Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2022-0102 + 2023-0002

[redacted] Jr.

Date of Birth: January 29, 2021
Date of Death: February 5, 2022

[redacted]

Date of Birth: November 1, 2021
Date of Death: December 29, 2022

Investigation Start: October 25 & January 23, 2023

Recommendation Issued: April 17, 2025

Case Background

[redacted] Jr. and [redacted] were both one-year-olds when they died on February 5, 2022, and December 29, 2022, respectively. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatalities. On January 23, 2023, the OCA opened an investigation into the administrative actions of MDHHS regarding [redacted] death. On October 25, 2023, the OCA opened an investigation into the administrative actions of MDHHS regarding [redacted] Jr.'s death. [redacted] Jr. and [redacted] cases shared a similar fact pattern. During both children's foster care cases, no unannounced home visits were completed where the children were residing and there were incomplete assessments of each family's living situations. Additionally, both children died while under the care and supervision of MDHHS. The following report summarizes the information and evidence found during the OCA's investigations.

Case Objective

The objective of this review is to identify areas for improvement in the child welfare system by looking at how CPS investigations and foster care cases involving [redacted] Jr. and [redacted] were handled by MDHHS in Genessee and Lapeer counties, Centralized Intake (CI), PAFC staff, 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 [redacted] Jr. and [redacted] cases; 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	Responses
1. The child advocate finds that both Genesee and Lapeer County foster care staff only completed scheduled visits to the homes were [redacted] Jr. and [redacted] were placed while they were in foster care.	**MDHHS Response to Finding 1:** MDHHS agrees.
2. The child advocate finds that MDHHS policy doesn't require foster care staff to conduct certain activities that would help ensure the safety of foster children. These activities include unannounced home visits; private interviews with all children residing in or frequently visiting a home where a foster child resides; viewing the entirety of the home when conducting visits; drug screening caregivers or other adults in the home when there is a reasonable cause to suspect substance abuse; and interviewing medical or mental health providers when a condition is reported that could affect a caregiver's ability to care for a child.	**MDHHS Response to Finding 2:** MDHHS agrees in part. This consideration must be balanced with foster family rights, recruitment/retention of foster homes, and consideration that some families may have larger number of children that are older and engaged in extracurricular activities, making connection more incorporation into policy. MDHHS does agree that quarterly unannounced home visits to a home where a foster child resides should be required and policy will be amended to reflect this change. MDHHS also agrees that viewing the entirety of the home where a foster child resides when conducting each required home visit should be required and policy to be amended to reflect this change. MDHHS does not have the authority to require drug screens as part of the placement assessment or ongoing placement outside of a Children's Protective Services investigation. Staff are not prohibited from requesting a release and speaking to a health professional or asking for medical documentation if there is a medical or mental health concern that warrants that level of follow-up. Staff are also not prohibited from requesting a release to speak with a health professional when there is a health concern. This allows the case manager to follow up appropriately and, if needed, safety

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[redacted] [redacted] Jr. & [redacted] [redacted]

Response received from MDHHS: November 13, 2025

Findings

Responses

MDHHS Response to Finding 2 (Continued):
plan, or assess the viability of the placement. The current process and requirements are consistent with federal guidance and recommendations for relative caregivers and provide the necessary flexibility to address concerns on a case-by-case basis. Unlicensed relative foster homes do not fall under licensing rules or requirements, so there is no mechanism to enforce this as a policy requirement. There is no immediate correlation between the relative caregiver's hospitalization and their ability to provide safe care. Relative placements should also be afforded the presumption of competence to care unless the specialist finds evidence to indicate otherwise.

3. The child advocate finds additional efforts are needed to ensure the safety and well-being of children placed in foster care.

MDHHS Response to Finding 3:
MDHHS agrees. There is value in continually reviewing policies and procedures to support safe placements and outcomes for our children in care.

Recommendations

Responses

1. The child advocate recommends MDHHS provide an explanation for why FOM 722-06H was changed on July 1, 2019, to say unannounced home visits to foster children's placements is at the discretion of the case manager or supervisor.

MDHHS Response to Recommendation 1:
MDHHS agrees. This change was made based on feedback from foster care staff. Michigan is a vast and diverse state, and it was challenging for case managers to drive extended distances to foster homes to find the family was not home. This combined with the consideration that many foster families often have other children and obligations, making it difficult for them to be available for unannounced visits.

