS are listed in the petition that CPS filed on May 28, 2021, requesting removal of the children. Based on the new information provided to CPS by the OCO, CPS found that a preponderance of evidence existed that D[redacted] and A[redacted] improperly supervised, physically neglected, and placed the children in threatened harm. This decision was based on L[redacted] wandering away from the home unsupervised on two occasions, D[redacted] and A[redacted] getting into a physical altercation while under the influence with the children present, the unsuitable conditions of the V[redacted] family home, D[redacted] and A[redacted]'s continued substance abuse, and their failure to follow the

agreed upon safety plans. The investigation was classified as Category I, and the children were removed from home and placed in foster care

OCO Investigation #2: V[redacted] K[redacted]

Background and History

K[redacted] C[redacted] is the biological mother of K[redacted] M[redacted] (DOB [redacted]) and V[redacted] K[redacted] (DOB [redacted]). K[redacted]'s biological father is M[redacted] M[redacted], and V[redacted]'s biological father is C[redacted] K[redacted].

From 2015 to 2018, Centralized Intake received numerous complaints concerning K[redacted]'s substance abuse and related issues. The following history is meant to inform the reader of the pattern of substance abuse and related issues that the OCO uncovered during the investigation. The history from 2015 to 2018 is not the basis for this OCO investigation but is included to provide a full picture of CPS history and frequent interactions between CPS and K[redacted] and C[redacted]. The OCO did not investigate the cases from 2015 to 2018 and therefore issues no findings relating to the CPS investigations completed during that timeframe. K[redacted] and C[redacted] have extensive CPS histories including struggles with drug use, mental health, housing, and domestic violence.

2018

- May 23, 2018. CPS was contacted and initiated an investigation because K[redacted] tested positive for marijuana, morphine, and benzodiazepines while pregnant with V[redacted]. K[redacted] tested positive for marijuana when V[redacted]a was born. V[redacted] was born positive for Buprenorphine, Norbuprenorphine, and Gabapentin. All the medications V[redacted] tested positive for were prescribed to K[redacted]. V[redacted] was hospitalized for approximately a month and a half due to the withdrawals from the medication. Because K[redacted] was prescribed all the medications V[redacted] tested positive for, CPS found that K[redacted] did not abuse or neglect V[redacted]. The May 23, 2018, CPS investigation was then closed on August 31, 2018.
- May 31, 2018, June 28, 2018, July 27, 2018, and August 16, 2018. While the May 23, 2018 CPS investigation was open, four additional CPS complaints were made against K[redacted] and C[redacted] alleging substance abuse and domestic violence between them. The CPS complaints made on May 31 and June 28, 2018, were rejected by CPS for investigation. The July 27 and August 16, 2018, complaints were assigned for investigation.
- July 27, 2018. The CPS investigation revealed that V[redacted] was present for a domestic violence incident that took place between K[redacted] and C[redacted]. Based on this, CPS opened an ongoing case to monitor the family and provide them with services to address these issues. The case was open until June 25, 2019. CPS found that no abuse or neglect took place in the July 27, 2018, investigation.

- July 27, 2018. During the eleven months of the July 27, 2018, ongoing CPS case, there were eight additional CPS complaints made against either K or C involving their care of V. These complaints involved allegations of substance abuse, homelessness, and improper supervision. Of the eight complaints made, two were assigned for investigation while the other six were rejected. MiSACWIS shows that the six complaints were rejected since they could be addressed by the CPS worker assigned to the July 27, 2018, ongoing case. No abuse or neglect was found in the two complaints that were investigated.
- July 27, 2018. During the ongoing CPS investigation, V was in an unstable environment because she was moved around between K, C, and other people's care. These other people were relatives and others who K and C met through their service providers. One of these individuals was, M H. At one point during this timeframe, V was cared for by relatives in a POA.

