Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2022-0821

[redacted], [redacted]

Date of Death: August 6, 2022

Investigation Start: September 12, 2022

Recommendation Issued: July 30, 2025

Case Background

[redacted] was one year old when he died on August 6, 2022. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatality. On September 12, 2022, the OCA opened an investigation into the administrative actions of CPS and courts prior to [redacted] death. The following report summarizes the information and evidence found during the OCA investigation.

Case Objective

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 Genesee County MDHHS, and the involvement of MDHHS staff, the court, medical professionals, and law enforcement. This review reinforces the idea that the safety and well-being of a child is a 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 advocate for changes within it on behalf of similarly situated children.

Response received from MDHHS: November 13, 2025

Findings

1. The child advocate finds MDHHS appropriately included [redacted] as a respondent on their initial removal petition in July 2022. The child advocate finds this petition did not include pertinent information including:

    a. Allegations regarding [redacted] absence of a relationship and involvement in [redacted] life, nor the fact that he had never provided for [redacted]
        i. Based on statements made by [redacted] during prior CPS investigations, [redacted] was not involved in [redacted] life.
        ii. Per information gathered from the Friend of the Court by MDHHS, [redacted] had never paid his court ordered child support.

    b. The child advocate finds MDHHS reviewed [redacted] criminal history but missed a warrant for his arrest at the time the petition was filed in July 2022. The warrant was for felony dangerous drugs (methamphetamine) and would have added additional concern to the petition presented to the court.

2. The child advocate finds the testimony provided to support the July 2022 petition and allegations regarding [redacted] CPS history was not adequately presented to the court.

    a. There was no testimony provided regarding the serious injuries [redacted] caused to an infant in 2014.
    b. There was no testimony provided regarding the severe physical neglect [redacted] caused to a child in 2020.
    c. There was minimal testimony provided regarding the seriousness of [redacted] domestic violence history and methamphetamine use.
    d. No services to rectify the concerns had been provided to [redacted] by MDHHS.

Responses

MDHHS Response to Finding 1:
MDHHS agrees in part. Although there were times when mother, [redacted] said that [redacted] was not involved in [redacted] life in previous investigations, she also noted that [redacted] was working to obtain a home for her and her children. The degree to which [redacted] was involved in [redacted] life was hard to determine based on contacts made in the report. MDHHS agrees that [redacted] did not pay his court-ordered child support. MDHHS also agrees that information regarding the warrant was not included in the petition filed in July 2022.

MDHHS Response to Finding 2:
MDHHS agrees in part. The petition documented [redacted] Children's Protective Services (CPS) history, and that information remained in the court records, regardless of whether there was direct testimony or the reading of the petition was waived.

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Case Number: 2022-0821

[redacted] [redacted]

Response received from MDHHS: November 13, 2025

Findings	Responses
3. The child advocate finds MDHHS staff have limited training with court testimony.	**MDHHS Response to Finding 3:** MDHHS agrees. All new Children Protective Services, Foster Care, and Adoption staff receive training on court testimony during the Pre-Service Institute (PSI). MDHHS will evaluate whether additional training is needed regarding court testimony as an ongoing supplemental training for all service specialists.
4. The child advocate finds the assigned assistant prosecuting attorney provided no guidance or assistance to the MDHHS case manager during testimony.	**MDHHS Response to Finding 4:** No response.
5. The child advocate finds following testimony, the court removed [redacted] as a respondent from the petition.	**MDHHS Response to Finding 5:** MDHHS agrees.
6. The child advocate finds there is an opportunity for improvement in training provided to case managers regarding petition writing and court testimony. a. Various webinars are available and offered yearly to case managers, however, these webinars do not provide hands on experience to adequately prepare a case manager for testimony. b. Webinars do not provide case managers with the opportunity to practice testifying in a court room setting. c. A mock trial is completed at the MDHHS Child Welfare Training Institute; however, this only allows for a handful of case managers to practice, and according to interviews performed by the OCA, does not provide adequate preparation for a court room setting.	**MDHHS Response to Finding 6:** MDHHS agrees in part. Training for court testimony could be enhanced with additional resources and will be explored. Training for petition writing has recently been enhanced for new specialists during Pre-Service Institute (PSI).
7. The child advocate finds that [redacted] was a non-custodial parent in July of 2022.	**MDHHS Response to Finding 7:** MDHHS agrees.
8. The child advocate finds Protective Services Manual (PSM)715-3, Problem Court and Administrative Hearing Orders, lacks guidance for MDHHS staff on what to do when a court removes a non-custodial parent as a respondent. a. In situations such as this case, an amended petition requesting in-home jurisdiction could have been filed with the court to ensure services were provided to [redacted] b. Given the seriousness of [redacted] CPS history, and [redacted] never having care and custody of [redacted] court ordered participation in services would have provided additional support for [redacted] and [redacted]	**MDHHS Response to Finding 8:** MDHHS agrees in part. While the Department recognizes the opportunities for improvement in this specific case, the finding will be reviewed further and to determine if this is a systemic issue and how best to mitigate the area of concern.