2. The child advocate recommends MDHHS enhance foster care policy to require foster care staff to complete additional activities that would help ensure the safety of foster children. These activities should include the following:

a. Amend FOM 722-06H to require a minimum of quarterly unannounced home visits to a home where a foster child resides
b. Amend FOM 722-06H to require monthly private face-to-face interviews with all verbal children residing in, or frequently visiting, a home where a foster child resides
c. Amend FOM 722-06H to require viewing the entirety of the home where a foster child resides when conducting each required home visit
d. Amend FOM 722-03B (section: obtaining required information) to require drug screening any caregiver or other adult in a home where a foster child will reside, when there is a substantiated CPS history involving substance abuse by the adult or if there is a reasonable cause to suspect current substance abuse
e. Amend FOM 722-06H (section: contact with child's caregivers) to require drug screening any caregiver or other adult in a home where a foster child resides, when there is a reasonable cause to suspect substance abuse

MDHHS Response to Recommendation 2:
MDHHS overall agrees in part.

- Amend FOM 722-06H to require a minimum of quarterly unannounced home visits to a home where a foster child resides.
  - o MDHHS agrees.
- Amend FOM 722-06H to require monthly private face-to-face interviews with all verbal children residing in, or frequently visiting, a home where a foster child resides.
  - o MDHHS agrees in part. This consideration must be balanced with foster family rights, recruitment/retention of foster homes, and consideration that some families may have larger number of children that are older and engaged in extracurricular activities making connection more challenging. MDHHS agrees to evaluate this further and consider for incorporation into policy.
- Amend FOM 722-06H to require viewing the entirety of the home where a foster child resides when conducting each required home visit.
  - o MDHHS agrees.

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[redacted] [redacted] Jr. & [redacted] [redacted]

Response received from MDHHS: November 13, 2025

Recommendations

2. (continued)
   f. Amend FOM 722-03B (section: obtaining required information) to require interviewing medical and mental health providers when a caregiver reports a condition that could affect their ability to care for a foster child(ren)
   g. Amend FOM 722-03 (section: unusual incident reporting) to require foster parents to notify the child placing agency when a foster parent has been hospitalized. This should also include a requirement for MDHHS staff to interview the medical and mental health providers to determine if their condition affects their ability to care for a foster child(ren)

Responses

MDHHS Response to Recommendation 2 (continued):

- Amend FOM 722-03B (section: obtaining required information) to require drug screening any caregiver or other adult in a home where a foster child will reside, when there is a substantiated CPS history involving substance abuse by the adult or if there is a reasonable cause to suspect current substance abuse.
  - MDHHS disagrees. MDHHS does not have the statutory authority to require drug screens as part of the placement assessment or ongoing placement outside of a Children's Protective Services investigation.
- Amend FOM 722-03B (section: obtaining required information) to require interviewing medical and mental health providers when a caregiver reports a condition that could affect their ability to care for a foster child(ren).
  - MDHHS disagrees. Staff are not prohibited from requesting a release and speaking to a health professional or asking for medical documentation if there is a medical or mental health concern that warrants that level of follow-up.
  - The current process and requirements are consistent with federal guidance and recommendations for relative caregivers and provide the necessary flexibility to address concerns on a case-by-case basis.
- Amend FOM 722-03 (section: unusual incident reporting) to require foster parents to notify the child placing agency when a foster parent has been hospitalized. This should also include a requirement for MDHHS staff to interview the medical and mental health providers to determine if their condition affects their ability to care for a foster child(ren).
  - MDHHS disagrees. Unlicensed relative foster homes do not fall under licensing rules or requirements, so there is no mechanism to enforce this as a policy requirement. Furthermore, there is no immediate correlation between the relative caregiver's hospitalization and their ability to provide safe care. Relatives should be afforded the presumption of competence to care unless the specialist finds evidence to indicate otherwise.
  - Staff are also not prohibited from requesting a release to speak with a health professional when there is a health concern. This allows the specialist to follow up appropriately and, if needed, safety plan, or assess the viability of the placement.

Office of the Child Advocate

[redacted] Jr.

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Date of Death: February 5, 2022

[redacted]

Date of Birth: November 1, 2021
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Introduction

The objective of this review is to identify areas for improvement in the child welfare system by looking at how CPS investigations and foster care cases involving [redacted] Jr. and [redacted] were handled by MDHHS in Genessee and Lapeer counties, Centralized Intake (CI), PAFC staff, 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 [redacted] Jr. and [redacted] cases; 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.

[redacted] Jr. and [redacted] were both one-year-olds when they died on February 5, 2022, and December 29, 2022, respectively. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatalities. On January 23, 2023, the OCA opened an investigation into the administrative actions of MDHHS regarding [redacted] death. On October 25, 2023, the OCA opened an investigation into the administrative actions of MDHHS regarding [redacted] Jr.'s death. [redacted] Jr. and [redacted] cases shared a similar fact pattern. During both children's foster care cases, no unannounced home visits were completed where the children were residing and there were incomplete assessments of each family's living situations. Additionally, both children died while under the care and supervision of MDHHS. The following report summarizes the information and evidence found during the OCA's investigations.

