STATE OF MICHIGAN
GRETCHEN WHITMER | OFFICE OF CHILDREN'S OMBUDSMAN | RYAN SPEIDEL
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Report of Findings and Recommendations Preamble

June 7, 2023

Office of Children's Ombudsman (OCO) Case No: 2020-0440

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.

The Michigan Department of Health & Human Services (MDHHS) previously released several child protective services reports regarding the death of Trinity Chandler. The released MDHHS reports made some information, that would have otherwise been redacted from an ombudsman report, available to the public. The same publicly released information is not redacted in the ombudsman's report.

This 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 the children's ombudsman, I support the findings and recommendations made in this document.

Ryan J. Speidel
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's is exempt from disclosure under the Freedom of Information Act.

Date: March 27, 2023

Case No: 2020-0440

DOB: August 18, 2017

DOD: December 19, 2020 (3 years old)

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),* an autopsy report, service reports, medical records, social work contacts, court documents, photographs, text messages, drug screens, and law enforcement reports including search warrants. The OCO also interviewed DHHS staff, medical professionals, 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 child protective services investigations involving Trinity Chandler was handled by Oakland 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,

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procedure, and practice of DHHS and partners within the child welfare system; and to advocate for changes within it on behalf of similarly situated children.

Trinity Chandler died on December 19, 2020. Pursuant to the Child Protection Law, MCL 722.627k, the DHHS notified the OCO of the child fatality. On January 6, 2021, the OCO opened an investigation into the administrative actions of CPS regarding Trinity Chandler's death. The following report summarizes the information and evidence found during the OCO investigation.

Background and History:

Justine Comstock and . are the birth parents of Trinity Chandler (DOB: 8/18/2017) and (DOB:). Samual Smart is the living-together-partner (LTP) of Trinity's mother, Justine. Justine has two additional children, (DOB:) and (DOB), who reside with their father, . According to case file documentation, Justine communicates with and but has not seen them since some time in 2018. Samual is the father of , who resides with her mother. Prior to Trinity's death, Justine had been substantiated in two Category II* cases and one Category I* case with trends of improper supervision, physical abuse, and failure to protect. Prior to Trinity's death, Samual had been substantiated in one Category III* case with a trend of improper supervision.

In 2012, a Category II* case was opened on and Justine due to failure to protect and physical neglect of . The case subsequently ended in 2013 when and Justine voluntarily released their parental rights to . Details in this case are limited because the event predates the implementation of MiSACWIS,* meaning full case details are not available in the system.

In October of 2016, Justine was substantiated for physical abuse due to concerns she was hitting and with a bungy cord. At the end of the investigation, the case was closed as a Category II*. MiSACWIS* records document that the Friend of the Court (FOC)* awarded full custody of and to their father, , with no visitation for Justine.

In February 2020, allegations of improper supervision and physical neglect were reported to Centralized Intake* by Trinity's father, . During this time, Trinity was living in her father's house. Also living in the home were (LTP to) and her daughter, Justine, and Samual.

Evidence shows reported to Centralized Intake* that Justine and Samual were asked to leave his home due to nonpayment of rent. explained to Centralized Intake* that Samual became violent and attacked with a hockey stick with Trinity present in the room where the altercation was taking place. also told Centralized Intake* that he believed Samual had an unknown mental health concern that made him violent.

The CPS investigation determined that a physical altercation took place between Samual and [redacted] over rent payment. The CPS investigation was closed on March 16, 2020, as a Category IV* with a moderate risk level.*

Summary of OCO Investigation into CPS Actions:

On October 7, 2020, Michigan State Police (MSP) received a complaint regarding possible child abuse of a three-year-old Trinity Chandler, who resided in Groveland Township, Oakland County. The 911 call was made by Trinity's babysitters, [redacted] and [redacted]. They noticed unexplained markings on Trinity's face and wanted to make law enforcement aware because they were concerned for Trinity's safety. They believed the injuries were caused by Samual Smart.

On that same day, an MSP trooper arrived at the babysitter's home in response to the 911 call and initiated his investigation. The trooper documented the injuries on Trinity's face. The trooper reported the complaint to Centralized Intake* within the 24 hours required by the Child Protection Law, MCL 722.628. The allegations were received and assigned for CPS investigation.

Evidence shows that on the day before the MSP investigation began, October 6, 2020, [redacted] was babysitting Trinity at [redacted]'s home, and Trinity bumped into a counter causing a bruise. At this time, [redacted] said Trinity had no other markings on her forehead. Trinity was nearsighted and because of her poor vision, Trinity frequently bumped into things like walls and corners. On October 7, 2020, when Trinity came over, [redacted] observed several new markings, bruises, and abrasions on Trinity's face. There was a notably large bruise on Trinity's left cheek. According to reports reviewed, the trooper was concerned about the extent of Trinity's injuries, calling them "disturbing." When interviewed by the trooper, the babysitter said Trinity told her that "Moo Moo (Samual Smart) hurt me because he was grumpy" and "Moo Moo said I hit the wall." The babysitter photographed the injuries and shared them with Trinity's mother. Trinity's mother indicated that she did not know how Trinity received the bruises. Trinity was checked by EMS on the scene.

During the OCO investigation, the trooper acknowledged his lawful ability to remove Trinity pursuant to Juvenile Code, MCL 712A.14a however he did not believe the circumstances rose to the statutory threshold for protective custody. The trooper decided not to remove Trinity from her home and continued his investigation.