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Case Number: 2022-0821

[redacted] [redacted]

Response received from MDHHS: November 13, 2025

Recommendations	Responses
1. The child advocate recommends Children's Services Agency (CSA) amend PSM 715-3 Problem Court and Administrative Hearing Orders to include notification to the Children's Services Legal Division (CSLD) when a court or referee removes a respondent from a petition and the department disagrees with the decision.	**MDHHS Response to Recommendation 1:** MDHHS agrees in part. Although CSA staff is required to contact CSLD in the event a petition is dismissed, and the respondent father's removal from this petition may be considered a de facto dismissal in accordance with the policy, adding this type of scenario to the policy would clarify the requirement to contact CSLD for further review. MDHHS will explore opportunities to provide clearer guidance in policy.
2. The OCA recommends that the Michigan Legislature Codify the requirement for a Child Welfare Training Academy (CWTA) and simulation labs that incorporate experiential learning on courtroom testimony.	**MDHHS Response to Recommendation 2:** No response.
3. The OCA recommends that the Michigan Legislature adequately fund the purchase, equipping, staffing, and maintenance of MDHHS regional simulation labs for child welfare training.	**MDHHS Response to Recommendation 3:** No response.
4. The child advocate recommends MDHHS institute simulation training on courtroom testimony that would allow all new case managers to be trained and existing case managers to have ongoing training on providing courtroom testimony. a. The child advocate recommends MDHHS require all case managers complete the training as part of their initial child welfare training and then repeat it on a routine basis as determined by MDHHS. b. The child advocate recommends this training be conducted jointly with the local prosecuting attorney's office, the Attorney General's office and/or with the department's retained counsel in each county to ensure the most relevant and effective training is provided in the jurisdiction where testimony is provided. c. The child advocate recommends this training be conducted in a simulation environment involving hands-on mock trials for all participants. d. The child advocate recommends this training be conducted in a simulation environment involving hands-on mock trials for all participants.	**MDHHS Response to Recommendation 4:** MDHHS agrees. The department has executed a contract with Michigan State University School of Social Work to implement a simulation pilot for child welfare specialists and implementation is anticipated in 2026. Due to cost and logistical constraints, the pilot is limited in scope and volume but will inform the feasibility of utilizing a simulation format for an expanded audience and range of content in the future. The implementation of statewide mock trials in a simulation environment would require additional funding to compensate legal experts and resources to coordinate logistics with local jurisdictions. MDHHS has recently enhanced the Pre-Service Institute to require all trainees to complete a petition during training and have it reviewed by their local office/agency supervisor. Additionally, ongoing training in testifying and petition writing is available as an in-service training for experienced specialists
5. The child advocate recommends supervision, or mentors attend court hearings with inexperienced staff.	**MDHHS Response to Recommendation 5:** MDHHS agrees. MDHHS will collaborate with regional and local office leadership to evaluate this recommendation and determine whether enhanced practice guidance is warranted and will issue it accordingly.

Office of the Child Advocate

[redacted]

Date of Birth: April 8, 2021
Date of Death: August 6, 2022

Case Number: 2022-0821

Investigation Start: September 12, 2022

Recommendation Issued: July 30, 2025

Family History and Background

[redacted] and [redacted] are the parents of [redacted] has four other children: [redacted] and [redacted] is [redacted] father. [redacted] is [redacted] and [redacted] father. [redacted] is the father of [redacted] and they reside in another state. [redacted] has one additional child, [redacted] who primarily resides with his mother, [redacted]

[redacted] has extensive CPS history dating back to 2007 involving improper supervision, physical neglect, physical abuse, and sexual abuse investigations. Outside of the scope of this investigation, [redacted] was substantiated in multiple prior cases, including a Category I removal in 2019 for improper supervision due to substance abuse. Throughout CPS' involvement with [redacted] she was provided a variety of services including parenting classes, Families Together Building Solutions, Families First, Access services, YWCA services and services with the Genesee Health System.

As it relates to the scope of this investigation, the OCA review included history pertaining to [redacted] and [redacted]

[redacted] (Mother) CPS History

In the two years proceeding [redacted] death, there were four CPS investigations. The first investigation (MiSACWIS ID: 105943405) began on April 16, 2021, following [redacted] being born positive for marijuana, hydromorphone, and hydrocodone. [redacted] did not experience withdrawals. However, CPS had concerns for [redacted] health and well-being due to [redacted] not taking [redacted] for his well-child examinations following his birth. During the investigation, [redacted] advised CPS [redacted] father was unknown. [redacted] was substantiated for physical neglect as a Category II and an ongoing services case was opened on May 28, 2021. The ongoing case (MiSACWIS ID: 221639) was closed on July 16, 2021, after [redacted] was seen for a well-child examination and there were no concerns for abuse or neglect. [redacted] was offered services through CPS ongoing, but she refused to cooperate.