Family History and Background regarding [redacted] Jr :

According to CPS records, [redacted] is [redacted] Jr.'s mother. CPS records also state [redacted] is the mother of [redacted] Jr.'s twin sibling, [redacted] (4 at time of investigation), [redacted] (17 at time of investigation) and [redacted] (18 at time of investigation). [redacted] Sr. is [redacted] Jr. and [redacted] father. CPS records show [redacted] had a CPS history involving neglect of [redacted] and [redacted] due to substance abuse and domestic violence issues. In 2018, CPS records indicate CPS staff, [redacted] and [redacted] father, [redacted] arranged for [redacted] and [redacted] to live with their maternal grandmother, [redacted] under a power of attorney (POA). Foster care records show that foster children, [redacted] (13) and [redacted] (18), were also living with [redacted] in 2018. Foster care records state [redacted] adopted [redacted] and [redacted] in 2020.

CPS records show that on February 1, 2021, Hurley Hospital personnel reported to CI staff that [redacted] Jr. and [redacted] were born at the hospital on January 29, 2021. CPS records state morphine was being administered to both children by hospital personnel to treat withdrawal symptoms from in utero opiate exposure. CPS records indicate [redacted] admitted to hospital personnel that she used heroin and fentanyl during her pregnancy. CPS records also say [redacted] identified the children's father as [redacted] Sr. [redacted] Sr. had been banned from visiting [redacted] at the hospital because hospital personnel caught him trying to smuggle drugs into the hospital for [redacted] CPS records show CI staff assigned this complaint to Genessee County CPS staff for investigation on February 1, 2021.

According to CPS records, Genessee County CPS staff's investigation of the February 1, 2021, complaint resulted in CPS staff making a finding against [redacted] for physically abusing [redacted] Jr. and [redacted] CPS records show this finding was based on the children's withdrawal symptoms and because opiates were detected by hospital staff in both children's meconium drugs screens. CPS records indicate CPS staff then filed a removal petition for both children on February 19, 2021, with the Genesee County 7th Circuit Court. CPS records indicate [redacted] Sr. ([redacted] Jr. and [redacted] father) was not included as a respondent on the petition because he had not established legal paternity.

CPS and court records state the court authorized a removal petition on February 19, 2021, and [redacted] Jr. and [redacted] were removed from [redacted] and placed by CPS staff in foster care on February 20, 2021, with their maternal grandmother, [redacted]

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[redacted] Jr. & [redacted]

Review of [redacted] Jr.'s foster care case:

According to the Shiawassee County Sheriff's Office (SCSO) and foster care records obtained and reviewed by the OCA investigator, [redacted] Jr. died on February 5, 2022, while in foster care under the care and supervision of MDHHS. The OCA investigator obtained and reviewed [redacted] Jr.'s autopsy report, and it states his cause of death was acute fentanyl toxicity and his manner of death was indeterminate.

While reviewing foster care records and interviewing child welfare staff, the OCA investigator determined assessments performed by foster care staff, of the children's placement with [redacted] and [redacted] Sr.'s ability to care for the children, were incomplete. What the OCA investigator discovered is discussed in this section.

A MDHHS-5770: Relative Placement Safety Screen was completed on [redacted] on February 22, 2021, and a DHS-3130A: Children's Foster Care Relative Placement Home Study was completed on March 3, 2021. Both the safety assessment and home study outlined concerns for [redacted] following the DHHS policies and safety plans regarding [redacted] was living with [redacted] at the time of the removal. [redacted] told MDHHS staff she would move across the street and live with her grandmother, however during both assessments [redacted] was observed at the home.

SCSO and MDHHS records reviewed state that on February 5, 2022, [redacted] Sr. contacted 911 about finding [redacted] Jr. unresponsive on a couch in the "farmhouse" located on the property where [redacted] Sr. lived. SCSO records also state that when officers and emergency services arrived at [redacted] Sr.'s property, they found [redacted] Sr., [redacted] Jr., and [redacted] in the farmhouse. This farmhouse is next to the home where [redacted] Sr. previously told foster care staff he lived. SCSO and MDHHS records further indicate this farmhouse was where [redacted] Jr. and [redacted] had been living with their parents since they were removed from [redacted] care and placed in foster care with [redacted] on February 20, 2021.

SCSO records reviewed revealed officers searched the farmhouse on February 5, 2022, and found methamphetamine, heroin, five pounds of marijuana, and six unsecured firearms. The records state some of the firearms were loaded. SCSO records also say the firearms and drugs were in areas the children could access.

The OCA investigator learned from reviewing foster care records and interviewing child welfare staff, that on the day [redacted] Jr. died, the children were not supposed to be having unsupervised visits with [redacted] Foster care and court records indicate [redacted] visits with the children were required to be supervised due to [redacted] not being compliant with services. Foster care records further state [redacted] Sr. was not authorized by foster care staff or the court to supervise [redacted] visits.

