STATE OF MICHIGAN
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GOVERNOR
OFFICE OF CHILDREN'S OMBUDSMAN
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CHILDREN'S OMBUDSMAN

Children's Ombudsman Report of Findings and Recommendations

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Date: October 17, 2023

Case No.: 2022-0581

Child: [redacted]

DOB: February 26, 2019

DOD: June 11, 2022 (3 years old)

Introduction:

The Office of Children's Ombudsman (OCO) is tasked with making recommendations to effect change in policy, procedure, and legislation. This is done by investigating and reviewing actions of the Michigan Department of Health and Human Services (MDHHS), child placing agencies, or child caring institutions. The Children's Ombudsman Act, Public Act 204 of 1994, also requires the OCO ensure laws, rules, and policies pertaining to Children's Protective Services (CPS), Foster Care, and Adoption are being followed. The OCO is an autonomous entity, separate from the MDHHS.

This 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, and law enforcement reports. The OCO also interviewed MDHHS staff, medical professionals, and law enforcement personnel. Due to the confidentiality of OCO investigations, the OCO cannot disclose the identity of witnesses or complainants, 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 CPS investigations involving [redacted] were handled by Kent County CPS, and the involvement of MDHHS staff, physicians, and law enforcement. This review reinforces the safety and well-being of a child is the shared responsibility of the family, community, law enforcement, and medical professionals 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 MDHHS and partners within the child welfare system; and to advocate for changes within it on behalf of similarly situated children.

[redacted] was three years old when he died on June 11, 2022. Pursuant to MCL 722.627k, MDHHS notified the OCO of the child fatality. On July 18, 2022, the OCO opened an investigation into the administrative actions of CPS regarding [redacted]'s death. The following report summarizes the information and evidence found during the OCO investigation.

Background and History:

[redacted] is the birth mother of [redacted] (DOB: 05/31/2016), [redacted] (02/26/2019), and [redacted] (02/26/2019). [redacted]'s father is [redacted] and was not involved in [redacted]'s life during the scope of this investigation. [redacted] is the father of [redacted] and [redacted]. Prior to [redacted]s death, [redacted] and [redacted], shared custody of [redacted] and [redacted], following a week on week off schedule. During the investigations reviewed by the OCO, [redacted]'s boyfriend, [redacted], was residing in the home and assisted with the care of [redacted]'s children. [redacted] has no children of his own.

In July 2020 [redacted] was investigated by CPS for physical abuse of [redacted]. The investigation resulted in a Category IV, which is a finding of no child abuse or neglect. [redacted] was residing in the home during this investigation but was not identified as an alleged perpetrator.

Review of 2020 CPS Investigation

The focus of the OCO's investigation starts in July 2020 when [redacted] was observed with bruising and swelling to his face and nose area, suspected patterned bruising on his back, and concern for physical abuse. The CPS investigation was opened on July 23, 2020, and closed on September 15, 2020. The OCO review of this CPS investigation found several deficiencies and missed opportunities when MDHHS CPS attempted to determine what caused [redacted]'s injuries. In summary the OCO discovered:

- [redacted] was identified as the only suspected perpetrator of physical abuse, despite the children being in the care of her live-in boyfriend, [redacted].
- There was a breakdown in the coordination between CPS and law enforcement.
- The CPS case manager did not interview a potential witness.
- CPS did not interview the emergency room (ER) doctor who examined [redacted]'s injuries.
- CPS did not follow up with the social worker from Helen DeVos regarding [redacted]'s follow up examination.
- The CPS case manager and supervisor did not follow up with the Center for Child Protection.

On July 23, 2020, [redacted] ([redacted]'s father) brought him to the ER at Spectrum Health after picking him up from [redacted]'s home. [redacted] had bruising and swelling to his face and nose, and a mark that appeared to be a pattern bruise on his back. According to CPS and medical documentation, these injuries were not consistent with the explanation provided by [redacted], therefore a complaint was made to CPS Centralized Intake (CI).

The complaint was opened for an investigation and assigned to Kent County CPS. CPS began their investigation on July 24, 2020, by contacting the ER social worker from Spectrum Health. CPS was informed [redacted] was brought into the hospital for a medical examination by his father due to bruising to his face and back. The ER social worker advised CPS the story provided for the cause of the bruises was possible but suspicious. The ER social worker told CPS photos had been taken of the injuries and the child was with his father for the night.

