Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2023-0062

[redacted]

Date of Death: January 22, 2023

Investigation Start: February 7, 2023

Recommendation Issued: November 13, 2024

Case Background

[redacted] was five years old when he died on January 22, 2023. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatality. On February 7, 2023, the OCA opened an investigation into the administrative actions of CPS regarding [redacted] death. The following report summarizes the information and evidence found during the OCA investigation.

Case Prelude

The Death of [redacted] was caused by the two individuals [redacted] should have received protection from. These individuals, Shane Shelton Sr. and Valerie Hamilton were held criminally liable for [redacted] death. Michigan's child advocate act requires the child advocate hold reports of findings and recommendations until there is no open criminal investigation. Shane Shelton and Valerie Hamilton were sentenced on October 11, 2024, thus ending the open criminal investigation. The child advocate was not permitted to release this report until after the criminal sentencing of Shane Shelton Sr. and Valerie Hamilton.

The findings and recommendations in this report were shared with the Lincoln Park Police Department, the Wayne County Prosecutors Office, and with the Michigan Department of Health and Human Services (MDHHS). Lincoln Park and MDHHS provided responses within the 60-day response window. Wayne County Prosecutor's office did not respond.

Research Source Materials

https://my.clevelandclinic.org/health/symptoms/raccoon-eyes

Response received from MDHHS: February 7, 2025
Response received from Lincoln Park Police Department: February 13, 2025

Findings	Responses
1. The Child Advocate finds [redacted] Sr. and Valerie Hamilton were convicted of killing [redacted] Both were sentenced to life in prison on October 11, 2024.	**MDHHS: Agree** **Lincoln Park PD: Agree**
2. The Child Advocate finds in the 2021 child abuse investigation neither CPS or law enforcement contacted a medical child abuse expert to confirm the injuries on [redacted] and [redacted] were a result of non-accidental trauma.	**MDHHS: Agree** **Lincoln Park PD: LPPD agrees that law enforcement did not contact a medical child abuse expert during the 2021 child abuse investigation. Since receiving the findings of this report, the entire patrol and investigative divisions of the department have and continue to receive training and case management protocols for child abuse and neglect investigations utilizing a multidisciplinary team approach. In addition, personnel have also received training in the TEN-4-FACESp rule.**
3. The Child Advocate finds CPS, the treating hospital, and law enforcement did not take photographs of the injuries to [redacted] and [redacted] during the 2021 CPS investigation. The photographs were provided by a relative and provide no evidentiary value.	**MDHHS: Agree that CPS did not take photographs** **Lincoln Park PD: LPPD agrees that during the 2021 investigation Law Enforcement did not take photographs of the injuries to [redacted] and [redacted] and the only photographs the LPPD received were from a relative.**

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2023-0062

[redacted]

Response received from MDHHS: February 7, 2025
Response received from Lincoln Park Police Department: February 13, 2025

Findings	Responses
4. The Child Advocate finds the Lincoln Park police report concerning the 2021 incident documents the wrong hospital and wrong prior police agency. Additionally, law enforcement did not interview the mother, the paternal aunt, or the medical professional who examined the children.	**MDHHS: No Response** **Lincoln Park PD: The patrol officer who interviewed and collected the information for the initial report from [redacted] the maternal grandmother, is no longer employed with the department, therefore limited information is known as to what was reported to him regarding which hospital the children were taken to for evaluation by the paternal aunt, [redacted]** **The Law Enforcement Notification (LEN) from CPS was initially sent to the Brownstown Police Department, who later sent it to LPPD after determining it was not in their jurisdiction. The CPS LEN fax cover sheet received by LPPD from Brownstown PD has "Motts Children Hospital" printed on it along with "21-3831". 21-3821 has since been identified to be Brownstown PD's incident number which was started after they received the CPS LEN.** **The mother, [redacted] and the paternal aunt, [redacted] were both separately contacted and spoke with law enforcement; however, it was not documented in a report. The mother, [redacted] was initially cooperative, but stopped communicating with Law Enforcement after she and [redacted] Sr. allegedly spoke with an attorney.** **Interviews were not conducted by law enforcement with the medical professional who examined the children.**
5. The Child Advocate finds a warrant packet was sent to the Wayne County Prosecutor's Office in 2021 by Lincoln Park Police Department. This warrant packet was reviewed by the Wayne County prosecutor's office and the case was returned to Lincoln Park Police Department for further investigation. The Wayne County prosecutor requested Lincoln Park Police Department gather medical records of the abused children.	**MDHHS: No response** **Wayne Co. Prosecutor: No response** **Lincoln Park PD: LPPD agrees that the 2021 case was returned by the Wayne County Prosecutor's Office requesting the medical records be collected. No further follow-up or communication occurred between law enforcement and the Wayne County Prosecutor's Office.**
6. The Child Advocate finds the 2021 CPS ongoing services case did not ensure the substantiated perpetrator, [redacted] Sr., participated in services to address the identified needs.	**MDHHS: Agree** **Lincoln Park PD: No response**