On October 8, 2020, the first day of the CPS investigation, the CPS caseworker met with Justine, Samual, and Trinity. During the visit, Trinity was observed to be clean and appropriately dressed. Trinity was observed with a minor scratch above her right eye near the eyebrow, a bruise approximately the size of a penny on her forehead, several small scratches on and around her nose, a very dark bruise about the size of a quarter on her left cheek, several small bruises and a small scratch on her right cheek, a dark bruise-like mark on her right eyelid, and a purple mark on the top of her left ear that appeared to be a scratch. The CPS caseworker documented that Trinity said she needed her glasses and repeated the statement continually. Trinity's mother claimed that she didn't know where the bruises on Trinity's face came from, and that Trinity is usually with Justine's LTP

Samual or the babysitter, [redacted], while Justine is at work. Samual denied using any physical discipline and said he believed that the bruises occurred at the babysitter's house.

The CPS caseworker established a safety plan* with Justine and Samual. They agreed to use alternatives to physical discipline, such as timeouts, while the investigation was ongoing. If Trinity sustained more injuries, Justine agreed to take Trinity to a doctor. Justine voluntarily added that she would not allow Samual, [redacted], or [redacted] to be alone with Trinity until the cause of her injuries was determined.

In addition to the statements by Justine and Samual indicating a lack of knowledge for a source of the injuries, evidence showed that a satisfactory home assessment* was completed during the home visit. Trinity's bedroom was appropriate, there was an adequate amount of food in the home and there were no visible health or safety hazards. No medication, alcohol, or drug paraphernalia was observed during the home assessment.*

The CPS caseworker requested Justine take Trinity in for a medical exam. The CPS caseworker arranged for the exam to occur at Ascension Genesys Hospital, but Justine did not take Trinity. The CPS caseworker made a second request for Justine to take Trinity, and again contacted the hospital to make arrangements. Justine called the CPS caseworker to request moving the exam to an urgent care due to an anticipated lengthy wait at the emergency room.

On October 9, 2020, Trinity was seen by a physician's assistant (PA) to provide a medical examination of her injuries. Before Trinity arrived at urgent care, the CPS caseworker contacted the urgent care office to inform them Trinity would be arriving for a medical exam. PSM 713-04.* Trinity was seen by Michael Beckley, PA at Springfield Urgent Care. Following the exam, the CPS caseworker documented that the PA explained that Trinity's bruising was "a little larger" than what could be caused by a fist, that "clearly she ran into something." The examination determined the injuries were consistent with Trinity's mother's explanation, that Trinity runs into walls and corners, and that her "clumsiness" was likely attributed to Trinity not wearing her glasses. During an interview with the OCO, the examining PA explained he had ten years of experience treating patients in an emergency room where he also conducted child abuse exams.

On October 12, 2020, the CPS caseworker discussed the medical examination with her supervisor. By policy, there is no narrative detailing what occurred in this supervision conversation. PSM 713-01.*

On October 16, 2020, the CPS caseworker contacted the trooper and informed him that Trinity had been examined at an urgent care on October 9. The medical examination determined that Trinity's injuries were consistent with the explanation provided by Trinity's mother. The trooper told the CPS caseworker that he doubted the explanation provided by Trinity's mother. His investigation determined that Trinity sustained the injuries while in Samual's care. Given his investigation, the trooper did not believe the injuries were caused by Trinity's clumsiness.

A forensic interview* for Trinity was conducted on October 22, 2020 at CARE House Oakland County.* Trinity arrived at CARE House appropriately dressed and free from visible marks or bruises. Present at the forensic interview was the forensic interviewer, Trinity, the CPS caseworker and an MSP detective. According to case documentation, there is no indication that there was a representative present from the Oakland County Prosecutor's Office to observe Trinity's interview. The CPS caseworker stated that prior to her interview, Trinity successfully answered the CARE House forensic interviewer's questions establishing competency. During the interview, Trinity identified Samual as "Moo Moo." Trinity was shown pictures of her injuries. Once shown the photos, Trinity wanted to show the pictures to her mother. Trinity said she did not run into any walls. Toward the end of the interview, Trinity was asked for a final time about where her "boo boos" came from, Trinity said, "I opened my mouth and Moo Moo told me to shut my mouth." At the end of the interview, there was a determination that Trinity's statements did not amount to a clear disclosure of abuse. The CPS caseworker told Trinity's mother that if any new marks or bruises were noticed on Trinity, that she contact the CPS caseworker and the trooper, and that she take Trinity in for a medical examination. The CPS caseworker reminded Trinity's mother that her responsibility is to protect Trinity from harm. The safety plan* was lifted by the CPS caseworker.

On November 4, 2020, the CPS caseworker followed up with the babysitter to see if she witnessed any signs of abuse or neglect on Trinity while under her care. The babysitter repeated to the CPS caseworker what she had previously told the trooper. The babysitter also told the CPS caseworker she has personally seen Justine's LTP, Samual kick cats and dogs and heard that he has a history of aggression. The babysitter also told the CPS caseworker about previous marks and bruises she observed on Trinity. However, the OCO confirmed the babysitter did not report those previous marks and bruises either to law enforcement or to Centralized Intake*.

On November 5, 2020, the trooper called the CPS caseworker to tell her he was seeking a search warrant for Justine's and Samual's cell phones. The search warrant intended to secure possible conversations regarding the source of Trinity's injuries and any evidence about Trinity being coached for her CARE House forensic interview. Based on this information, the CPS caseworker requested an extension of the CPS investigation which was approved by her supervisor on November 6, 2020.

On November 5, 2020, CPS obtained Trinity's medical records from her three-year well child examination at Fenton Family Medicine which occurred on October 22, 2020. The medical records stated there were no concerns regarding Trinity's health and recommended she return next year for her four-year checkup.

The CPS caseworker met with Trinity on November 5, 2020, and observed a "very small, thin, faint scratch" on the side of Trinity's face. Trinity's mother told the caseworker that the scratch was from a cat. Trinity was observed to be very happy and energetic throughout the visit. She was running around on the home's porch and in the front yard. Trinity's mother also reported to the CPS caseworker that Trinity attended an eye doctor appointment, and a new pair of glasses would be arriving in two weeks.