The same day CPS sent the Kent County Sheriff's Department a law enforcement notification (LEN). Due to [redacted] and [redacted] being with their father, CPS also completed a home visit to [redacted]'s

home. [redacted] and [redacted] were observed but could not be interviewed due to their age and developmental abilities. The children were one year old at the time of this CPS investigation. [redacted] was documented by CPS to have a small, curved cut on the front of his left eyebrow, a few centimeters in length, a reddish bruise to the bridge of his nose, a brownish bruise in the middle of his upper forehead, two curved red bruises that looked like a bite mark from a child between his upper shoulder blades, a small green/brownish bruise on his right shoulder blade, a light bruise on the left side of his ribs near his armpit, four red marks on the inside of his right bicep, and a linear bruise on the top of his right forearm.

[redacted] told CPS, [redacted] informed him that [redacted] (age 4 during the 2020 CPS investigation) hit [redacted] with a large metal rod which caused the marks and bruises. [redacted] said he did not believe this explanation could cause so many injuries and that is why he had [redacted] medically examined.

On July 27, 2020, CPS and law enforcement conducted a joint home visit with [redacted], her son [redacted], and [redacted]'s boyfriend, [redacted]. The CPS report documents CPS interviewed [redacted] while the detective interviewed [redacted] and [redacted]. CPS documented [redacted] immediately began telling CPS about a net falling apart that scratched [redacted]'s forehead and he got in trouble. [redacted] was unable to provide CPS with any details on what the net looked like or describe how the scratch occurred. Without prompting, [redacted] told CPS [redacted] had bug bites on his back. When asked about the injuries on [redacted]'s back, [redacted] denied biting [redacted] and said the dog bit [redacted]'s arm and left bruises. [redacted] denied any kids get hit and asked if he could be done talking.

The CPS report documents law enforcement's summary of contact with [redacted] and [redacted]. [redacted] informed law enforcement she left [redacted] in charge of [redacted] and [redacted] while she went to the store. [redacted] advised she had been gone for about ten minutes when [redacted] called her, and stated [redacted] got hurt. [redacted] told the detective [redacted] had a circular mark near the side of his nose, and a mark on his back when she returned home. [redacted] said she believed [redacted] accidentally hit [redacted] with a butterfly net that broke. She told law enforcement the net was thrown out. [redacted] also explained she cleaned [redacted] up, took pictures, and sent those photos to [redacted] informing him of what happened. [redacted] thought everything was fine, but then [redacted] refused to bring [redacted] home.

[redacted] informed law enforcement he was home with his roommate [redacted], as well as [redacted], and [redacted] when [redacted] went to the store. He advised he was using the restroom when he heard [redacted] scream, so he ran out to see what happened. [redacted] told law enforcement he ran into [redacted] who was in her bedroom located next to the bathroom. When he got to the living room, he saw [redacted] rocking in a chair holding a broken butterfly net. [redacted] was "sprawled out like a drunk person" on the entertainment center. There is no documented interview or attempt to interview the roommate, [redacted], to corroborate the explanation of events. [redacted] was a potential witness to the incident that caused [redacted]'s injuries, CPS did not document interviewing or attempting to interview [redacted]. This interview could have provided additional information which would either corroborate or refute [redacted]'s explanation of events.

On July 30, 2020, a social worker from Helen DeVos Children's Hospital Academic General Pediatric Clinic emailed CPS to inform the case manager that [redacted] was seen for a follow-up visit for

suspected non-accidental trauma. The social worker advised the CPS case manager she had a release signed by [redacted] to speak freely with the case manager about the case and asked that the case manager email or call her directly. There is no response or conversation documented between the social worker and CPS case manager in the CPS report. The OCO was unable to interview the case manager assigned to this CPS investigation as the person is no longer employed with the State of Michigan. Of note, there is a documented case conference between the CPS case manager and that individual's supervisor on August 13, 2020, however the OCO is not able to determine details of this case conference.

The next documented effort in MiSACIWS shows CPS requested the ER medical records for [redacted] on August 18, 2020. It does not appear the medical records were received from the hospital prior to CPS closing this case. Additionally, there is no indication that the medical records were reviewed by the CPS case manager.

On August 22, 2020, the CPS case manager sent a text message to the assigned detective requesting confirmation no criminal charges were issued. There is no documented response in the CPS case file. The OCO could not verify if this request received a response.