During the ongoing case, a new CPS complaint was assigned for investigation on June 12, 2021, with concerns of physical neglect (MiSACWIS ID: 107522931). The complaint expressed concern [redacted] was using substances and had unstable housing. CPS found [redacted] had appropriate housing and there were no concerns expressed by the children for [redacted] ability to parent. [redacted] identified [redacted] as [redacted] father, stating [redacted] was not involved and she was unaware of his contact information. CPS located possible addresses for [redacted] but were not able to reach [redacted] during this investigation. The investigation was closed as a Category IV on July 20, 2021.

The next investigation began on September 12, 2021, with concerns for physical neglect and improper supervision of [redacted] by [redacted] (MiSACWIS ID: 109494467). A neighbor found [redacted] soiled and dirty. The complaint also expressed concern for [redacted] using substances and having poor home conditions. During the investigation, [redacted] admitted [redacted] snuck out of the home to play with a friend, but the friend was not home, and she ended up at a neighbor's home. [redacted] agreed to get locks/chimes for the doors. CPS documented the home had plenty of food and working utilities. When interviewed by CPS, [redacted] confirmed she left the home while everyone else was asleep. When asking standard parent questions, CPS inquired about the fathers of the children. [redacted] refused to identify [redacted] father and told CPS he was not involved. Although CPS should have had knowledge of who [redacted] father was from the prior investigation, CPS did not make any documented efforts to contact him during this investigation. [redacted] tested positive for amphetamines during this investigation, but no additional information was gathered relating to [redacted] drug use. CPS encouraged [redacted] to participate in prevention services. The case was closed as a Category IV with high risk stating there was not a preponderance of evidence [redacted] drug use was impairing her ability to care for the children, the home was appropriate, and the incident with [redacted] appeared isolated.

On June 28, 2022, MDHHS Centralized Intake received a new complaint for concerns of improper supervision and physical neglect of the children by [redacted] The complaint stated law enforcement dropped the family off to a shelter because they were in an abandoned home, the children were dirty with no shoes, matted hair, and they had not eaten. [redacted] was described in the complaint to be completely naked without a diaper, and a lot of the families' belongings had to be thrown away due to being covered in human feces. This complaint was accepted and assigned to Genesee County for investigation (MiSACWIS ID: 132434694).

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[redacted]

[redacted] (Mother) CPS History Continued

During the CPS investigation, CPS struggled to locate [redacted] and the children as the family was kicked out of the shelter because of [redacted] use of profanity and threatening behavior. Shelter staff informed CPS the Flint Police Department escorted the family from the shelter. CPS spoke with the Flint Police Department who advised they assisted [redacted] in getting a few things out of the shelter, and the family advised they were going camping. No further information was provided to CPS by the Flint Police Department. From June 29, 2022, to July 6, 2022, CPS made several unsuccessful attempts to locate [redacted] at her last known addresses.

On July 9, 2022, CPS received an additional complaint that was accepted and linked to the current complaint. This complaint stated the family was picked up from a property in Flint where the family was not authorized to be, the family was homeless, and the home they were in was deplorable. Additional concerns were expressed that [redacted] left the home, leaving [redacted] (age 15) in charge of the younger children (ages 7, 4, and 1).

CPS met with [redacted] and the children at the police station. It was confirmed the family was homeless and they had been staying in an abandoned house with no food, water, or electricity, for an unknown amount of time. [redacted] provided CPS with information for a friend, [redacted] who agreed to allow [redacted] and the children to stay with her for the weekend. On July 11, 2022, CPS was contacted by [redacted] husband who had concerns for statements [redacted] had been making. He was unsure if she was on substances and said she could only stay short term. On July 15, 2022, CPS was informed [redacted] and the children were no longer able to stay with the [redacted] family as they were destroying their property.

During the investigation, CPS completed a home assessment on [redacted] home ([redacted] father). He was able and willing to care for her, and his home was found to be appropriate. On July 18, 2022, CPS spoke with [redacted] by phone (father of [redacted] and [redacted] He informed CPS he was living in Tennessee and had room for his girls if placement was needed. On July 18, 2022, CPS completed a home visit at [redacted] home. The home was documented by CPS to be appropriate. According to the CPS report, [redacted] advised having domestic violence history with [redacted] both as the aggressor and as the victim. He denied having any mental health diagnosis, substance abuse history or criminal history. However, the investigation report documents past CPS history pertaining to [redacted] including his placement on Central Registry for physical abuse.

The CPS case manager submitted the investigation for review on July 28, 2022, as a Category I with a preponderance of evidence supporting physical neglect and improper supervision by [redacted] The supervisor approved and closed the investigation on August 11, 2022. The case was transferred to CPS ongoing to provide services for the family.