2019

- June 25, 2019. By the time the July 27, 2018, ongoing case was closed on June 25, 2019, V was under the care and supervision of her father, C. C, however, had been using M H and others to care for V for extended periods of time. The CPS Updated Service Plan stated that the July 27, 2018, ongoing case was closed because V had been with C for six months without a POA and no concerns were expressed by anyone. CPS found that C participated in services and closed the case on July 27, 2018.
- July 2019. Within a month of the July 27, 2018, ongoing case closing, three additional CPS complaints were made (July 2, 9, and 24, 2019) against K, C, or both. These complaints alleged that C and K were back together using substances and, consequently, were not adequately caring for V. The allegations said they did not have stable housing, were not attending to V's needs, were using drugs in front of V, and were leaving drugs and drug paraphernalia within V's reach. The July 2 and 24, 2019, complaints were assigned for investigation and the July 9, 2019, complaint was rejected for investigation. The CPS investigations on July 2, 2019, and July 24, 2019, found a preponderance that C and K neglected V. The July 2, 2019, investigation was closed on August 14, 2019.

Summary of OCO Investigation into DHHS Actions (K)

This investigation originated after a complaint was made to the OCO alleging the agency failed to file a timely petition to keep V safe after continued exposure to substance abuse, homelessness, and domestic violence. The OCO found that the parent's failure to comply with appropriate services caused V to be unsafe in their custody. Instead of filing a petition for removal, the agency allowed K and C to create a temporary POA, placing V with M H in July 2019 and again in September 2019. While

under the POA, K[redacted] and C[redacted] did not comply with CPS services and often did not want to increase the frequency of parenting time. In June 2020, K[redacted] and C[redacted] wanted to dissolve the POA because they wanted V[redacted] back in their care. After K[redacted] and C[redacted] requested that M[redacted] return V[redacted] to their custody, M[redacted] filed a petition for guardianship of the child, which after several months, was granted by the court.

The OCO's focus for this investigation stems from a complaint made to CPS on July 24, 2019. The complaint filed with Centralized Intake stated that the home K[redacted] and C[redacted] were living in was a drug house and both parents injected methamphetamine and Suboxone in front of V[redacted] who was 14 months old at the time. The complaint states that needles were left out where V[redacted] could access them while K[redacted] and C[redacted] slept for extended periods of time, ignoring V[redacted] when she cried. The complainant also informed CPS that C[redacted] purposefully poked V[redacted] in the neck with a needle and was planning to blame K[redacted] so she would be in trouble. Additionally, the complainant stated there was no running water in the home. CPS found a preponderance of evidence existed that K[redacted] and C[redacted] improperly supervised, physically neglected, and placed V[redacted] in a situation of threatened harm. The threatened harm preponderance was a result of K[redacted] and C[redacted] continually exposing V[redacted] to instability when they removed V[redacted] from safety plans and POAs. The case was identified as a Category II and an ongoing case was opened for monitoring and services. Another POA was used to place V[redacted] with M[redacted] H[redacted].

When the July 24, 2019 ongoing case was opened, V[redacted] was in a POA with M[redacted], while her parents were in inpatient substance abuse treatment. Records indicate that C[redacted] left his program early and retrieved V[redacted] from M[redacted] on September 6, 2019. On September 12, 2019, CPS found C[redacted], K[redacted], and V[redacted] at an apartment. C[redacted] and K[redacted] appeared to be under the influence and had been involved in a recent domestic violence altercation. CPS convinced K[redacted] and C[redacted] to agree to place V[redacted] back in a POA with M[redacted] H[redacted] while they received help through services. A safety plan was developed with K[redacted]. She agreed to leave V[redacted] in the care of [redacted] H[redacted]. K[redacted] agreed that if the safety plan is not followed, then CPS will file a petition to remove V[redacted] from her care. She also agreed to supervised visits with V[redacted].

K[redacted] and C[redacted] located housing and employment in Houghton County, Michigan, in October 2019. They agreed to participate in drug screens and co-occurring mental health and substance abuse counseling. A CPS courtesy worker from Houghton County was assigned to their case with Marquette County still having primary responsibility.

K[redacted] completed a substance abuse assessment on October 21, 2019, and was diagnosed with severe opioid, amphetamine, alcohol, cocaine, and cannabis use disorders. Due to her diagnosis, the service provider, [redacted], recommended K[redacted] complete bi-weekly/monthly individual therapy sessions and weekly group sessions. [redacted] also recommended she address her legal and mental health concerns. C[redacted] also completed a substance abuse assessment and was diagnosed with severe opiate,

methamphetamine, and alcohol use disorder and mild cannabis use disorder. [redacted] also recommended he complete bi-weekly outpatient substance abuse therapy.