On December 1, 2020, the trooper updated the CPS caseworker about the status of his request for a search warrant. The trooper was unable to obtain an authorized search warrant from the court, due to a determination by the court that the search warrant lacked probable cause. After the search warrant was denied, the trooper sought assistance from an MSP detective and resubmitted the search warrant. Again, the search warrant was denied by the court. After the second denial, the trooper requested help from an assistant prosecutor from the Oakland County Prosecutor's Office. After consulting with the Oakland County Prosecutor's Office, the trooper submitted a third request for a search warrant, which was also denied. Journal entries contained in the MSP report show that the trooper's actions to obtain an authorized search warrant in this case occurred between November 20, 2020 to December 9, 2020.

The OCO reviewed documentation from December 7, 2020, which showed that Trinity received her new glasses from the eye doctor. Trinity's mother informed the CPS caseworker that Trinity was still a little clumsy while wearing her glasses, but stated she believed it was because Trinity was getting used to having bifocals. On December 11, 2020, Trinity's mother sent a text message to the CPS caseworker with photos of Trinity wearing her new glasses. The first photo received by the CPS caseworker depicted a shadow on part of Trinity's face. The CPS caseworker requested a different photo with better lighting. Trinity's mother sent an additional photo of Trinity in her new glasses. In that photo, a small mark, possibly a bruise, was visible on Trinity's left shoulder. In the second photo, Trinity is wearing a different shirt and her hair is in a different style.

On December 11, 2020, the CPS caseworker called the optometrist to understand the severity of Trinity's eyesight. The optometrist said although Trinity's prescription worsened over time, Trinity's mother was not neglectful in her delay to obtain Trinity's new glasses.

As part of the CPS investigation, the CPS caseworker contacted Samual's Training and Treatment Innovations (TTI) case manager on December 14, 2020. Samual was voluntarily receiving services at TTI. The TTI links individuals and their families with available services needed to maintain good mental and physical health and stability. The case manager reported that Samual was receiving services for mental health and sobriety treatment through TTI. The case manager said she had not been in contact with Samual recently because he obtained a new cell phone. She told the CPS caseworker that as far as she was aware, Samual was complying with his medication and treatment plan. The TTI case manager denied Samual had issues following his treatment plans or engaging in services in the past. The case manager said she has 'no concerns at all' regarding Samual being around children or his capability to care for children. The TTI case manager told the CPS caseworker she would visit Samual at home during the upcoming week.

CPS determined that the evidence collected during the investigation did not rise to the level of a preponderance of the evidence for child abuse or neglect because:

- The medical examination determined the injuries were consistent with Trinity's mother's explanation, that Trinity runs into walls and corners, and that her "clumsiness" was likely attributed to Trinity not wearing her glasses.

- The determination that the forensic interview did not result in Trinity making a clear disclosure of abuse.
- The optometrist reported no concerns of medical neglect.
- Samual's TTI case manager reported no known issues regarding Samual being around children.

The OCO learned during the investigation that the CPS caseworker remained uncomfortable because of Trinity's injuries and statements made by the babysitter.

On Friday, December 18, 2020, the CPS caseworker met with Trinity's mother and Trinity at 3:50 P.M. Another more experienced CPS caseworker was in the car while Trinity's caseworker was talking to the family. In light of the CPS determination of a lack of preponderance of the evidence, the case was to be closed on Monday, December 21, 2020. The CPS caseworker made contact on this day to ensure that the family was engaged in services prior to case closure. After arriving at Trinity's home, the CPS caseworker knocked on the door several times because she could hear people inside the house. Trinity's mother came outside, followed shortly by Trinity, who was wearing a one-piece pajama set and tennis shoes. While Trinity walked around outside looking at the snow, the CPS caseworker observed new injuries on Trinity's head. Specifically, the CPS caseworker observed a yellowish-brown bruise on Trinity's right cheek, a small scratch near her lip, and a small, light scratch near her left ear. Trinity also appeared to have a broken blood vessel in the lower portion of her left eye. When asked about the bruising on Trinity's face, her mother said Trinity had misplaced her glasses "for a minute" and had fallen while playing in her room because it was a "mess." The CPS caseworker photographed the newly observed injuries on Trinity's head. Trinity appeared excited to have her photo taken. Trinity did not appear fearful of her mother.

The OCO investigation determined that after observing Trinity's face, the CPS caseworker believed the new injuries provided sufficient evidence to establish a preponderance of evidence to substantiate Trinity's mother and Samual on child abuse. Given her inexperience as a new caseworker, she was unsure how to proceed after seeing Trinity's new injuries. The CPS caseworker called the on-call supervisor because her direct supervisor was on leave. There is evidence to show that the on-call supervisor advised the CPS caseworker that she did not need to report Trinity's new injuries into Centralized Intake because they would discuss the case on Monday. Trinity's CPS caseworker was not comfortable with waiting until Monday, so she went back to the car to seek advice from her colleague. They decided to call and leave a voicemail for the Oakland County CPS program manager. The CPS program manager did not return the CPS caseworker's phone call that evening. Instead of returning the CPS caseworker's call, the program manager called the on-call supervisor, and it was determined that they would wait until Monday to discuss the new injuries. The OCO interviewed the parties involved and there are discrepancies on the interaction between the caseworkers, supervisor, and program manager that cannot be clarified. The record shows that a supervision contact took place between Trinity's caseworker and the on-call supervisor, but no details were entered per DHHS policy. PSM 713-01.*

During the evening of December 18, 2020, Samual and Trinity were at his brother's home until approximately 12:00 A.M. After they returned home Trinity stated she had a bellyache. Samual said she vomited and went to bed. According to Samual, when he tried to wake Trinity up around 6:00 A.M. on December 19, 2020, she was acting sluggish and moving slow. Samual said he and Trinity went to their van to pick Trinity's mother up from work and said he tried to keep Trinity awake but she kept "nodding off." Samual called his father and after speaking with him, Samual took Trinity to the fire station. CPR was started and Trinity was transported to the hospital. Trinity was pronounced dead at Ascension Genesys Hospital on December 19, 2020, at 7:25 A.M. The cause of death was unknown, but there were concerns regarding abuse. Findings included bruises and a left subconjunctival hemorrhage.* When interviewed by MSP after Trinity's death, Trinity's mother admitted that she felt Samual was capable of killing Trinity and had been assaultive toward Trinity's mother in the past. These statements from Trinity's mother were inconsistent with previous statements she had made to the CPS caseworker and the trooper earlier in the investigation.