[redacted] (Father) CPS History

As part of the OCA investigation, [redacted] CPS history was reviewed. [redacted] has the following substantiated CPS history:

2011:

On August 23, 2011, [redacted] was involved with [redacted] and was arrested for felonious assault. CPS received a complaint regarding the incident and an investigation was conducted. During the investigation, CPS discovered [redacted] and [redacted] were involved in several domestic violence incidents. During the incident that occurred on August 23, 2011, [redacted] son, [redacted] (8), was a witness to the domestic violence. [redacted] informed CPS [redacted] pulled his mom "off the couch and into the dining room, punching and kicking his mom in the face and ears." Mt. Morris Police Department advised CPS [redacted] had been arrested four additional times in the sixty days prior to August 23, 2011. [redacted] filed a personal protection order (PP0) against [redacted] and moved to Virginia. [redacted] was substantiated for threatened harm as a result of domestic violence. The investigation was closed as a Category II on September 16, 2011. [redacted] was not provided any services.

2014:

In March of 2014, [redacted] resided with [redacted] and her son, [redacted] (age 1). On March 25, 2014, CPS received a complaint stating [redacted] was brought to the hospital with bruising and swelling to the side of his face, forehead, and cheek with fresh linear bruising to his neck and chest area. The complaint stated [redacted] was caring for [redacted] while [redacted] was at work, and [redacted] was in his crib when [redacted] heard a "thump." He found [redacted] on the floor near his crib. [redacted] was called to the home and observed bruising to [redacted] resulting in her taking him to the hospital. CPS spoke with [redacted] examining physician at the hospital who advised the injuries were not consistent with a fall. [redacted] was observed by CPS to have significant bruising to the left side of his face, a bruise on his left shoulder, a bruise in the middle of his back, scratches on the right side of

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[redacted]

[redacted] (Father) CPS History Continued

his neck, and a scratch behind his right ear. [redacted] said [redacted] was very upset about what happened and that he had fallen asleep after putting [redacted] in his crib. [redacted] parents agreed not to allow [redacted] to care for [redacted] during the investigation. [redacted] informed CPS a "Lego cart" matched the lines on [redacted] face and she believed [redacted] was telling the truth. While waiting for a second opinion from a child abuse expert, Dr. [redacted] advised CPS she was moving back in with [redacted] Dr. [redacted] advised CPS the injuries to [redacted] were indicative of abuse. CPS found a preponderance of evidence for physical abuse of [redacted] by [redacted] and [redacted] was removed from [redacted] care. During this investigation [redacted] advised CPS he had a seven-year-old son who resided somewhere in Flint, but no documented efforts were made to identify or locate his child. [redacted] was not provided any services.

[redacted] was involved in two investigations concerning improper supervision and physical neglect involving [redacted] and her children. The first investigation (MiSACWIS ID: 7324505) began on November 28, 2014, which stated [redacted] had to be hospitalized for two to three days after [redacted] beat her up, and the children were with their father while she healed. During this investigation, [redacted] denied [redacted] beating her up, advising CPS she was jumped outside a bar by two females. The children denied witnessing any domestic violence between their mom and [redacted] expressing no concerns at home. CPS found no preponderance of evidence and closed the case as a Category IV on January 8, 2015. On May 2, 2015, another complaint came in with concerns for improper supervision and threatened harm by [redacted] (MiSACWIS ID: 7439889). Initially, [redacted] denied domestic violence and stated [redacted] accidentally hit her with a broom. During this investigation, [redacted] children told CPS, [redacted] and their mom fight every day and the police have been called. No further descriptions were provided of what their fighting looked like. During a subsequent home visit on June 4, 2015, [redacted] advised CPS another incident occurred which included [redacted] biting her ear, which led to [redacted] getting arrested and her obtaining a PPO against him. [redacted] was substantiated for threatened harm of [redacted] children as a Category III and [redacted] was offered services by CPS. The case was closed on June 25, 2015. [redacted] was not provided any services.

2020:

On February 2, 2020, a CPS investigation began involving concerns of improper supervision, medical neglect, and physical neglect of [redacted] son of [redacted] by [redacted] and [redacted] (MiSACWIS ID: 80392531). At the time of this investigation, [redacted] and [redacted] were living together. Concerns were expressed [redacted] had autism, was visually impaired, and was often left in soiled diapers. Additional concerns expressed [redacted] was only fed one meal, [redacted] and [redacted] did not interact with [redacted] was selling methamphetamine out of the home, and both [redacted] and [redacted] were using methamphetamine and other substances.

During this CPS investigation, [redacted] was non-compliant with taking a drug screen, denied having any children of his own, and told CPS the allegations were not true. CPS identified [redacted] had a 14-year-old son, [redacted] who resided with his mother, [redacted] CPS spoke with [redacted] who advised she was not afraid of [redacted] and would not allow [redacted] to ever see [redacted] told CPS [redacted] was abusive in their past relationship.