Foster care records also indicate the children were not supposed to be living with [redacted] Sr. or [redacted] The OCA investigator learned from foster care staff they didn't know [redacted] Sr. and [redacted] were living together or the children were living with them. The OCA developed evidence showing foster care staff believed [redacted] Sr. was living in the home next to the farmhouse, and [redacted] was living separately in a home with friends. Foster care and court records further indicate [redacted] Sr. began court ordered unsupervised visits with the children on January 20, 2022. Foster care records also state [redacted] Sr. was not court ordered, or voluntarily participating, in any services prior to the court ordering he be allowed unsupervised visits. On January 20, 2022, the court granted permission for [redacted] Sr. to have "unrestricted and unlimited" time with the children while in the process of establishing paternity.

Child welfare staff did not provide the court with information about [redacted] Sr. smuggling drugs into the hospital for [redacted] The OCA learned foster care did not view this as important because CPS did not address the issue. Additionally, [redacted] Sr. was not listed on the petition so the court would not have heard this information. The OCA investigator discovered foster care did not know [redacted] Sr. had a criminal history despite foster care policy (FOM 722-06) stating "Law Enforcement Information Network (LEIN) checks must be conducted on all household members when a child will be having parenting time at the parent's home". The OCA investigator completed a criminal history check on [redacted] Sr. and found he had criminal convictions for misdemeanor use of narcotics and possession of marijuana, misdemeanor and felony operating a motor vehicle while impaired, and felony fleeing a police officer. The OCA investigator also discovered that [redacted] Sr. had an active arrest warrant during the open foster care case. This arrest warrant was active while [redacted] Sr. was caring for the children by himself. Foster care was unaware of [redacted] Sr.'s arrest warrant.

The OCA investigator learned by reviewing foster care records and interviewing child welfare staff, during the open foster care case, staff completed eleven scheduled face-to-face home visits with the children at [redacted] residence. Foster care records indicate [redacted] was present at five of the face-to-face home visits, and [redacted] Sr. was present at three home visits. Absent from foster care records are interviews with the four other teenage children residing in [redacted] home. It was confirmed through OCA interviews that foster care staff did not interview these children because it is not required by foster care policy.

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[redacted] Jr. & [redacted]

Review of [redacted] Jr.'s foster care case (continued):

The OCA investigator learned through interviews no unannounced home visits were completed at [redacted] residence during the open foster care case because it is not required by policy. MDHHS staff interviewed informed the OCA investigator they don't believe there is enough time to complete unannounced visits due to caseload sizes and other extenuating circumstances. Extenuating circumstances include, but are not limited to, the distance between their work location and homes needing unannounced visits.

According to interviews the OCA investigator completed, and the foster care records reviewed, foster care staff didn't visit either parent's residence during the open foster care case until January 21, 2022. That visit was at [redacted] Sr.'s home and was to determine if it was appropriate for placement of the children. According to interviews conducted with child welfare staff, the home that was looked at on January 21st was the main residence on the property, and it was appropriate. Child welfare staff said they observed the farmhouse, but [redacted] Sr. told them he was renting it to someone so foster care had no reason to see the inside of the farmhouse.

The OCA investigator learned between September and November 2021, maternal aunt, [redacted] informed foster care staff [redacted] had been in and out of the hospital. During this time foster care staff were informed that [redacted] was caring for [redacted] Jr. and [redacted]

The OCA learned that no foster care staff contacted [redacted] medical providers to inquire about [redacted] hospitalizations and to determine if her conditions affected her ability to care for [redacted] Jr. and [redacted] Foster care staff attempted to get [redacted] signature on a release of information form however [redacted] refused to sign.

Review of CPS Maltreatment in Care (MIC) investigation of [redacted] Jr.'s death:

MDHHS records state foster care and CI staff were notified of the situation surrounding [redacted] Jr.'s death on February 5, 2022, and a CPS MIC investigation was opened and assigned.

In addition to discovering further facts about the circumstances that led to [redacted] Jr.'s death, the OCA investigator also determined that foster care staff could have more thoroughly assessed [redacted] Sr., [redacted] and their living situations prior to [redacted] Jr.'s death. The facts and the outcome of the CPS MIC investigation are discussed in this section.

CPS records show [redacted] Sr. and [redacted] admitted to CPS staff that [redacted] Jr. and [redacted] had been living with them unsupervised in [redacted] Sr.'s farmhouse since the foster care case was opened in February 2021.

CPS records indicate [redacted] was drug screened by CPS staff on February 5, 2022, and she tested positive for methamphetamine and fentanyl. CPS records also state CPS staff offered [redacted] Sr. a drug screen the same day, but he refused to complete it.