K[redacted] and C[redacted] partially participated in treatment, they would attend some appointments and not others. They were still testing positive for THC, which their treatment provider informed them they should stop using. K[redacted] also tested positive for Dextrorphanol, and both K[redacted] and C[redacted] tested positive for Kratom. K[redacted] was no longer employed, and they were considering a potential move. K[redacted] was eventually discharged from treatment for missed appointments.

In May 2020, C[redacted] and K[redacted] wanted V[redacted] back from M[redacted]. CPS responded to this by developing a safety plan for this to occur gradually over time. However, K[redacted] and C[redacted] were not in favor of this plan and wanted V[redacted] to return to them right away. Out of concern for the welfare of V[redacted], and CPS' response to the situation, M[redacted] filed for guardianship.

On November 30, 2020, during the open services case, a complaint was made to Centralized Intake stating on November 28, 2020, C[redacted] and K[redacted] had a visit with V[redacted] and there was concern they were using marijuana while V[redacted] was in their presence. Their vehicle smelled strongly of marijuana, but it was unknown if K[redacted] and C[redacted] were under the influence. After the visit, V[redacted] was coughing intermittently for an hour.

Due to the parents refusing to agree to a limited guardianship, a trial was held on the guardianship petition. On March 29, 2021, a decision was rendered by a judge ordering M[redacted] to serve as temporary guardian of V[redacted] while a transition back to the parents occur. The transition was to include all the parties participating in mediation to work on issues of increased parenting time. In the meantime, parenting time was to occur every other weekend. The guardianship was to be reviewed on June 2, 2021. The parents chose not to participate in the court-ordered mediation. As a result, the parenting time order consisted of overnights every other weekend. There were some video visits that took place.

K[redacted] and C[redacted] found a new home and moved in February 2021. They continued to work intermittently. They also continued to participate in counseling and substance use services, which they reported they planned to continue with once the CPS case closed. The July 24, 2019, ongoing case closed on April 10, 2021, based on the granting of the temporary guardianship and the parents' compliance with services.

Findings:

Use of Safety Plans or Power of Attorney in Lieu of a Petition for Removal

1. During Marquette County's involvement with each family, safety concerns involving these children increased in frequency and severity. Safety plans and guardianships were used by CPS in lieu of filing a petition to address the escalated abuse and neglect.
    a. CPS continued to use safety plans that the families failed to adhere to on multiple occasions.
    b. Regarding V[redacted], a POA was utilized as a safety plan. The child's parent wanted to take V[redacted] back and dissolve the POA. Concerned for V[redacted]'s safety due to her parents' history of non-compliance with services, continued substance abuse, and domestic violence, the agent of the POA applied for full guardianship to prevent V[redacted] from being returned to her parents.
2. Failure of safety plans, a dissolution of a POA, and additional evidence obtained throughout the course of these investigations unequivocally show that the individuals responsible for the children in these investigations were abusive and/or neglectful towards them, and a petition for removal was required under MCL 722.628d(1)(e)(ii).
3. After the OCO communicated with Marquette County DHHS management about concerns regarding the V[redacted] case, a petition was filed by Marquette County DHHS which was subsequently granted by Marquette County Circuit court.

The Multidisciplinary Team

4. Contrary to the Multidisciplinary Team (MDT) best practice model[1], evidence in the OCO's investigation highlights a substantial lack of communication and cooperation among the county's child welfare partners including child protective services and law enforcement.
    a. Through its investigations, the OCO found that the relationship between Marquette County DHHS management and the law enforcement in Marquette County, was and continues to be strained. In interviews the OCO conducted, it was reported that law enforcement officers develop their own safety plans with relatives of children directly rather than calling allegations into Centralized Intake due to the breakdown of the MDT relationship.