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2023-0062

[redacted]

Response received from MDHHS: February 7, 2025
Response received from Lincoln Park Police Department: February 13, 2025

Findings	Responses
7. The Child Advocate finds that closing Category II cases due to lack of cooperation from families or perpetrators is not supported by law or policy, potentially endangering children. The Child Advocate also recognizes that it is impossible to determine if [redacted] death could have been avoided had the case remained open and [redacted] Sr. received the required services and participated in them. a. The child advocate's case statistics indicate that in 75% of category II cases that are closed without the abusers participating in or benefiting from services, the result is a child's death.	**MDHHS: Agree in part. DHHS agrees that closing a Category II solely due to non-cooperation with services, absent other factors, is not a valid reason for a case closure. MDHHS agrees that [redacted] Sr.'s lack of cooperation should have been considered before closing the case. Other factors were considered when closing the case, including Ms. [redacted] compliance with the department, and the reduced risk assessment.** **Lincoln Park PD: No response**
8. The Child Advocate finds that in the 2021 investigation, although CPS and law enforcement had contact with one another, a joint multidisciplinary team (MDT) investigation did not occur. a. Law enforcement was unaware of the outcome of the CPS investigation. b. The CPS ongoing services case was closed without knowing if charges were issued against [redacted] Sr.	**MDHHS: Agree** **Lincoln Park PD: LPPD agrees that although during the 2021 investigation, law enforcement and CPS had communication with one another, they did not coordinate their investigations collectively or with a joint MDT approach. Neither Law Enforcement nor CPS were aware of one another's outcome.**
9. The Child Advocate finds that the [redacted] children were purportedly homeschooled and thus had limited or no exposure to mandated reporters of child abuse.	**MDHHS: Agree** **Lincoln Park PD: No response**
10. The Child Advocate finds prior recommendations were made to MDHHS and the legislature to amend policy and law regarding the use of multi-disciplinary teams, however the recommended changes have not been made.	**MDHHS: Agree in part. MDHHS recognizes the need for stronger use of multi-disciplinary teams across Michigan. MDHHS is a member of the Governor's Task Force on Child Abuse and Neglect Child Death Investigation Protocol Utilizing a Multidisciplinary Approach subcommittee to strengthen multidisciplinary partnering and improve practice.** **Lincoln Park PD: No response**

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2023-0062

[redacted]

February 7, 2025

Response received from Lincoln Park Police Department: February 13, 2025

Recommendation	Responses
1. The Child Advocate recommends MDHHS add a question to the risk assessment and the vulnerable child assessment surrounding Ten-4FACESp to help identify cases where children have injuries and help ensure proper medical examinations are completed.	**MDHHS: MDHHS agrees in part. Based on the intent of the risk assessment and vulnerable child assessment, it does not appear adding a reference to TEN-4-FACESp in these assessments would meet the need identified by the OCA. Based on the identified need, MDHHS will explore an enhancement to PSM 713-04, Medical Examination and Assessment, to capture the specific areas/considerations highlighted in the TEN-4-FACESp acronym, in addition to the other circumstances outlined in PSM 713-04 that require a medical exam.** **Lincoln Park PD: No response**
2. The Child Advocate recommends MDHHS require a medical assessment within 24 hours if a child presents with injuries in the locations identified in Ten-4FACESp, and that the case specialist have direct contact with the medical provider who examines the child(ren).	**MDHHS: MDHHS agrees in part. Before committing to a 24-hour timeframe to complete a medical exam, MDHHS would like to consult with the department's Medical Advisory Committee, comprised of child abuse pediatricians and providers from across the state, local child welfare leaders, and other partners to discuss the recommendation in detail to help make an informed decision. PSM 713-04 requires the following: Case managers must make efforts to speak directly with the examining medical practitioner; however, if the medical practitioner is not available, the case manager may provide the information to a professional at the medical facility and provide case manager contact information for any questions** **the medical practitioner may have. Attempts must be made throughout the duration of the investigation to speak to the examining medical practitioner. Efforts must be documented in social work contacts.** **Lincoln Park PD: No response**
3. The Child Advocate recommends that the legislature allocate funding to establish statewide regional child abuse medical centers. These centers would be required for the MDHHS and placing agency foster care (PAFCs) to utilize for medical examinations when injuries are identified in children. The purpose of these centers is to assist CPS in directing children to the appropriate facilities for their examinations. Furthermore, it will ensure that these examinations are conducted under the guidance of a specialist, specifically a Child Abuse Pediatrician, who is trained to accurately diagnose and manage injuries. Additionally, the centers will facilitate follow-up discussions and findings with CPS workers, enhancing collaboration and care for affected children.	**MDHHS: MDHHS agree in part. External partners would have to agree with this decision. Regional centers would present geographical challenges with getting the children to the facilities timely depending on the nature of their injuries.** **Lincoln Park PD: No response**