CPS records state [redacted] Sr. and [redacted] admitted to CPS staff that prior to [redacted] Jr.'s death, when foster care staff completed announced visits to [redacted] home, they would bring the children from the farmhouse to [redacted] Records also show [redacted] Sr. and [redacted] admitted they had been using methamphetamine, heroin, and fentanyl throughout the open foster care case and consistently for three days leading up to [redacted] Jr.'s death.

CPS and SCSO records indicate [redacted] also admitted to officers and CPS staff that she was using methadone, heroin, oxycodone, and fentanyl, throughout the open foster care case. The records state [redacted] further admitted the two times she was hospitalized in September and November 2021, were not due to illnesses and back issues, but from overdoses caused by using these substances. The records further show that [redacted] said if foster care staff completed unannounced home visits, they would have likely discovered the children were not living with her and she was using these substances.

MDHHS records indicate that due to [redacted] admissions another CPS MIC investigation was opened on February 14, 2022, regarding the other children residing in [redacted] home. CPS records indicate [redacted] was substantiated during that investigation for neglecting the other children due to her substance abuse, and because she allowed [redacted] Jr. and [redacted] to live with their parents unsupervised. MDHHS staff arranged for [redacted] to be placed in a licensed foster home, and [redacted] and [redacted] to live with their father, [redacted] [redacted] CPS records show CPS staff allowed [redacted] adoptive children, [redacted] and [redacted] to continue to reside with [redacted]

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[redacted] Jr. & [redacted]

Review of CPS MIC investigation of [redacted] Jr.'s death (continued):

David Bannister Sr. pled guilty to felony firearm and felony homicide–manslaughter-involuntary on March 18, 2024, in relation to [redacted] Jr's death. He was sentenced to prison. His earliest release date is October 20, 2042, and maximum release date is February 20, 2076.

Jennifer Kincaid was found guilty of felony possession of methamphetamine and felony homicide- manslaughter-involuntary on April 5, 2024, in relation to [redacted] Jr's death. She was sentenced to prison. Her earliest release date is April 17, 2035, and maximum is October 17, 2052.

[redacted]

[redacted] was 14 months old when he died on December 29, 2022. Below is a summary of the OCA's investigation of MDHHS's management of [redacted] cases before his death.

Family History and Background regarding [redacted]

According to CPS records, [redacted] is [redacted] mother. [redacted] is [redacted] legal father, as he was married to [redacted] when [redacted] was born. [redacted] was identified by [redacted] as [redacted] biological father. [redacted] did not establish legal paternity prior to [redacted] death.

MDHHS records indicate [redacted] was removed from [redacted] ([redacted] mother) on November 9, 2021, due to her parental rights previously being terminated to her two other children. MDHHS records state [redacted] rights were terminated to those children because she physically neglected and improperly supervised them. She also failed to rectify the situation that led to those children's removal.

MDHHS records state when [redacted] was initially removed from [redacted] he was placed in a licensed foster home. MDHHS records further state [redacted] was moved by foster care staff to his maternal aunt, [redacted] home on January 20, 2022. Foster care records state [redacted] daughter, [redacted] (11), lived with [redacted] when [redacted] was placed with her.

OCA staff discovered seven years before placing [redacted] into [redacted] home, [redacted] had one prior substantiated CPS complaint made against her. This complaint and investigation occurred in September 2015, and it was regarding [redacted] daughter, [redacted] That complaint involved circumstances relevant to [redacted] death. That complaint said [redacted] was shooting up an unknown drug and smoking crack-cocaine while [redacted] was present. The complaint also stated [redacted] was leaving the syringes she was using out and accessible to [redacted]

Based on CPS staff's investigation, CPS found a preponderance of evidence for child neglect. [redacted] improperly supervised [redacted] and placed her in a situation of threatened harm. CPS records say the preponderance of evidence was found because [redacted] tested positive for marijuana and cocaine during the investigation. CPS records state CPS staff created a safety plan with [redacted] The safety plan said [redacted] agreed not to use substances when [redacted] was present, or to have a sober caregiver watch [redacted] when [redacted] used. CPS records indicate CPS staff then closed their investigation on October 20, 2015.

Review of [redacted] foster care case:

According to the Flint Township Police Department (FTPD) and foster care records obtained and reviewed by the OCA investigator, [redacted] died on December 29, 2022, while in foster care under the care and supervision of MDHHS. The OCA investigator obtained and reviewed [redacted] autopsy report, and it states his cause of death was due to complications of methamphetamine toxicity and hyponatremia, and his manner of death was a homicide.

In addition to discovering the facts that led to [redacted] death, the OCA investigator determined that MDHHS staff's initial and ongoing assessment of [redacted] placement and safety with [redacted] were incomplete. What the OCA investigator discovered is discussed in this section.