The CPS case manager spoke with [redacted] by phone on September 10, 2020. It is documented she was questioned further regarding [redacted]'s injuries. Documentation shows [redacted] believed the two injuries on the top of [redacted]'s mid back were from falling onto the entertainment center and did not believe it was a bite mark because [redacted] is the only child that bites others. [redacted] denied knowing about red marks or bruises on [redacted]'s arms as she did not see them when [redacted] was with her. [redacted] agreed to forward photos of [redacted] that she took directly after the incident, as well as screenshots of her text messages informing [redacted]. [redacted] also advised having [redacted]'s medical records concerning the injuries and agreed to send CPS photos of the records. [redacted] told CPS [redacted] would not allow her to see the children if [redacted] was visiting her home, so she no longer is allowing [redacted] to visit. [redacted] informed the case manager she did not know where [redacted] was. [redacted] told CPS, [redacted] was only a friend and denied she lived in the home.

CPS documented reviewing the screenshots and pictures. A summary of the text messages shows [redacted] informed [redacted] about [redacted]'s injuries. [redacted] explained in texts to [redacted] that [redacted] was not listening after he was told to stop swinging a butterfly net around, and [redacted] hit [redacted] so hard it knocked [redacted] off his feet causing [redacted] to hit the entertainment center with his back. She also sent photos of the butterfly net to [redacted], which was described in the CPS case file as "…a long metal rod with a red handle. The tip of the rod is also metal and has a circular opening at the end, like a straw."

CPS received screen shot photos of the medical records from [redacted] for [redacted]'s ER visit on July 23, 2020. According to the CPS investigative report, [redacted]'s medical records state the physical exam found bruising and swelling to the bridge of his nose. The medical records also indicate photographs were taken, however there are no photographs from the hospital in the CPS case record. The medical report documented "a parental concern about possible child physical abuse." According to CPS documentation, medical records state [redacted] told staff that he picked [redacted] up and noticed the injuries and immediately contacted [redacted] who said an older sibling hit him with a telescope.

The CPS investigative report documents a case summary and photographs were sent to the Helen DeVos Children's Hospital Center for Child Protection[1] (CCP) on September 12, 2020. There is no documented follow up or response from the CCP. The case manager also attempted to reach [redacted], at a phone number previously provided, leaving a voice message. There is no documentation to show if a return phone call was received from [redacted].

CPS concluded their investigation as a Category IV, stating there was no preponderance of evidence of physical abuse by [redacted] towards [redacted]. CPS documented that the statements given by [redacted] at the hospital were clearly false given the evidence of text messages provided by [redacted]. The investigation was closed with a moderate risk level on September 15, 2020.

The OCO investigator interviewed CCP staff about the requests submitted to them by CPS during the CPS investigation. A staff member informed the OCO investigator that the CPS case manager wanted to "run the case by them" for their (CCP's) opinion.

The CCP made it clear they are unable to diagnose a child they have not seen. CCP staff explained when the concerns are regarding physical abuse, it is time sensitive in terms of labs, but also visualizing injuries. One exception would be if CPS obtained evidentiary photographs with a scale, and proper lighting. There were no photographs of evidentiary value in this CPS case. CCP staff explained that they would not be able to evaluate the bruising the case manager was referencing, two months after the injuries occurred.

The OCO investigator asked how often a second opinion request this late into a case occurs. CCP staff advised they view these requests as more of a "curbside consult," adding that CPS running a case by them to get their "blessing" is not, in any way, a second opinion. CCP staff indicated they do get these requests often, despite reminding case managers to contact them immediately after their investigation starts.

Death of [redacted]:

As previously mentioned, the death of [redacted] is what brought these cases to the attention of the OCO. On June 9, 2022, [redacted] was found unresponsive in the family home while being cared for by [redacted]. According to documentation reviewed by the OCO, [redacted] presented to the ER with numerous injuries, including a significant massive acute hemorrhage on his brain, cerebral edema, subdural hemorrhages, diffuse subarachnoid hemorrhage, multiple abrasions to his trunk, one abrasion to his forehead, soft tissue hemorrhaging in his pelvis around the urinary bladder, and a proximal left humerus fracture. [redacted] was also found to have retinal hemorrhages and retinoschisis with no natural disease. [redacted] passed away from his injuries on June 11, 2022. [redacted]'s cause of death was determined to be craniocerebral trauma. Due to some injuries being consistent with non-accidental trauma and other injuries being consistent with an accidental fall, the manner of death was indeterminate. CPS' investigation found a preponderance of evidence of

[1] The Helen DeVos Children's Hospital CCP is a multidisciplinary, medical consultation team that collaborates with other professionals to identify, diagnose, and treat child abuse and neglect.

physical abuse of [redacted] by [redacted], and the investigation was placed in a Category II.