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2023-0062

[redacted]

February 7, 2025

Response received from Lincoln Park Police Department: February 13, 2025

Recommendation	Responses
4. The Child Advocate continues to recommend county prosecuting attorneys, or their designee, conduct regular MDT meetings to increase communication among members. The OCA has seen positive outcomes when the MDT is actively involved in case-by-case decision-making to facilitate and support the work of its members. The MDT can include members of law enforcement, medical personnel, mental health personnel, and Child Advocacy Centers.	**MDHHS: MDHHS agrees in part. CSA agrees that there are positive outcomes when an MDT is utilized. However, CSA lacks authority over a prosecuting attorney's willingness to conduct regular MDT meetings.** **Lincoln Park PD: LPPD has contacted our local Child Advocacy Center, and our investigative personnel have all and will continue to receive training, updates and case assistance through our local MDT meetings. Case management protocols from start to finish for child abuse and neglect investigations are in place and being used.**
5. The Child Advocate recommends the Michigan Legislature amend Child Protection Law, MCL 722.628(6), to require that, as the lead criminal investigators, law enforcement be added to the MDT, along with the prosecuting attorney and the department.	**MDHHS: MDHHS agrees that law enforcement is a necessary component of the MDT.** **Lincoln Park PD: LPPD would support this amendment.**
6. The Child Advocate recommends the Michigan Legislature provide funding for MDHHS liaisons to the MDT for each county MDHHS office.	**MDHHS: Agree.** **Lincoln Park PD: LPPD would support this recommendation.**
7. The Child Advocate recommends MDHHS create positions that are solely responsible for MDT Liaison duties, which can include but are not limited to, serving as a bridge between MDT members, assisting the MDT leader in facilitating monthly MDT case review meetings, collaboration with MDHHS central office on policy changes, and actively participate in serious abuse and neglect investigations as an advisor to the MDT. Serious investigations include, but are not limited to, when a child presents with abnormal or suspicious bruising or injury, severe injury, sexual assault, or death.	**MDHHS: MDHHS agrees with this recommendation, provided that the necessary funding is afforded.** **Lincoln Park PD: No response**

Office of the Child Advocate

[redacted]
Date of Birth: July 20, 2017
Date of Death: January 22, 2023

Case Number: 2023-0062

Investigation Start: February 7, 2023

Recommendation Issued: November 13, 2024

Case Prelude

The Death of [redacted] was caused by the two individuals [redacted] should have received protection from. These individuals, Shane Shelton Sr. and Valerie Hamilton were held criminally liable for [redacted] death. Michigan's child advocate act requires the child advocate hold reports of findings and recommendations until there is no open criminal investigation. Shane Shelton and Valerie Hamilton were sentenced on October 11, 2024, thus ending the open criminal investigation. The child advocate was not permitted to release this report until after the criminal sentencing of Shane Shelton Sr. and Valerie Hamilton.

OCA Background

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

This OCA review included reading confidential records and information in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), service reports and social work contacts. The OCA also interviewed MDHHS staff, and reviewed law and policy surrounding adoption. Due to the confidentiality of OCA investigations, the OCA cannot disclose the identity of witnesses or complainants or sources of statements and evidence.

The objective of this review is to identify areas for improvement in the child welfare system by looking at how CPS investigations involving [redacted] were handled by Wayne County MDHHS, and the involvement of MDHHS 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 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.

Given the nature of our responsibilities, the OCA review is inherently prompted by a worst-case scenario. The investigation and review aim to give a voice to the child, or children involved. It is important for readers to understand the majority of cases investigated and managed by child protective services, foster care, and adoption, do not lead to the 'worst-case scenario.' The OCA has also reviewed hundreds of instances where MDHHS' child welfare programs have been successful for children and families, where dedicated child welfare professionals help families remain strong and together in the face of adversity. While the OCA reviews specific cases, the items identified in the findings of this document highlight missed opportunities often observed by the OCA. If addressed by MDHHS the OCA believes it can help prevent future instances of harm.