Rejected Complaints During an Open Investigation or Ongoing Services Case

5. Specific to the V[redacted] family, the OCO found that between 2015 and 2021, there were twelve occasions new allegations were called into Centralized Intake during an open active abuse/neglect investigation or an open ongoing services case. The new allegations were rejected *or* accepted and linked to the current case. The allegations

[1] MCL 722.627b(4); State of Michigan Governor's Task Force on Child Abuse and Neglect: A Model Child Abuse and Neglect Protocol Utilizing a Multidisciplinary Team Approach, DHS-Pub-794.

were only emailed to the current CPS or ongoing services specialist. In those twelve instances, the OCO did not find evidence that the CPS or ongoing specialists either reviewed or investigated the new allegations. By policy[2], DHHS is not required to investigate rejected allegations, only accepted and linked allegations.

In May of 2021, the central part of the OCO investigation, new allegations of severe physical abuse were called in to Centralized Intake by a medical practitioner. Due to the open CPS investigation, these allegations were accepted and assigned for investigation with a notice going to the CPS specialist assigned to the current investigation.

a. The OCO found that in May of 2021 the CPS specialist did not promptly investigate these new allegations.
b. It was only after the Children's Ombudsman spoke to the reporting source in May of 2021, and informed Marquette County DHHS management, was a petition for removal filed for the V[redacted] children.

Specific to the K[redacted] family, the OCO found that between 2018 and 2019 there were nine occasions new allegations were called into Centralized Intake during an open active abuse/neglect investigation or an open ongoing services case. The new allegations were rejected and emailed to the current CPS or ongoing services specialist.

6. The OCO found the reject and email process allows a gap for an employee working with the family to do what the employee chooses with little oversight.

7. The OCO found that when new allegations are rejected and emailed to the current CPS specialist there are instances where the new allegations are not addressed in the current investigation.

8. The OCO found that regardless of whether new allegations were accepted or rejected, it was unclear if the current investigator or ongoing case services specialist addressed the new allegations.

[2] PSM 711-2 - Reject the complaint. A decision is made not to investigate the complaint and the complaint is not appropriate for transfer to another agency.

PSM 712-5 (Multiple Complaints) If there is already an assigned investigation or an open case, a copy of the rejected complaint must be forwarded to the assigned worker for his/her information and any necessary follow-up regarding the allegations. See PSM 712-8.

Recommendations:

Recommendations are intended to impact positive systemic change to address significant issues that are discovered during the OCO investigation process. The OCO recommends the following:

1. Regarding the **use of safety plans or power of attorney in lieu of a petition for removal,** the OCO recommends Marquette County DHHS adhere to MCL 722.628d in determining when to file a petition. Safety plans, temporary voluntary arrangements altering custody, powers of attorney, and guardianships, both limited and full, be used when appropriate, but not as a replacement for filing a petition.

2. Regarding the findings surrounding the **multidisciplinary team,** the OCO recommends that child welfare partners in Marquette County set a standing monthly or bi-monthly meeting to:
    a. Clarify local policies and procedures to determine the role and responsibilities of each child welfare partner regarding the use of formal and informal dispositions and identifying when formal proceedings should be used to achieve the goals of obtaining safe and timely permanency for children.
    b. Discuss case specific information with all child welfare partners.
    c. Develop partnerships and communicate openly and freely with each other regarding child welfare policy and work to agree on how each profession, including but not limited to, law enforcement, DHHS CPS/Foster care, the courts, medical professionals, mental health professionals, and child advocacy centers, will work together to keep children safe in Marquette County.

3. Regarding **Rejected Complaints During an Open Investigation or Ongoing Services Case,** the OCO found that the ability for Centralized Intake to reject *or* accept and link to the current case allows the new allegations to go uninvestigated.

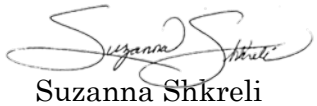
    The OCO recommends that DHHS develop a new process to ensure case specialists are adequately investigating and addressing new allegations that come in during an open investigation or open services case.

Conclusion:

Under authority granted under MCL 722.903, the OCO respectfully submits this findings and recommendations report.

It is the Children's Ombudsman's position that the matters addressed in this report be further considered by DHHS to effect change and improve the lives of similarly situated children involved in Michigan's child welfare system.

Before publishing, DHHS has 60 days to respond to this report. The published report will include any statement of reasonable length made to the OCO by MDHHS in defense or mitigation of the action.