On December 19, 2020, the trooper obtained an authorized search warrant for Samual's phone. The search of the phone led to MSP restoring a deleted video recorded on December 14, 2020. According to the autopsy report, the video revealed a person "strike the decedent's nose and she started crying, then the person placed a pillow on her chest while she was laying supine on the floor and external force from the person (possibly kneeling) was applied against the pillow with her chest under it for approximately 17 seconds. She became unresponsive, the pillow was removed and the person stopped exerting force on her. She regained consciousness. Approximately 30 seconds later, the person placed a pillow on her chest again while she was laying supine on the floor and external force from the person (possibly kneeling) was placed against the pillow with her chest under it for approximately 20 seconds. The person stopped applying force to the pillow and the decedent was told to go sit down. She was subsequently kicked to the floor while walking to a chair. She got up from the floor and sat on the chair."

On June 24, 2021, a phone call was documented between the CPS caseworker and the Genesee County Assistant Medical Examiner, Dr. Bechinski, who verified that the cause of death for Trinity was "complication of blunt force trauma to the chest" and the manner of death was ruled homicide. Dr. Bechinski advised that, "the injury to Trinity's heart are [sic] consistent with being caused by the actions depicted in the video from December 14, 2020 found on Samual Smart's phone, which showed him kneeling on Trinity's chest." It was also documented that, "Dr. Bechinski advised Trinity's heart was examined by Dr. Cohle in Kent County and it is Dr. Cohle's opinion the injury was sustained several days prior to Trinity's death. Dr. Bechinski stated any time an injury to the tissues around the heart are visible when viewed under a microscope, as Trinity's was, the injury is severe enough to cause death. He stated the injury to Trinity's heart was not caused the morning she died, as an acute (recent) injury would have shown acute inflammation around the heart, which was not observed. Dr. Bechinski advised he does not know if it would be reasonable for Trinity to be exhibiting any symptoms or signs of injury or distress between when she sustained the injury and when she died, but he did state he 'finds it interesting' she was reportedly experiencing nausea and vomiting the night prior to her death because those are common symptoms of a heart attack, which is a similar injury to Trinity's."

The CPS investigation into the death of Trinity Chandler was opened on December 19, 2020 and was submitted for disposition on July 14, 2021. The case was substantiated as a Category II* with an intensive risk level* that Trinity Chandler was physically abused by Samual and this abuse ultimately led to her death on December 19, 2020. Additionally, Trinity's mother was substantiated on failure to protect Trinity from this abuse.

On November 21, 2021, in accordance with the Children's Ombudsman Act, MCL 722.929(5),* the OCO sent a letter to Oakland County Prosecutor, Karen McDonald. The letter informed the Oakland County Prosecutor that the OCO investigation was complete and inquired about the status of the ongoing law enforcement investigation and whether the release of the OCO report would interfere with the criminal investigation. On June 2, 2022, the Oakland County Prosecutor's Office, responded to the November 21, 2021 OCO letter and stated there was an ongoing investigation in the matter and a release of the OCO report may interfere with the criminal investigation. The Oakland County Prosecutor's Office asked the OCO not to release its report until the criminal investigation was completed.

On January 26, 2023, the OCO contacted the Oakland County Prosecutor's Office to see if there was an ongoing criminal investigation in this case. The Oakland County Prosecutor's office then notified the OCO that there was no longer an ongoing criminal investigation, as the defendant in this matter, Samual pled no contest to the Second Degree Murder of Trinity Chandler and awaited sentencing before the Oakland County Circuit Court.

Findings:

1. The OCO finds, pursuant to the medical examination of Trinity, the injuries that caused her death were sustained several days prior to the day she died.

2. The OCO finds the injuries that caused Trinity's death are consistent with the actions depicted in a video on Samual's phone of a person kneeling on Trinity's chest. The video was dated December 14, 2020.

3. The OCO finds that PSM 713-04* creates gaps in communication between the examining practitioner and a CPS caseworker regarding allegations of child abuse. The policy allows the CPS caseworker to talk to a professional at the medical facility when the medical practitioner is not available.

    a. The OCO finds that in accordance with this policy, the CPS caseworker spoke to the receptionist of the medical facility.

    b. The OCO finds that allowing the CPS caseworker to talk to a professional at the medical facility in lieu of directly speaking to the medical practitioner is inadequate to help inform the practitioner about the possibility of abuse as a potential cause of injuries.

4. The OCO finds that PSM 713-01* prohibits narratives about supervisory case conference discussions from being memorialized in MiSACWIS.* This issue of not documenting narratives in case conferences has proven to be material in the OCO investigation of DHHS administrative acts prior to Trinity's death.

    a. During this investigation the OCO received conflicting statements. Because this policy prohibits narratives, the OCO investigation could not distinctly determine whether supervision:

        i. Reviewed photographs of Trinity's injuries from October 8, 2020, prior to her death.

        ii. Discussed the adequacy of the safety plan.

        iii. Provided clear guidance to the CPS caseworker on how to further investigate injuries observed the day before Trinity's death.

        iv. Provided the CPS caseworker with adequate support needed relative to the CPS caseworker's experience.