When CPS interviewed [redacted] she denied the allegations and initially refused to provide a drug screen for CPS. CPS later discovered [redacted] was arrested for felony substance/delivery/manufacture, schedules 1, 2, 3 except marijuana, and she pled to misdemeanor substance use, narcotic/cocaine/methamphetamine/ecstasy. CPS was informed by medical professionals there was a concern for medical neglect of [redacted] refused to have him routinely seen by a medical professional. [redacted] fictive caregiver for [redacted] informed CPS [redacted] used methamphetamine, and it is manufactured in the home. CPS was further advised by [redacted] that [redacted] called her on New Year's Eve asking for her to come rescue her and [redacted] after [redacted] had beat her. [redacted] told CPS [redacted] had bruises on her body and had to walk through glass to get out of the home. [redacted] drug screen came back positive for amphetamine, methamphetamine, benzoylecgonine, and cocaine, with the results for amphetamine and methamphetamine being "above the upper limit of linearity, indicating the levels were at or above this level for testing." A petition was drafted and filed with the court on February 13, 2020.

The investigation was concluded as a Category I with a preponderance of evidence supporting improper supervision and physical neglect of [redacted] by [redacted] and [redacted] and medical neglect of [redacted] by [redacted] The removal petition was authorized removing [redacted] from his mother's home on February 20, 2020. [redacted] was not a respondent on the petition as he was not [redacted] father. [redacted] was not provided any services.

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[redacted]

Additional Information

In review of the petition filed against [redacted] and [redacted] in July 2022, CPS included the substantiated CPS history for domestic violence and physical abuse concerning [redacted] The petition also included his criminal history which detailed numerous assault and domestic violence charges dating back to 2002 up until 2015. The warrant for [redacted] arrest related to felony dangerous drugs was not included on the original petition filed by CPS in July 2022.

In interviews conducted with MDHHS staff the OCA investigation was unable to determine why [redacted] charge of and arrest warrant for felony dangerous drugs (methamphetamine) was missed. MDHHS staff expressed this was possibly overlooked and the recognized error. MDHHS staff also recognized their lack of training and experience for courtroom testimony. The assigned case manager had only filed a few petitions throughout their career, and the court hearing for the petition against [redacted] and [redacted] was this staff member's first in-person court hearing since proceedings had been virtual due to the COVID-19 pandemic. The in-person court hearing heightened their nerves, leading to concerns surrounding [redacted] CPS history of physical abuse not being fully communicated to the court. MDHHS staff informed the OCA investigator that the assigned Assistant Prosecuting Attorney (APA) did not assist in ensuring the petition was fully communicated to the court and did not ask the case manager any questions during the hearing to help elicit information. MDHHS staff believed asking for removal from [redacted] was going to be difficult due to the most recent history being two years prior to this case. However, [redacted] had never cared for [redacted] who was only one year old, and [redacted] had never been serviced through his prior substantiations, which included a substantiation for severe physical abuse of an infant.

On February 23, 2023, the OCA reviewed the video of the recorded court hearing that took place on July 20, 2022. In review of this video, the OCA observed the case manager testify to the reasons for removal and reasonable efforts in relation to [redacted] The case manager did not testify to the full details of the petition and the concerns surrounding [redacted] CPS history. The case manager was asked why the child should be removed from [redacted] care and the case manager responded because of his criminal history and CPS history, which was unrelated to his child. The case manager testified [redacted] CPS history involved domestic violence in the presence of children, stating this was the concern and why he was a respondent. The referee inquired if there were any current concerns for domestic violence written in the petition or if any PPOs were in effect concerning his child; the case manager denied both. There were no additional questions asked by the APA representing MDHHS to assist in bringing the concerns of the petition to the courts' attention. The APA was observed on their phone throughout the hearing. As a result, the history presented, of prior domestic violence investigations, did not raise enough concern to the court to remove [redacted] from [redacted] care and custody. The court removed [redacted] as a respondent from the petition, resulting in no orders being put into place regarding [redacted] or [redacted] This further limited MDHHS' ability to engage [redacted] in services as he was not bound by court orders to participate.

MDHHS staff and the OCA examined the available training options and provided guidance for MDHHS staff on court testimony. Staff members from around the state have advised the OCA that there is a significant lack of training in this area. Webinars are offered annually, such as "Testifying in Court" by the State Court Administrative Office (SCAO) and "I am a Witness, CATS Webinar." However, these are limited and often repeat the same content each year. Additionally, there is an in-person training called "Crime Scene to Courtroom: The Multidisciplinary Approach to the Investigation and Prosecution of Abusive Head Trauma and Serious Physical Abuse in Children." The OCA was informed that this training is intended more for the multidisciplinary team as a whole rather than specifically focusing on court testimony for Child Welfare staff. Moreover, MDHHS staff indicated that a mock trial is part of the Child Welfare Training Institute (CWTI) for new case managers entering child welfare programs. However, participation is voluntary, so not everyone gains hands-on experience.