Suzanna Shkreli
Children's Ombudsman

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

May 8, 2023

Ryan Speidel
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 findings and recommendations from the Office of Children's Ombudsman (OCO) Report of Findings and Recommendations regarding L[redacted] V[redacted] and V[redacted] K[redacted].

Finding(s):

Use of Safety Plans or Power of Attorney (POA) in Lieu of a Petition for Removal

1. During Marquette County's involvement with each family, safety concerns involving these children increased in frequency and severity. Safety plans and guardianships were used by CPS in lieu of filing a petition to address the escalated abuse and neglect.
    a. CPS continued to use safety plans that the families failed to adhere to on multiple occasions.
    b. Regarding V[redacted], a POA was utilized as a safety plan. The child's parent wanted to take V[redacted] back and dissolve the POA. Concerned for V[redacted]'s safety due to her parents' history of non-compliance with services, continued substance abuse, and domestic violence, the agent of the POA applied for full guardianship to prevent V[redacted] from being returned to her parents.

2. Failure of safety plans, a dissolution of a POA, and additional evidence obtained throughout the course of these investigations unequivocally show that the individuals responsible for the children in these investigations were abusive and/or neglectful towards them, and a petition for removal was required under MCL 722.628d(1)(e)(ii).

3. After the OCO communicated with Marquette County DHHS management about concerns regarding the V[redacted] case, a petition was filed by Marquette County DHHS which was subsequently granted by Marquette County Circuit court.

MDHHS Response to Finding 1-3: Agree.

The Multidisciplinary Team

4. Contrary to the Multidisciplinary Team (MDT) best practice model[1], evidence in the OCO's investigation highlights a substantial lack of communication and cooperation among the county's child welfare partners including child protective services and law enforcement.
    a. Through its investigations, the OCO found that the relationship between Marquette County DHHS management and the law enforcement in Marquette County, was and continues to be strained. In interviews the OCO conducted, it was reported that law enforcement officers develop their own safety plans with relatives of children directly rather than calling allegations into Centralized Intake due to the breakdown of the MDT relationship.

MDHHS Response to Finding 4: Agree.

Rejected Complaints During an Open Investigation or Ongoing Services Case

5. Specific to the V[redacted] family, the OCO found that between 2015 and 2021, there were twelve occasions new allegations were called into Centralized Intake during an open active abuse/neglect investigation or an open ongoing services case. The new allegations were rejected *or* accepted and linked to the current case. The allegations were only emailed to the current CPS or ongoing services specialist. In those twelve instances, the OCO did not find evidence that the CPS or ongoing specialists either reviewed or investigated the new allegations. By policy[2], DHHS is not required to investigate rejected allegations, only accepted and linked allegations.
In May of 2021, the central part of the OCO investigation, new allegations of severe physical abuse were called in to Centralized Intake by a medical practitioner. Due to the open CPS investigation, these allegations were accepted and assigned for investigation with a notice going to the CPS specialist assigned to the current investigation.

    a. The OCO found that in May of 2021 the CPS specialist did not promptly investigate these new allegations.
    b. It was only after the Children's Ombudsman spoke to the reporting source in May of 2021, and informed Marquette County DHHS management, was a petition for removal filed for the V[redacted] children.

Specific to the K[redacted] family, the OCO found that between 2018 and 2019 there were nine occasions new allegations were called into Centralized Intake during an open active

[1] MCL 722.627b(4); State of Michigan Governor's Task Force on Child Abuse and Neglect: A Model Child Abuse and Neglect Protocol Utilizing a Multidisciplinary Team Approach, DHS-Pub-794.
[2] PSM 711-2 - Reject the complaint. A decision is made not to investigate the complaint and the complaint is not appropriate for transfer to another agency.
PSM 712-5 (Multiple Complaints) If there is already an assigned investigation or an open case, a copy of the rejected complaint must be forwarded to the assigned worker for his/her information and any necessary follow-up regarding the allegations. See PSM 712-8.

abuse/neglect investigation or an open ongoing services case. The new allegations were rejected and emailed to the current CPS or ongoing services specialist.

MDHHS County Response to Finding 5: Agree.

6. The OCO found the reject and email process allows a gap for an employee working with the family to do what the employee chooses with little oversight.