5. The OCO finds PSM 713-04* provides guidance to CPS caseworkers about seeking second medical opinions. Based on facts presented in the investigation, a second medical opinion could have been, but was not sought in this case.

6. The OCO finds SRM-103* does not currently mandate annual in-service training for CPS case workers regarding objectives on detecting injuries attributable to child abuse.

7. The OCO finds that the safety plan* developed by the CPS caseworker and Trinity's mother removed Trinity's childcare providers. Trinity's mother rejected alternative childcare providers suggested by the CPS caseworker and allowed Samual to continue to care for Trinity while she was at work, contrary to the safety plan.

8. The OCO finds that Trinity's mother did not share crucial information about Samual's violent tendencies during the joint CPS and law enforcement investigation. Throughout the investigation, Trinity's mother continually reinforced that Samual had a healthy and loving relationship with Trinity. Only after Trinity's death, did Trinity's mother inform CPS that she believed Samual killed Trinity and disclosed a history of violent behavior exhibited by him.

9. The OCO finds that Samual was initially criminally charged by the Oakland County Prosecutor's Office with First Degree Felony Murder, MCL 750.316. The Oakland County Prosecutor's Office offered, and Samual accepted, a reduced charge of Second Degree Murder MCL 750.317. Samual tendered a no contest plea and entered into a sentencing agreement with the Oakland County Prosecutor's Office to a minimum of 40 years in prison. On February 22, 2023, pursuant to the sentencing agreement,

Samual was sentenced in the Oakland County Circuit Court to 40 years to 99 years in prison for the murder of Trinity Chandler.

Recommendations:

1. The OCO recommends PSM 713-04* be amended to:

    a. Remove the provision that allows the CPS caseworker to provide information to a professional at the medical facility when the medical practitioner is not available. It is critical that the examining practitioner be provided with case details directly from the CPS caseworker *before* the exam is conducted.

2. The OCO recommends PSM 713-01* be amended to require that case conferences between CPS caseworkers and their supervisors be documented in narrative format in the case's social work contacts.

3. This issue of not documenting narratives in case conferences has proven to be material in the OCO investigation into the administrative actions before Trinity's death. Case conferences are the critical point in a CPS investigation where "gut" feelings are discussed and where knowledge from more experienced child welfare staff is passed onto new staff. It is these conversations where learning can occur, and critical thinking skills developed. The lack of documentation present for these case conferences can create a lack of priority and accountability for CPS supervision. Ensuring MiSACWIS* has adequate notes from case conference discussions is integral to the exchange of information if a new CPS caseworker or supervisor joins the case.

    a. Because of this, the OCO recommends PSM 713-01* be amended to specify the importance of initial case conferences taking place soon after a new investigation is assigned, provide a guide that details a list of issues in the case to be discussed, viewed, and decided at the initial conference, and require that the initial case conference and all subsequent case conferences provide a detailed narrative in the investigative report. Anything less leaves room for recollection error and lack of accountability which is not in the best interest of Michigan's children.

4. The OCO recommends that DHHS require local county directors to:

    a. Develop processes in coordination with the local Multi-Disciplinary Team (MDT)* to include detailed direction on how to request and access a second medical opinion.

    b. Develop a county specific protocol on how to obtain a second medical opinion in accordance with PSM 713-04.*

    c. Train CPS caseworkers on the county specific protocols on how to obtain a second medical opinion in accordance with PSM 713-04.*

  d. Train CPS caseworkers and supervisors about the impact of obtaining a second medical opinion in a timely manner so the injuries can be viewed by the medical practitioner before healing.

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

   a. The Department of Licensing and Regulatory Affairs (LARA) collaborate with the Michigan Boards of Medicine, Osteopathic Medicine and Surgery, and Nursing to promulgate rules to require continuing education for healthcare licensees on detection of injuries attributable to child abuse as a requirement of licensure.

   b. LARA share an annual message to all healthcare licensees providing training resources and information regarding the detection of child abuse injuries.

6. Child welfare investigations require law enforcement and CPS caseworkers be proficient in detecting abuse and neglect. Physical abuse may be overlooked or misdiagnosed in children under the age of 4 due to their vulnerable characteristics. Training enhancements to better equip our investigators is critically needed to best protect Michigan's children.

   a. The OCO recommends SRM-103* be amended to *mandate* the annual in-service training include objectives on the detection of injuries attributable to child abuse.

7. The OCO recommends that DHHS provide assistance to families when a safety plan* removes the support system currently in place.

   a. DHHS could independently search for and seek out relatives, other than those provided by the parent or caretaker, who can provide supports for families with open CPS investigations and ongoing cases.

   b. DHHS could provide state-available supports including, but not limited to, a childcare subsidy for families with open CPS investigations and ongoing cases.

8. The OCO recommends that DHHS require local county directors to:

    a. Collaborate with their MDT to develop a working list of medical practitioners who have specialized training in detecting child abuse and neglect, examining, and interviewing children in accordance with PSM 713-04.*

    b. Maintain and update the list of statewide and local child abuse medical experts with CPS caseworkers and supervisors.

    c. Train CPS caseworkers and supervisors on the critical importance of using the child abuse medical expert list when scheduling initial and second opinion medical examinations.

    d. Instruct CPS caseworkers on what medical practitioners, who have specialized training in detecting child abuse and neglect, are available to conduct medical assessments after hours within their respective counties.

    e. Invite the medical practitioners from the child abuse and neglect list to MDT meetings and case reviews.