OCO Investigations with Similar Circumstances:

OCO case 2022-0263 concerning the death of [redacted] had a similar case issue. The medical provider who examined [redacted] was not directly contacted or interviewed by the assigned case manager. This caused the incorrect disposition to be reached. In [redacted]'s case, had the assigned case manager spoken directly to the medical provider, they would have been informed that [redacted]'s injuries were highly indicative of physical abuse, and were not accidental. The case manager did not do this, and relied on another case manager, in another county, who incorrectly documented their conversation with the doctor. The injuries were then mistaken for accidental trauma by CPS. [redacted] died a few months later at the hands of his abuser.

OCO case 2020-0440 concerning the death of Trinity Chandler also has a similar circumstance, as the medical provider was not contacted prior to the child being medically assessed. If CPS had contacted the medical provider prior to the child's examination, more specific details of the case manager's concerns could have been relayed to the provider and may have changed the way the provider handled the examination. The case manager investigating the abuse of Trinity Chandler prior to her death, did not seek a second medical opinion.

OCO case 2021-0974 concerning the death of [redacted], is an example of a case manager speaking with medical professionals to gain information regarding a child's injuries. The case manager had a sit-down interview with the doctor who examined [redacted]. This interview provided the case manager with insight into [redacted]'s injuries, and helped CPS understand those injuries were not all caused on the day of her death. This conversation provided the case manager sufficient evidence to support filing a petition for termination regarding [redacted]'s surviving sibling. When interviewed by the OCO the case manager said speaking with the examining physician was very helpful in determining the outcome of the case.

Factual Findings:

Introduction:

The ombudsman shall prepare a report of the factual findings of an investigation and make recommendations to the department or the child placing agency if the ombudsman finds one or more of the following:

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

The ombudsman believes the findings should be further considered by the department, an administrative act should be corrected, and additional actions by MDHHS and other child welfare partners are necessary to help detect and prevent child abuse.

Findings:

1. The children's ombudsman finds the 2020 CPS investigation concerning physical abuse of [redacted] was inadequate.

2. The children's ombudsman finds CPS failed to contact and interview appropriate medical professionals during the 2020 CPS investigation concerning physical abuse of [redacted].

3. The children's ombudsman finds a recommendation from the Michigan Child Death State Advisory Team's 2015-2020 report states, "In CPS cases where a child is referred for a medical evaluation, require that direct communication occur between the CPS worker and the medical staff completing the evaluation to ensure that workers obtain a full understanding of the findings of that evaluation."

4. The children's ombudsman finds the assigned case manager from the 2020 CPS investigation into [redacted]'s injuries, is no longer employed with the State of Michigan, and the assigned supervisor from the 2020 CPS investigation was not able to fully recall details of the case given the amount of time passed. As a result, it is unclear what direction was provided to the case manager concerning any requests for follow up with medical professionals concerning [redacted]'s injuries.

5. The children's ombudsman finds a prior ombudsman recommendation to MDHHS from March 2023 suggests PSM 713-01 be amended to require case conferences between CPS case managers and their supervisors be documented in a narrative format in the case's social work contacts.

    a. The OCO received the following response to this recommendation from MDHHS: "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."

6. The children's ombudsman finds that MDHHS should correct the investigation disposition into [redacted]'s death to a category I case.

Recommendations:

The children's ombudsman recently provided similar recommendations concerning medical assessments and contact with medical providers through OCO investigations, 2020-0440, 2022-0263, and the 2022 Office of Children's Ombudsman annual report.

1. The OCO recommends MDHHS amend 'PSM 713-04 Medical Examination and Assessment', to require the **assigned** case manager **conduct interviews** with treating medical professional(s) as part of an investigation into physical abuse, sexual abuse, and/or severe physical injury.

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

3. The OCO recommends MDHHS correct the category II disposition of the investigation into [redacted]'s death to a category I.