7. The OCO found that when new allegations are rejected and emailed to the current CPS specialist there are instances where the new allegations are not addressed in the current investigation.

8. The OCO found that regardless of whether new allegations were accepted or rejected, it was unclear if the current investigator or ongoing case services specialist addressed the new allegations.

MDHHS Response to Finding 6-8: Agree. Currently, Children's Protective Services (CPS) specialists receive notification of rejected referrals through an automated email notification process and CPS policy provides detailed guidance for responding to "accept and link" referrals including requiring contact with the victims, identified perpetrators, and other relevant collateral contacts. However, MDHHS agrees to further review and assess the need for policy enhancements to ensure CPS clearly addresses, assesses, and documents rejected and transferred referrals. MDHHS will also explore enhanced technical solutions as they develop the new Comprehensive Child Welfare Information System (CCWIS) technology. Although the department has been working to improve this area through the strategies noted above, the department will continue to work to improve in this area.

Recommendations:

Recommendations are intended to impact positive systemic change to address significant issues that are discovered during the OCO investigation process. The OCO recommends the following:

1. Regarding the **use of safety plans or power of attorney in lieu of a petition for removal,** the OCO recommends Marquette County DHHS adhere to MCL 722.628d in determining when to file a petition. Safety plans, temporary voluntary arrangements altering custody, powers of attorney, and guardianships, both limited and full, be used when appropriate, but not as a replacement for filing a petition.

MDHHS Response to Recommendation 1: Agree.

Regarding the findings surrounding the **multidisciplinary team,** the OCO recommends that child welfare partners in Marquette County set a standing monthly or bi-monthly meeting to:

a. Clarify local policies and procedures to determine the role and responsibilities of each child welfare partner regarding the use of formal and informal dispositions and identifying when formal proceedings should be used to achieve the goals of obtaining safe and timely permanency for children.

b. Discuss case specific information with all child welfare partners.
c. Develop partnerships and communicate openly and freely with each other regarding child welfare policy and work to agree on how each profession, including but not limited to, law enforcement, DHHS CPS/Foster care, the courts, medical professionals, mental health professionals, and child advocacy centers, will work together to keep children safe in Marquette County.

MDHHS Response to Recommendation 2: Agree. Marquette DHHS recognizes the importance of collaboration with law enforcement during joint investigations and acknowledges the lack of communication that currently exists between the local DHHS and law enforcement agencies. To improve collaboration efforts, Marquette administrators have established ongoing monthly meetings with local law enforcement and have offered training to all Marquette law enforcement, including the recruit school at Northern Michigan University, regarding the requirements of mandatory reporters, the code to bypass the Centralized Intake queue, as well as steps to report referrals electronically. The department will continue to work to improve in this area to increase communication and collaboration.

2. Regarding **Rejected Complaints During an Open Investigation or Ongoing Services Case,** the OCO found that the ability for Centralized Intake to reject *or* accept and link to the current case allows the new allegations to go uninvestigated.

   The OCO recommends that DHHS develop a new process to ensure case specialists are adequately investigating and addressing new allegations that come in during an open investigation or open services case.

MDHHS Response to Recommendation 3: Agree. CPS specialists receive notification of rejected referrals through an automated email notification process and CPS policy provides detailed guidance for responding to "accept and link" referrals including requiring contact with the victims, identified perpetrators, and other relevant collateral contacts. However, MDHHS agrees to further review and assess the need for policy enhancements to ensure CPS clearly addresses, assesses, and documents rejected and transferred referrals. MDHHS will also explore enhanced technical solutions as they develop the new CCWIS technology. The department will continue to work to improve in this area to ensure that case specialists are adequately investigating and addressing new allegations..

Conclusion:

Under authority granted under MCL 722.903, the OCO respectfully submits this findings and recommendations report.

It is the Children's Ombudsman's position that the matters addressed in this report be further considered by DHHS to effect change and improve the lives of similarly situated children involved in Michigan's child welfare system.

Before publishing, DHHS has 60 days to respond to this report. The published report will include any statement of reasonable length made to the OCO by MDHHS in defense or mitigation of the action.

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
Senior Deputy Director
Children's Services Administration