9. The OCO recommends county prosecuting attorneys, or their designee, conduct regular MDT meetings to increase communication among members. The OCO has seen positive outcomes when the MDT is actively involved in case-by-case decision-making to facilitate and support the work of its members. The MDT should include members of law enforcement, medical personnel, mental health personnel, and Child Advocacy Centers.

    a. The OCO recommends the Michigan Legislature fund and DHHS hire liaisons to the MDT for each county. Liaison duties could include but are not limited to, serving as a bridge between MDT members, assisting the MDT leader in facilitating monthly MDT case review meetings, collaboration with DHHS central office on policy changes, and actively participate in the investigation as an advisor to the MDT when the child presents with abnormal or suspicious bruising or injury, severe injury, sexual assault or death.

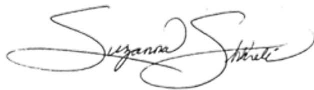
10. The OCO recommends anyone identified as a person with firsthand knowledge of the allegations when the complaint is called into Centralized Intake* must be contacted directly by the CPS caseworker in a timely manner. These individuals should be identified as a primary reporting source.

Conclusion:

Under authority pursuant to The Children's Ombudsman Act, MCL 722.923, the OCO respectfully submits this findings and recommendations report.

As the Children's Ombudsman, it is important that the matters addressed in this report be further considered by DHHS, the Michigan Legislature, and the Governor. If implemented, these recommendations will effectuate positive 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 DHHS 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 26, 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 recommendations from the Office of Children's Ombudsman (OCO) Report of Findings and Recommendations regarding Trinity Chandler.

Thank you for the opportunity to respond to this report. For each of the approximately 69,000 child abuse cases we investigate every year, MDHHS not only works diligently to protect and serve those children, but we also learn from each process – and grow as advocates and fighters for Michigan's children and families. Below are steps that we have taken.

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.

Recommendations:

1. The OCO recommends PSM 713-04* be amended to:

    a. Remove the provision that allows the CPS caseworker to provide information to a professional at the medical facility when the medical practitioner is not available. It is critical that the examining practitioner be provided with case details directly from the CPS caseworker *before* the exam is conducted.

    MDHHS Response to Recommendation 1a: MDHHS recognizes for any case where CPS requests a medical exam, speaking directly with the examining practitioner is ideal; however, medical professionals are not always immediately available to respond to a CPS specialist.

Avoiding delays is important for the department to take quick actions to protect the safety and well-being of children. Policy allows specialists to speak to other professionals at the medical facility to gather and relay information to avoid potentially critical delays in examination and treatment of children.

2. The OCO recommends PSM 713-01* be amended to require that case conferences between CPS caseworkers and their supervisors be documented in narrative format in the case's social work contacts.

   MDHHS Response to Recommendation 2: MDHHS is working with appropriate experts to assess this recommendation. The department will thoughtfully research potential revisions to policy to provide additional guidance around documentation of case conferences between specialists and supervisors to avoid any unintended consequences that would negatively affect children.

3. This issue of not documenting narratives in case conferences has proven to be material in the OCO investigation into the administrative actions before Trinity's death. Case conferences are the critical point in a CPS investigation where "gut" feelings are discussed and where knowledge from more experienced child welfare staff is passed onto new staff. It is these conversations where learning can occur, and critical thinking skills developed. The lack of documentation present for these case conferences can create a lack of priority and accountability for CPS supervision. Ensuring MiSACWIS* has adequate notes from case conference discussions is integral to the exchange of information if a new CPS caseworker or supervisor joins the case.

   a. Because of this, the OCO recommends PSM 713-01* be amended to specify the importance of initial case conferences taking place soon after a new investigation is assigned, provide a guide that details a list of issues in the case to be discussed, viewed, and decided at the initial conference, and require that the initial case conference and all subsequent case conferences provide a detailed narrative in the investigative report. Anything less leaves room for recollection error and lack of accountability which is not in the best interest of Michigan's children.

      MDHHS Response to Recommendation 3a: The MDHHS Children's Services Administration has begun researching potential revisions to policy to include a timeframe for an initial case conference and further guidance around documentation. MDHHS has developed an intervention tool that requires regular communication between caseworkers and their

supervisors during key points of an investigation as part of the department's Keep Kids Safe Action Agenda. The department also is developing an ongoing quality assurance process focused on providing independent feedback to investigators to improve investigation quality.

4. The OCO recommends that DHHS require local county directors to:

   a. Develop processes in coordination with the local Multi-Disciplinary Team (MDT)* to include detailed direction on how to request and access a second medical opinion.

   b. Develop a county specific protocol on how to obtain a second medical opinion in accordance with PSM 713-04.*

   c. Train CPS caseworkers on the county specific protocols on how to obtain a second medical opinion in accordance with PSM 713-04.*

   d. Train CPS caseworkers and supervisors about the impact of obtaining a second medical opinion in a timely manner so the injuries can be viewed by the medical practitioner before healing.

   MDHHS Response to Recommendation 4 a-d: The Children's Services Administration will collaborate with regional directors to determine what actions their local county directors can take to address these opportunities.

   Completing multiple real-time reviews of physical abuse cases to evaluate safety planning and ensure decision-making was appropriate is part of the Keep Kids Safe Action Agenda.

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

   a. The Department of Licensing and Regulatory Affairs (LARA) collaborate with the Michigan Boards of Medicine, Osteopathic Medicine and Surgery, and Nursing to promulgate rules to require continuing education for healthcare licensees on detection of injuries attributable to child abuse as a requirement of licensure.

b. LARA share an annual message to all healthcare licensees providing training resources and information regarding the detection of child abuse injuries.

MDHHS Response to Recommendation 5 a-b: MDHHS agrees with the recommendation that all individuals in the medical field who may encounter children in their practice receive this type of ongoing training. Including outside expertise in child abuse and neglect cases where feasible can assist our CPS specialists to better protect children and families.