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[redacted] Jr. & [redacted]

Review of [redacted] foster care case (continued):

Foster care records show that prior to [redacted] placement with [redacted] Lapeer County MDHHS licensing staff completed the MDHHS Relative Placement Home Study (3130-A) for [redacted] on January 19, 2022. The OCA investigator obtained and reviewed the 3130-A, and it states child welfare staff addressed the September 22, 2015, CPS investigation with [redacted] The 3130-A states [redacted] admitted to using substances when the September 22, 2015, CPS investigation occurred. The 3130-A also states [redacted] told the child welfare specialist she stopped using all other substances but currently uses marijuana. The child welfare staff did not have concerns about [redacted] substance use. At the time the 3130-A was completed no safety plan surrounding marijuana use and parenting was established.

The 3130-A additionally states [redacted] told child welfare staff she used those substances in 2015 due to peer pressure by a boyfriend. The report says [redacted] told child welfare staff she ended her relationship with that boyfriend in 2015. The 3130-A further states [redacted] told staff she went to therapy to develop healthier coping skills after the September 22, 2015, CPS investigation concluded.

The 3130-A also states [redacted] told child welfare staff she was currently taking Prozac and Klonopin for anxiety, but these things didn't interfere with her ability to parent. The 3130-A doesn't state whether child welfare staff contacted [redacted] prescribing doctor to verify if what [redacted] said was accurate. There was recognition from child welfare staff that making collateral contacts about [redacted] medication would have been a better way to assess this situation. The 3130-A states recommended [redacted] be placed with [redacted]

Foster care records show [redacted] was placed in [redacted] home by foster care staff on January 30, 2022. These records also show that from January 30, 2022, to May 10, 2022, foster care staff completed four scheduled home visits at [redacted] residence. Records reviewed show [redacted] and [redacted] were both present at each visit. OCA interviews indicated foster care staff did not view [redacted] entire home.

During interviews conducted by the OCA investigator, it was learned foster care staff spoke to [redacted] during each home visit however these discussions were not documented in MiSACWIS. The OCA was informed that the conversations with [redacted] were not documented because it is not a policy requirement to interview other children who reside in the home that are not children in care.

The child welfare staff interviewed expressed their belief that policy regarding home visits should require staff to privately interview all children residing in the foster home.

On May 10, 2022, foster care records state [redacted] and [redacted] moved to a new home. The records indicate [redacted] told the foster care staff it was only her, [redacted] and [redacted] living in the new home. Records show [redacted] told foster care staff her mother was watching [redacted] and [redacted] when she worked. Foster care records also show staff completed nine announced visits to [redacted] home to see [redacted] between May 10, 2022, and December 19, 2022.

Foster care records show that [redacted] mother's parental rights were terminated on June 29, 2022. Records state when this happened, Adoption and Foster Care Specialists, Inc., began the adoption process with [redacted] Beginning in August 2022, these records state adoption staff began expressing concerns to foster care staff that they were having a difficult time contacting [redacted] The records indicate adoption staff expressed these concerns to foster care staff again in October and November 2022. The records show foster care staff spoke with [redacted] about this each time, and [redacted] said her lack of contact was due to being busy with work.

According to MDHHS records foster care staff completed their last announced home visit to [redacted] home on December 1, 2022. On December 19, 2022, MDHHS records show CI staff received a complaint that [redacted] found [redacted] unresponsive and pale at her home. These records also stated [redacted] boyfriend, [redacted] was present at the home when this happened. On December 19, 2022, [redacted] left [redacted] with [redacted] when she went to work. When [redacted] returned home from work on December 19, 2022, she found [redacted] unresponsive with [redacted] called 911, and took [redacted] to Hurley Hospital.

MDHHS records further state [redacted] had multiple bite marks on his left hand and several bruises on his head, arms, legs, buttocks, and lower back. The records also indicate [redacted] had burn marks on his left hand, and "a lot of water coming out of his stomach and mouth." Doctors suspected he drowned while in [redacted] care. CI staff assigned this complaint to CPS MIC for investigation on December 19, 2022.

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[redacted] [redacted] Jr. & [redacted] [redacted]

Review of CPS MIC's investigation of [redacted] [redacted] death:

In addition to discovering further facts about the circumstances surrounding [redacted] death, the OCA investigator found evidence to show [redacted] home was a safety concern. These things were not previously known to foster care staff. The facts discovered by the OCA investigator and the outcome of the CPS MIC investigation of [redacted] death are discussed in this section.

CPS records state [redacted] was drug tested at Hurley Hospital on December 19, 2022, and the results were positive for methamphetamine. Records also state due to his methamphetamine exposure and injuries; hospital staff admitted him for treatment.