Conclusion:
Under authority pursuant to The Children's Ombudsman Act, MCL 722.903, the OCO respectfully submits this report of findings and recommendations.

It is important that the matters addressed in this report be further considered by MDHHS. These recommendations may effectuate positive change and can improve the lives of similarly situated children involved in Michigan's child welfare system.

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

Ryan Speidel
Children's Ombudsman
Office of Children's Ombudsman
111 S. Capitol Avenue
Lansing, Michigan 48933

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

December 20, 2023

Ryan Speidel
Office of Children's Ombudsman
111 S. Capitol Ave.
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 [redacted].

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

Findings:

1. The children's ombudsman finds the 2020 CPS investigation concerning physical abuse of [redacted] was inadequate.

   MDHHS Response to Finding 1: MDHHS agrees and on November 7, 2023, the assigned supervisor, section manager, district manager, and county director met to discuss the findings of this report related to the 2020 investigation. Additionally, during an All-Staff meeting held on November 15,2023, county administration shared policy requirements and expectations related to medical follow up with all first-line staff.

2. The children's ombudsman finds CPS failed to contact and interview appropriate medical professionals during the 2020 CPS investigation concerning physical abuse of [redacted].

   MDHHS Response to Finding 2: MDHHS agrees and on November 7, 2023, the assigned supervisor, section manager, district manager, and county director met to discuss the findings of this report related to the 2020 investigation. Additionally, on November 9, 2023, section managers followed up with all CPS supervisors regarding the policy expectations related to medical exams on

November 12, 2023, county administrators shared the information with all first-line staff at an All-Staff meeting.

3. The children's ombudsman finds a recommendation from the Michigan Child Death State Advisory Team's 2015-2020 report states, "In CPS cases where a child is referred for a medical evaluation, require that direct communication occur between the CPS worker and the medical staff completing the evaluation to ensure that workers obtain a full understanding of the findings of that evaluation."
4. **MDHHS Response to Finding 3:** 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 case manager.

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

5. The children's ombudsman finds the assigned case manager from the 2020 CPS investigation into [redacted]'s injuries, is no longer employed with the State of Michigan, and the assigned supervisor from the 2020 CPS investigation was not able to fully recall details of the case given the amount of time passed. As a result, it is unclear what direction was provided to the case manager concerning any requests for follow up with medical professionals concerning [redacted]'s injuries.

   MDHHS Response to Finding 4: Agree.

6. The children's ombudsman finds a prior ombudsman recommendation to MDHHS from March 2023 suggests PSM 713-01 be amended to require case conferences between CPS case managers and their supervisors be documented in a narrative format in the case's social work contacts.

   a. The OCO received the following response to this recommendation from MDHHS:
   "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."

MDHHS Response to Finding 5: MDHHS agrees, has prepared draft policy language, and is soliciting final feedback prior to implementation.

7. The children's ombudsman finds that MDHHS should correct the investigation disposition into [redacted]'s death to a category I case.

   MDHHS Response to Finding 6: MDHHS agrees and has updated the June 10, 2022, investigation in SACWIS to reflect a Category I disposition.

Recommendations:

The children's ombudsman recently provided similar recommendations concerning medical assessments and contact with medical providers through OCO investigations, 2020-0440, 2022-0263, and the 2022 Office of Children's Ombudsman annual report.

1. The OCO recommends MDHHS amend 'PSM 713-04 Medical Examination and Assessment', to require the **assigned** case manager **conduct interviews** with treating medical professional(s) as part of an investigation into physical abuse, sexual abuse, and/or severe physical injury.

   MDHHS Response to Recommendation 1: MDHHS agrees that a policy change requiring the assigned case manager to pursue interviews with the treating medical professionals would be beneficial.

   Current policy allows case managers to speak to other professionals at the medical facility to gather and relay information to avoid potentially critical delays in examination and an update to require staff to pursue interviews with the treating physician will be explored.

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

   MDHHS Response to Recommendation 2: MDHHS agrees, has prepared draft policy language, and is soliciting final feedback prior to implementation.

3. The OCO recommends MDHHS correct the category II disposition of the investigation into [redacted]'s death to a category I.

   MDHHS Response to Recommendation 3 : MDHHS agrees and has updated the June 10, 2022 investigation in SACWIS to reflect a Category I disposition.

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