6. Child welfare investigations require law enforcement and CPS caseworkers be proficient in detecting abuse and neglect. Physical abuse may be overlooked or misdiagnosed in children under the age of 4 due to their vulnerable characteristics. Training enhancements to better equip our investigators is critically needed to best protect Michigan's children.

   a. The OCO recommends SRM-103* be amended to *mandate* the annual in-service training include objectives on the detection of injuries attributable to child abuse.

   MDHHS Response to Recommendation 6a: The Children's Services Administration is exploring a mandate for annual in-service training to include objectives on the detection of injuries attributable to child abuse.

7. The OCO recommends that DHHS provide assistance to families when a safety plan* removes the support system currently in place.

   a. DHHS could independently search for and seek out relatives, other than those provided by the parent or caretaker, who can provide supports for families with open CPS investigations and ongoing cases.

   b. DHHS could provide state-available supports including, but not limited to, a childcare subsidy for families with open CPS investigations and ongoing cases.

   MDHHS Response to Recommendation 7 a-b: The Children's Services Administration will explore this recommendation further and consider opportunities to enhance safety planning; however, there may be limitations to federal eligibility for benefits to meet the need for some types of services.

   The department does refer families to supports such as childcare subsidies; however, parents may not always follow through with these

referrals. The department is developing a pilot program to help enhance collaboration between CPS staff and the department's benefits eligibility services staff to enhance economic supports to families.

As part of its Keep Kids Safe Action Agenda, MDHHS is investing millions of dollars to create more Family Resource Centers. The number of Family Resource Centers recently expanded by five for a total of 11 in local communities. Family Resource Centers work with families who are at-risk of abuse and neglect to meet their needs sooner and strengthen their protective factors.

8. The OCO recommends that DHHS require local county directors to:

    a. Collaborate with their MDT to develop a working list of medical practitioners who have specialized training in detecting child abuse and neglect, examining, and interviewing children in accordance with PSM 713-04.*

    b. Maintain and update the list of statewide and local child abuse medical experts with CPS caseworkers and supervisors.

    c. Train CPS caseworkers and supervisors on the critical importance of using the child abuse medical expert list when scheduling initial and second opinion medical examinations.

    d. Instruct CPS caseworkers on what medical practitioners, who have specialized training in detecting child abuse and neglect, are available to conduct medical assessments after hours within their respective counties.

    e. Invite the medical practitioners from the child abuse and neglect list to MDT meetings and case reviews.

    MDHHS Response to Recommendation 8 a-e: The Children's Services Administration is collaborating with regional directors to determine what actions county directors can take to address these opportunities.

9. The OCO recommends county prosecuting attorneys, or their designee, conduct regular MDT meetings to increase communication among members. The OCO has seen positive outcomes when the MDT is actively involved in case-by-case decision-making to facilitate and support the work of its members. The MDT should include members of law enforcement, medical personnel, mental health personnel, and Child Advocacy Centers.

a. The OCO recommends the Michigan Legislature fund and DHHS hire liaisons to the MDT for each county. Liaison duties could include but are not limited to, serving as a bridge between MDT members, assisting the MDT leader in facilitating monthly MDT case review meetings, collaboration with DHHS central office on policy changes, and actively participate in the investigation as an advisor to the MDT when the child presents with abnormal or suspicious bruising or injury, severe injury, sexual assault or death.

MDHHS Response to Recommendation 9a: MDHHS is always willing to work with our legislative partners on any funding or policy that will help us protect children.

10. The OCO recommends anyone identified as a person with firsthand knowledge of the allegations when the complaint is called into Centralized Intake* must be contacted directly by the CPS caseworker in a timely manner. These individuals should be identified as a primary reporting source.

MDHHS Response to Recommendation 10: The MDHHS Children's Services Administration will explore a potential revision to policy requiring CPS specialists to contact the primary reporting source in a timely manner in all active CPS investigations. The department wants to ensure this practice would result in the intended benefits for children and families.

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

Glossary of Terms and Polices

Term:	Definition:
CARE House:	Child Advocacy Center (CAC) of Oakland County
Category I:	Court petition required. The department determines that there is evidence of child abuse or child neglect and one or more of the following are true: 1) A court petition is required under another provision of this act. 2) The child is not safe and a petition for removal is needed. 3) The department previously classified the case as category II, and the child's family does not voluntarily participate in services. 4) There is a violation, involving the child, of a crime listed or described in section 8a(1)(b), (c), (d), or (f) or of child abuse in the first or second degree as prescribed by section 136b of the Michigan penal code, 1931 PA 328, MCL 750.136b.
Category II:	Child protective services required. The department determines that there is evidence of child abuse or child neglect, and the structured decision-making tool indicates a high or intensive risk of future harm to the child. The department must open a protective services case and provide the services necessary under this act.
Category III:	Community services needed. The department determines that there is a preponderance of evidence of child abuse or child neglect, and the structured decision-making tool indicates a low or moderate risk of future harm to the child. The department must assist the child's family in receiving community-based services commensurate with the risk to the child. If the family does not voluntarily participate in services, or the family voluntarily participates in services, but does not progress toward alleviating the child's risk level, the department must consider reclassifying the case as category II.
Category IV:	Community services recommended. Following a field investigation, the department determines that there is not a preponderance of evidence of child abuse or child neglect, but the structured decision-making tool indicates that there is future risk of harm to the child. The department must assist the child's family in

	voluntarily participating in community-based services commensurate with the risk to the child.
Category V:	Services not needed. Following a field investigation, the department determines that there is no evidence of child abuse or child neglect.
Centralized Intake:	The Michigan Department of Health & Human Services' statewide centralized processing center for reports of suspected child abuse and child neglect.
Forensic Interview:	The goal of a forensic interview is to obtain a statement from a child—in a developmentally—sensitive, unbiased, and truth-seeking manner—that will support accurate and fair decision-making in the criminal justice and child welfare systems. Forensic interviews are part of investigations that sometimes involve retrieval of physical evidence, conversations with collateral contacts, and other fact-finding efforts. Therefore, interviewers should explore topics that might lead to other evidence keeping in mind that a forensic interview is only part of an investigation.[1]
Home assessment:	PSM 713-01 CPS Investigation- General Instructions ***Observation of Home Environment*** Caseworkers must view the primary residence of the alleged victim child(ren), as well as the location where the alleged abuse/neglect occurred, if applicable. If the allegations are about the conditions of the home, caseworkers must document home observations in a social work contact in the electronic case management system.
MiSACWIS:	**Mi**chigan **S**tatewide **A**utomated **C**hild **W**elfare **I**nformation **S**ystem
Multidisciplinary Team (MDT):	[A] team that includes prosecution, law enforcement, child protective services, medical professionals, mental