The OCA was informed during interviews with multiple MDHHS supervisors across several counties about the lack of available training on courtroom testimony, highlighting an area where MDHHS could improve. It was suggested that courtroom testimony training should be offered at least annually and required for all MDHHS case managers either every year, every other year, or every three years. It was recommended that this training be conducted jointly with the local prosecuting attorney's office in each county to ensure the most relevant and effective training is provided for the area where most petitions are likely to be filed. This training should be a stand-alone session, similar to forensic interviewing, involving hands-on mock trials for all participants.

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[redacted]

Review of MDHHS actions following placement in [redacted] home:

According to the Updated Services Plan (USP), report period July 29, 2022, to September 26, 2022, [redacted] and the children participated in a parenting time visit on July 29, 2022. [redacted] was also present and spoke with CPS. [redacted] advised CPS [redacted] was scheduled for an appointment at the Clio Health Care Center for immunizations on August 11, 2022. Another parenting time occurred on August 5, 2022, with [redacted] and [redacted] CPS documented [redacted] was observed walking around, laughing, and interacting well with his sister. [redacted] was documented to be acting weird, telling [redacted] it was her responsibility to go to [redacted] dad's home to supervise him and make sure [redacted] was ok. CPS documented that during parenting time, [redacted] said "the dad is using drugs, and I worry about him over there."

A parenting time was supposed to occur on August 10, 2022, with [redacted] and [redacted] did not bring [redacted] to the visit. CPS documented [redacted] appeared anxious, concerned, and having a difficult time concentrating. CPS documented [redacted] would often express her concern for [redacted] not attending the visit and was observed calling [redacted] and his friends inquiring about [redacted] CPS spoke with [redacted] on August 11, 2022, via text messages. [redacted] apologized to CPS for not bringing [redacted] to his parenting time with [redacted] advising CPS he overslept due to working all week. CPS informed [redacted] they needed to see [redacted] and he advised he could meet after work that day around 3pm. When CPS inquired about where [redacted] was while he worked, [redacted] informed CPS a babysitter in Tuscola County watched [redacted] but refused to provide the name or address of the babysitter. CPS documented [redacted] did not understand why CPS was making a big deal about it, stating [redacted] has been harassing him about it and he was not the "one on trial." CPS documented [redacted] then ignored CPS' call and text messages asking for him to arrange a Facetime, Zoom, Teams, or face to face with [redacted] It is further documented [redacted] informed CPS a second time that he was not the one on trial, he was in the process of moving and doing what he needed to care for his son.

On August 12, 2022, CPS texted [redacted] requesting his new address and inquiring whether [redacted] would be at the parenting time visit scheduled for that day. [redacted] did not respond until later in the afternoon, stating he needed to change visit days due to his work schedule. He advised CPS [redacted] was with a relative and when CPS requested the information on who [redacted] was with and where, [redacted] did not respond. The CPS supervisor documented leaving a voice message for [redacted]

[redacted] responded to the voice message via text, stating he was not the one with an open case, there was no jurisdiction over him, he has done everything asked of him, has received no help from CPS, and he did not have to continue to cooperate. CPS continued to attempt to see [redacted] and reach [redacted] at his last known addresses and relative homes. No successful contact was made. The supervisor responded to [redacted] text advising that CPS had jurisdiction over [redacted] and a judge ordered parenting time. The supervisor agreed he has done everything CPS asked of him and if he needed help with something, to ask so they can help. She confirmed switching parenting time days, but informed [redacted] [redacted] still needed to be seen.

Additional requests were made on the same day, August 12, 2022, from CPS on call to continue attempted home visits to see [redacted] and [redacted] that evening and over the weekend. CPS coordinated with law enforcement on some of these visits and was informed [redacted] had a felony warrant out for his arrest for methamphetamine. Multiple attempts were made without success.

On August 15, 2022, CPS sent [redacted] a text message advising [redacted] needed to be seen by noon and if he failed to show or respond, a petition would be filed with the court for removal of [redacted] from his care. No response was received. An emergency petition was filed by MDHHS on August 15, 2022, with no response from the court documented. [redacted] expressed concern [redacted] would not provide her with proof that her son was ok, and she was concerned he had not been seen. CPS followed up with the APA on August 16, 2022, and were informed that the referee did not see the petition as an emergency, because there was no allegation that [redacted] was at imminent risk. CPS documented parenting time visits were missed and their unsuccessful attempts to see [redacted] for the two-week time period before the petition was filed. CPS was notified a hearing will be scheduled for a later date as a regular preliminary hearing. CPS continued to make efforts to locate [redacted] and [redacted] including home visits, phone calls, text messages, and calls with [redacted] friends to determine if any information on his whereabouts could be provided.

On August 16, 2022, CPS requested assistance from on-call workers to continue efforts into the evening to locate [redacted] and [redacted] Additionally, on August 17, 2022, a courtesy request for Saginaw County was made requesting an attempted home visit with one of [redacted] relatives. No attempts made were successful.