CPS records state on December 19, 2022, [redacted] admitted to CPS staff she went to work earlier that day and left [redacted] alone with [redacted] [redacted] admitted to CPS staff she used methamphetamine during the week of December 12, 2022. On December 19, 2022, CPS staff asked [redacted] to complete a drug screen, she refused.

CPS records show that on December 19, 2022, CPS staff discovered [redacted] had an active CPS investigation in Lapeer County regarding a complaint made to centralized intake on December 5, 2022. That complaint stated [redacted] struck his seven-year-old son in the face with a closed fist, causing a split lip and bruising. CPS records say this incident occurred while at [redacted] home. CPS records further show neither the complaint nor the CPS investigation mention that [redacted] was a relative caregiver for a foster child. CPS records reviewed, and interviews conducted by the OCA investigator with CPS staff, also show the CPS staff assigned to the December 5, 2022, investigation had not made successful contact with [redacted] prior to [redacted] death. CPS staff did not know [redacted] had placement of a foster child.

The CPS records reviewed indicate CPS staff were informed by FTPD officers that a search of [redacted] residence was performed and FTPD found methamphetamine, marijuana, and a drug scale in [redacted] home. Officers also told CPS staff they completed a search of [redacted] and [redacted] phones and found that during the week of [redacted] death there were text messages between them about quitting methamphetamine use. CPS records further show officers told CPS staff [redacted] had four children of his own, who were all present at [redacted] home when [redacted] was found unresponsive.

CPS records state on December 21, 2022, FTPD officers contacted CPS staff and told them medical personnel at Hurley Hospital didn't believe the bites on [redacted] hand were self-inflicted. Officers also said hospital personnel told them there was a bruise on the same wrist as [redacted] bites indicating someone was holding his hand while they bit him.

CPS records also state medical personnel told officers the bites and burns on [redacted] were old and caused before December 19, 2022. FTPD officers told CPS staff [redacted] Googled "meth exposure" on his phone on December 15, 16, and 17, 2022. The records go on to say officers told CPS staff that doctors believe [redacted] was probably exposed to methamphetamine on December 15, 2022. Officers told CPS staff that medical personnel believed [redacted] and [redacted] were trying to flush [redacted] body out with water all weekend. Medical personnel came to this conclusion because [redacted] sodium levels were extremely low.

On December 21, 2022, officers told CPS staff when they interviewed [redacted] he admitted he bit [redacted] and shoved methamphetamine down his throat to try to wake him up because he was "sleeping too much." CPS records indicate [redacted] completed a drug screen for CPS staff on December 21, 2022, and the results were positive for methamphetamine.

On December 21, 2022, CPS staff filed a removal and termination petition against [redacted] with the 7th Circuit Court in Genessee County. On December 22, 2022, Lapeer County CPS staff filed a termination petition against [redacted] with the 40th Circuit Court in Lapeer County. CPS records show [redacted] was placed in foster care with her maternal grandparents and [redacted] children were to remain with their mothers.

On December 22, 2022, [redacted] and [redacted] were criminally charged with 1st degree child abuse, assault with intent to murder, torture, and delivery of methamphetamine to a minor.

[redacted] died at Hurley Hospital on December 29, 2022.

On June 5, 2023, [redacted] [redacted] was bound over to Genesee County Circuit on charges of felony homicide, 1st degree child abuse, felony torture, and felony-controlled substance delivery of methamphetamine to a minor.

Case Number: 2022-0102 + 2023-0002

[redacted] [redacted] Jr. & [redacted] [redacted]

Review of CPS MIC's investigation of [redacted] [redacted] death (continued):

CPS records note on January 9, 2022, CPS staff received the FTPD report regarding [redacted] death. CPS staff entered into their records that FTPD officers completed additional searches of [redacted] and [redacted] phones. When officers did this, they found [redacted] and [redacted] Facebook accounts contained messages between them about [redacted] injuries, how [redacted] didn't look ok, that [redacted] was not authorized by foster care staff to watch [redacted] and their methamphetamine use.

According to CPS records, CPS staff determined [redacted] and [redacted] had been seeing one another since May 2022, but [redacted] didn't tell foster care staff about [redacted] CPS records also state [redacted] had been watching [redacted] since they met, frequently visited [redacted] home and sometimes spent the night. Additionally, the records state [redacted] family and friends knew he had a history of methamphetamine use.

On March 28, 2022, CPS records state CPS staff learned from FTPD officers the medical examiner ruled [redacted] cause of death to be methamphetamine toxicity, and his manner of death was homicide.

The CPS investigation into [redacted] death was concluded on May 15, 2023. The records state a preponderance of evidence was found that [redacted] and [redacted] physically abused and improperly supervised [redacted] which led to his death. CPS records also state [redacted] improperly supervised her daughter, [redacted] CPS records further state [redacted] and [redacted] were placed on the child abuse and neglect Central Registry for this.