[1] DHS-PUB-0779 State of Michigan Governor's Task Force on Child Abuse and Neglect and Department of Health and Human Services Forensic Interviewing Protocol.

health providers, victim advocates, and other professionals involved in the case.[2]

PSM 713-01: CPS Investigation- General Instructions

Case Conference

Case conferences between the caseworker and supervisor must occur at least once on every assigned investigation, prior to disposition. When an extension is requested, a case conference must be held during each extension period. Caseworkers must document the case conference in a social work contact selecting supervision as the contact type and narrate only that the conference occurred.

PSM-713-04: Medical Examination and Assessment

Initial Consultation with Medical Professional

Caseworkers must consult with a medical practitioner immediately when an examination is needed. Consultation should include the child's parent whenever feasible. When contacting the medical practitioner, caseworkers should request an examination of the child and provide the following information:

- The reason the medical examination is being requested.
- The reason(s) for suspicion of abuse or neglect.
- All known health/medical information regarding the child and family.
- Any additional pertinent case information including:
    - History of alleged and confirmed abuse/neglect.
    - Household/family makeup.
    - Home environmental factors.
    - Parent's behavior toward the child.
    - Explanations provided for an injury.

Caseworkers should request to speak directly with the medical practitioner; however, if the medical practitioner is not available, they may provide the information to a professional at the medical facility and

[2] Children's Advocacy Centers of Michigan; https://cacmi.org/resources/cac/

provide caseworker contact information for any questions the medical practitioner may have.

If there are bruises, marks, or injuries present that have not been photographed due to visual assessment restrictions, the caseworker must request the practitioner take photographs during the exam; see PSM 713-01, CPS General Instructions and Checklist.

Results of a Medical Examination

A caseworker must contact the medical practitioner or other medical professional familiar with the medical exam, to have them interpret the medical-examination findings. Caseworkers should ask the medical practitioner if the medical examination findings are consistent with the caregiver's explanation. If the findings or implications are unclear, the caseworker must seek clarification.

Second Opinion

Caseworkers have the discretion to seek a second medical opinion during a CPS investigation. If an exam has not already been completed by a pediatric child abuse specialist, caseworkers should seek a second medical opinion in the following situations when initial medical findings are inconclusive:

- Medical findings conflict with other information or evidence, such as statements by the child or a witness.
- A non-mobile child was injured.
- Occurrence of bruising in uncommon locations, such as the abdomen, ears, neck, away from bony prominences or protuberances.
- Burns on a child under 3 years of age.

Referral Requirements

The referral for a second medical opinion must include the following information:

- A statement informing the medical practitioner that they are being asked to re-examine and evaluate the child or review medical records.

- The reason for the second opinion.
- All information required in the Consultation with Medical Professionals for a Medical Examination section in this item.
- All medical information/records obtained through investigation.

If a second opinion is required but not obtained, the caseworker must document in a social work contact and in the disposition questions the reason a second opinion was not obtained.

Process

Michigan Department of Health & Human Services (MDHHS) county offices should reach out to local and regional medical professionals with appropriate qualifications for medical examination of child abuse and neglect to determine a process of obtaining a second opinion.

Conflicting Opinions

When conflicting medical opinions exist, caseworkers may consult with a pediatric specialist or physician in their region who has experience assessing child abuse/neglect.

Risk Level: The Risk Assessment calculates risk based on answers to the abuse and the neglect scales. The risk level is based on the higher score of either the abuse or neglect scales. After completion of the Risk Assessment, the caseworker may determine if conditions exist for a mandatory or discretionary override.

Safety Plan: PSM 713-01 CPS Investigation- General Instructions

Safety Planning

Caseworkers must consistently assess the safety and need for protection of all children during an investigation. Safety plans must:

- Address immediate safety concerns (a safety plan is not a treatment plan).

- Be developed with the input and assistance of parents, family members, and tribe (if applicable).
- Include formal and informal supports and services.
- Include proactive and reactive steps.
- Be realistic, achievable, and understood by the parent/caregiver.
- Specify roles and expectations of pertinent individuals involved in the plan.
- Be modified as other safety concerns arise.
- Build on the strengths of the parent/caregiver.

Safety plans must be documented within a social work contact and uploaded into the electronic case management system.

SRM-103: ***In-Service Training***

Supervisors and staff must select in-service training topics related to their position. In-service training topics must enhance their current skills.

MDHHS and private caseload-carrying staff and specialized support staff must complete 32 hours of in-service training each calendar year.

First-line supervisors who manage caseload-carrying staff or specialized support staff must complete 16 hours of in-service training each calendar year.

New caseworkers are not required to complete in-service training hours until the calendar year following completion of PSI training.

Subconjunctival Hemorrhage: One or more blood spots appear on the white of the eye. The eye's conjunctiva contains many tiny blood vessels that can break. If they break, blood leaks between the conjunctiva and sclera resulting in a bright red spot on the white of the eye.[3]

[3] American Academy of Ophthalmology; https://www.aao.org/eye-health/diseases/what-is-subconjunctival-hemorrhage