On August 23, 2022, a dispositional review hearing was held in front of Judge [redacted] in Genesee County concerning the petition filed removing the children from [redacted] At this hearing, [redacted] pled to the petition and the court took jurisdiction over the children. The CPS case manager requested Judge [redacted] hear the petition concerning [redacted] and remove [redacted] from [redacted] care. Judge [redacted] advised a preliminary hearing should be scheduled in front of a referee to hear that petition.

Case Number: 2022-0821

[redacted]

Review of MDHHS actions following placement in [redacted] home continued

On August 24, 2022, CPS attempted to see [redacted] and [redacted] at the home of [redacted] a friend of [redacted] What appeared to be [redacted] truck was in the driveway, however, no one answered the door. CPS went back to the home later that afternoon with the Michigan State Police (MSP) and [redacted] answered the door. [redacted] advised CPS and MSP that she had not seen [redacted] in about a week or so and that [redacted] told her he gave [redacted] back to CPS three weeks ago. She allowed CPS and MSP to search her home; [redacted] and [redacted] were not located, and the truck observed earlier in the day was noted to be gone.

On August 26, 2022, CPS received notification a preliminary hearing for the petition requesting removal of [redacted] from [redacted] was set for September 6, 2022. Unfortunately, the same day, August 26, 2022, CPS learned a child's body was found in a ditch near the area CPS had been searching for [redacted] since August 12, 2022. The body was later confirmed to be the body of one year old, [redacted]

Review of CPS' Investigation of [redacted] Death (MiSACWIS ID 134663118):

On August 26, 2022, a new complaint was received by MDHHS Centralized Intake concerning the death of [redacted] The complaint expressed concern for [redacted] having a history of methamphetamine use, CPS having an active CPS case and recently filing another petition against [redacted] On this date (August 26, 2022), the body of [redacted] was found in a ditch, badly decomposed. [redacted] had been missing for approximately two weeks; the last time CPS saw him was on August 5, 2022. The complaint advised law enforcement located [redacted] and he advised "… [redacted] hit his head on a large rock in their yard, he did not know what to do, and he dumped [redacted] body in the ditch." This complaint was assigned for investigation to Genesee County CPS.

CPS began their investigation by documenting all of the efforts to locate [redacted] and [redacted] over the two weeks prior to [redacted] body being located. The detective from the Genesee County Sheriff's Department advised CPS [redacted] said he was at [redacted] home playing outside with [redacted] teaching [redacted] how to run, when [redacted] tripped over his feet or a rock and fell. [redacted] said [redacted] hit his head on a large landscaping rock in the yard. [redacted] did not tell anyone what happened and put [redacted] into the car. [redacted] informed the detective [redacted] was ok at first but later went in and out of consciousness, he drove around with [redacted] in this state for two days, administered CPR, but [redacted] passed away on the second day. The detective told CPS [redacted] stated he freaked out knowing he was going to spend the rest of his life in jail and dumped his son's deceased body into the ditch. The detective advised CPS [redacted] kept telling others that CPS removed his son two Tuesdays ago and he continued to repeat this, which in the detective's experience, was significant.

CPS met with [redacted] at the Genesee County Jail. He refused to speak to CPS about [redacted] or the circumstances of his death. [redacted] admitted to using methamphetamine daily for the past two years and was unsure of the number of times he used per day. He was informed a mandatory petition would be filed concerning his son, [redacted] On August 30, 2022, [redacted] was arraigned and notified he was being charged with first degree child abuse, felony murder, concealing a death, and domestic assault.

On September 1, 2022, CPS participated in a critical incident debrief with law enforcement, ATF, forensic scene investigators and anthropology. The home where [redacted] said the fall/injury to [redacted] occurred was searched and no large rock existed as [redacted] described.

On October 22, 2022, the medical examiner's office notified CPS the DNA results confirmed the child's body to be [redacted] The autopsy revealed [redacted] was positive for THC and methamphetamine.

During this investigation, CPS filed a mandatory petition requesting [redacted] parental rights to [redacted] be terminated. A trial occurred on November 30, 2022, where [redacted] pled no contest to the petition in its entirety. [redacted] rights were terminated to [redacted] and [redacted] was released to his mother.

The investigation was concluded by CPS as a Category I with a preponderance of evidence supporting medical neglect, improper supervision, and physical abuse of [redacted] by [redacted] was also substantiated for medical neglect and threatened harm of [redacted] The investigation was approved and closed by the supervisor on January 5, 2023.

During the OCA's investigation, the autopsy report was reviewed. [redacted] cause of death was determined to be blunt-force head injuries, and Methamphetamine and Cannabis Intoxication Complicated by Medical Neglect. His manner of death was ruled a homicide. The autopsy concluded his approximate date of death was on or around August 7, 2022.

Case Number: 2022-0821

[redacted]

Review of CPS' Investigation of [redacted] Death (MiSACWIS ID 134663118) Continued:

On February 7, 2024, [redacted] was found guilty by jury verdict of homicide-felony murder, 1st degree child abuse, concealing the death of an individual, and domestic violence-aggravated. [redacted] was sentenced to life in prison on March 18, 2024.