[redacted] released his parental rights to his children on July 20, 2023, and [redacted] had her parental rights terminated to [redacted] on October 8, 2024.

The OCA investigator was informed by MDHHS staff, following the death of [redacted] [redacted] Lapeer County implemented a revised best-practice standard for foster care case management. All case managers are now required to conduct unannounced home visits to the placements of children in foster care.

Timothy Coombs pled no contest to second degree murder, first degree child abuse, torture, and delivery of a controlled substance to a minor because of his involvement in [redacted] [redacted] death. He was sentenced to 31 to 53 years in prison on July 1, 2025.

Jasmin Jones-Bonner pled no contest to first degree child abuse and delivery of a controlled substance to a minor because of her involvement in [redacted] [redacted] death. She was sentenced to 9 to 40 years in prison on July 8, 2025.

Review of MDHHS policy:

As part of the OCA investigation, the OCA investigator reviewed historical and current MDHHS policy manuals regarding the issues identified in the cases involving [redacted] [redacted] Jr. and [redacted] [redacted] The following section is a review of what MDHHS policy says about these issues

On June 1, 2007, the requirement for foster care staff to complete quarterly unannounced visits to homes where foster children reside was added to FOM 722-6. On July 1, 2019, this section was moved to FOM 722-06H and changed to; "unannounced visits are not required but may be made at the discretion of the case manager or supervisor".

Since July 1, 2019, FOM 722-06H has stated foster care staff must have at least one face-to-face contact with a legal parent in their home during the first month after their child has been removed and placed in foster care. FOM 722-06H further states that after the first contact, one face-to-face contact with the parent in their home should occur quarterly.

Since December 1, 2017, SRM 700 has stated that criminal history checks should be completed prior to a parent having parenting time in their home.

MDHHS foster care policy doesn't require foster care staff to:

- Complete private interviews with other children residing in a home, unless they are foster children.
- View the entire home during each visit with a foster child.
- Drug screen a person being considered for placement of a foster child when there is reasonable cause to suspect substance abuse.
- Interview medical or mental health providers when there is a condition reported that could affect a person's ability to care for a child.

Case Number: 2022-0102 + 2023-0002

[redacted] [redacted] Jr. & [redacted] [redacted]

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 that both Genesee and Lapeer County foster care staff only completed scheduled visits to the homes were [redacted] Jr. and [redacted] were placed while they were in foster care.

2. The child advocate finds that MDHHS policy doesn't require foster care staff to conduct certain activities that would help ensure the safety of foster children. These activities include unannounced home visits; private interviews with all children residing in or frequently visiting a home where a foster child resides; viewing the entirety of the home when conducting visits; drug screening caregivers or other adults in the home when there is a reasonable cause to suspect substance abuse; and interviewing medical or mental health providers when a condition is reported that could affect a caregiver's ability to care for a child.

3. The child advocate finds additional efforts are needed to ensure the safety and well-being of children placed in foster care.

Recommendations

1. The child advocate recommends MDHHS provide an explanation for why FOM 722-06H was changed on July 1, 2019, to say unannounced home visits to foster children's placements is at the discretion of the case manager or supervisor.

2. The child advocate recommends MDHHS enhance foster care policy to require foster care staff to complete additional activities that would help ensure the safety of foster children. These activities should include the following:

a. Amend FOM 722-06H to require a minimum of quarterly unannounced home visits to a home where a foster child resides
b. Amend FOM 722-06H to require monthly private face-to-face interviews with all verbal children residing in, or frequently visiting, a home where a foster child resides
c. Amend FOM 722-06H to require viewing the entirety of the home where a foster child resides when conducting each required home visit
d. Amend FOM 722-03B (section: obtaining required information) to require drug screening any caregiver or other adult in a home where a foster child will reside, when there is a substantiated CPS history involving substance abuse by the adult or if there is a reasonable cause to suspect current substance abuse
e. Amend FOM 722-06H (section: contact with child's caregivers) to require drug screening any caregiver or other adult in a home where a foster child resides, when there is a reasonable cause to suspect substance abuse
f. Amend FOM 722-03B (section: obtaining required information) to require interviewing medical and mental health providers when a caregiver reports a condition that could affect their ability to care for a foster child(ren)
g. Amend FOM 722-03 (section: unusual incident reporting) to require foster parents to notify the child placing agency when a foster parent has been hospitalized. This should also include a requirement for MDHHS staff to interview the medical and mental health providers to determine if their condition affects their ability to care for a foster child(ren)

Case Number: 2022-0102 + 2023-0002

[redacted] [redacted] Jr. & [redacted] [redacted]

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.

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