Factual Findings

Introduction:

The child advocate shall prepare a report of the factual findings of an investigation and make recommendations to the department or the child placing agency if the child advocate 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 Child Advocate believes their findings should be further considered by the department, and additional actions by MDHHS and other child welfare partners are necessary.

Findings

1. The child advocate finds MDHHS appropriately included [redacted] as a respondent on their initial removal petition in July 2022. The child advocate finds this petition did not include pertinent information including:

    a. Allegations regarding [redacted] absence of a relationship and involvement in [redacted] life, nor the fact that he had never provided for [redacted]
        i. Based on statements made by [redacted] during prior CPS investigations, [redacted] was not involved in [redacted] life.
        ii. Per information gathered from the Friend of the Court by MDHHS, [redacted] had never paid his court ordered child support.
    b. The child advocate finds MDHHS reviewed [redacted] criminal history but missed a warrant for his arrest at the time the petition was filed in July 2022. The warrant was for felony dangerous drugs (methamphetamine) and would have added additional concern to the petition presented to the court.

2. The child advocate finds the testimony provided to support the July 2022 petition and allegations regarding [redacted] CPS history was not adequately presented to the court.

    a. There was no testimony provided regarding the serious injuries [redacted] caused to an infant in 2014.
    b. There was no testimony provided regarding the severe physical neglect [redacted] caused to a child in 2020.
    c. There was minimal testimony provided regarding the seriousness of [redacted] domestic violence history and methamphetamine use.
    d. No services to rectify the concerns had been provided to [redacted] by MDHHS.

3. The child advocate finds MDHHS staff have limited training with court testimony.

4. The child advocate finds the assigned assistant prosecuting attorney provided no guidance or assistance to the MDHHS case manager during testimony.

5. The child advocate finds following testimony, the court removed [redacted] as a respondent from the petition.

6. The child advocate finds there is an opportunity for improvement in training provided to case managers regarding petition writing and court testimony.

    a. Various webinars are available and offered yearly to case managers, however, these webinars do not provide hands on experience to adequately prepare a case manager for testimony.
    b. Webinars do not provide case managers with the opportunity to practice testifying in a court room setting.
    c. A mock trial is completed at the MDHHS Child Welfare Training Institute; however, this only allows for a handful of case managers to practice, and according to interviews performed by the OCA, does not provide adequate preparation for a court room setting.

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[redacted]

Findings

7. The child advocate finds that [redacted] was a non-custodial parent in July of 2022.

8. The child advocate finds Protective Services Manual (PSM)715-3, Problem Court and Administrative Hearing Orders, lacks guidance for MDHHS staff on what to do when a court removes a non-custodial parent as a respondent.

    a. In situations such as this case, an amended petition requesting in-home jurisdiction could have been filed with the court to ensure services were provided to [redacted]
    b. Given the seriousness of [redacted] CPS history, and [redacted] never having care and custody of [redacted] court ordered participation in services would have provided additional support for [redacted] and [redacted]

Recommendations

1. The child advocate recommends Children's Services Agency (CSA) amend PSM 715-3 Problem Court and Administrative Hearing Orders to include notification to the Children's Services Legal Division (CSLD) when a court or referee removes a respondent from a petition and the department disagrees with the decision.

2. The OCA recommends that the Michigan Legislature Codify the requirement for a Child Welfare Training Academy (CWTA) and simulation labs that incorporate experiential learning on courtroom testimony.

3. The OCA recommends that the Michigan Legislature adequately fund the purchase, equipping, staffing, and maintenance of MDHHS regional simulation labs for child welfare training.

4. The child advocate recommends MDHHS institute simulation training on courtroom testimony that would allow all new case managers to be trained and existing case managers to have ongoing training on providing courtroom testimony.

    a. The child advocate recommends MDHHS require all case managers complete the training as part of their initial child welfare training and then repeat it on a routine basis as determined by MDHHS
    b. The child advocate recommends this training be conducted jointly with the local prosecuting attorney's office, the Attorney General's office and/or with the department's retained counsel in each county to ensure the most relevant and effective training is provided in the jurisdiction where testimony is provided
    c. The child advocate recommends this training be conducted in a simulation environment involving hands-on mock trials for all participants
    d. The child advocate recommends petition writing be integrated into this training.

5. The child advocate recommends supervision, or mentors attend court hearings with inexperienced staff.

Conclusion

Under authority pursuant to The Child Advocate's Act, MCL 722.903, the OCA respectfully submits this report of findings and recommendations.

The matters addressed in this report must be further considered by MDHHS and the Michigan Legislature. 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 OCA by MDHHS.

Ryan Speidel, Michigan's Child Advocate
Office of the Child Advocate
111 S. Capitol Avenue
Lansing, Michigan 48933