[redacted] was five years old when he died on January 22, 2023. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatality. On February 7, 2023, the OCA opened an investigation into the administrative actions of CPS regarding [redacted] death. The following report summarizes the information and evidence found during the OCA investigation.

Family History and Background

[redacted] is the birth mother of [redacted] (DOB:06/26/2013), [redacted] (DOB: 07/20/2016), [redacted] (DOB:07/20/2017), and [redacted] Jr. (DOB: 12/26/2019). [redacted] Sr. is the father of [redacted] Jr. and was the live-together-boyfriend of [redacted] during both the 2021 and the 2023 CPS investigations. [redacted] Sr. shares three children with [redacted] (DOB: 10/14/2013), [redacted] (DOB: 04/01/2016), and [redacted] (DOB: 07/16/2012).

[redacted] is the birth father of [redacted] is the birth father of [redacted] and [redacted]

At the time of [redacted] death, [redacted] Jr., and [redacted] resided in the home with [redacted] and [redacted] Sr., [redacted] and [redacted] resided with their mother and her other children.

In 2021, within two years preceding [redacted] death, CPS investigated allegations involving physical abuse of [redacted] and [redacted] by [redacted] Sr. and [redacted] The investigation resulted in an open services case. The scope of the OCA investigation solely involved this history, as there was no history between the 2021 services case and [redacted] death. [redacted] and [redacted] have CPS history as a couple and as individuals prior to their romantic relationship.

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[redacted]

Review of February 2021 CPS Investigation

The focus of the OCA's investigation starts in February 2021 with concerns for physical abuse of [redacted] and [redacted] due to bruising on their legs and buttocks. A CPS investigation was opened on February 26, 2021, and closed on April 27, 2021.

On February 26, 2021, [redacted] and [redacted] were observed by their aunt with bruises all over their buttocks and legs. [redacted] had a black eye and other bruising on his head. The children were first taken to Beaumont Hospital in Trenton by their aunt, [redacted] However, due to concerns about physical abuse, they were transferred to Detroit Children's Hospital for specialized evaluations.

A complaint was made to CPS Centralized Intake (CI) as the bruising was suspected to be a result of physical abuse, and [redacted] told hospital staff his mother's boyfriend hits him and his brother. The complaint was assigned, and CPS began their investigation the same day (February 26, 2021). CPS sent a Law Enforcement Notification (LEN) to the Wayne County Prosecutor's Office and the Brownstown Police Department.

CPS contacted [redacted] and [redacted] at the hospital who were still with their aunt, [redacted] CPS documented [redacted] was observed with bruises, swelling on his left hand, and a bruise on his left eye. CPS documented [redacted] was observed with small red bruises on his left leg, a bruise on his right cheek, and discoloration of his left forearm. CPS attempted to interview [redacted] but all he verbalized was the bruises were from [redacted] and [redacted] Aunt) told CPS she had picked up the children from the maternal grandmother, [redacted] who was caring for the children. [redacted] further explained [redacted] Sr. had dropped them off to [redacted] due to [redacted] being in the hospital with medical concerns. [redacted] informed CPS [redacted] expressed concern to her about [redacted] hygiene and said she had noticed marks on him. [redacted] saw the marks on [redacted] herself while assisting him in the bathroom, leading her to take the children to the hospital for evaluation.

CPS spoke with the hospital social worker who advised CPS the children's injuries were consistent with physical abuse. [redacted] had more findings of physical abuse than [redacted] CPS documented calling and speaking with [redacted] (maternal grandmother) who said [redacted] Sr. dropped [redacted] and [redacted] Jr. off to her home on February 25, 2021, because he needed help caring for them while [redacted] was hospitalized. [redacted] advised that prior to this, she had not seen her grandchildren in several weeks, and suspected [redacted] Sr. of being physically abusive and controlling towards [redacted] informed CPS she observed marks on [redacted] when giving him a bath. She inquired about how he got the marks and at first [redacted] said he fell but then [redacted] said, "[redacted] did it."

CPS spoke with [redacted] by phone and confirmed she was hospitalized due to her own medical needs. CPS developed a safety plan with [redacted] where [redacted] agreed to have the children remain in the care of her mother, [redacted] also agreed to have [redacted] bring [redacted] Jr. to the hospital for a medical examination. [redacted] also agreed to the safety plan and said she would care for the children as long as needed.

CPS spoke with a police officer from the Brownstown Police Department who advised the incident did not take place within their jurisdiction, but that it occurred in Lincoln Park. CPS sent an updated LEN to Lincoln Park Police Department (PD). CPS requested well-being checks by law enforcement for [redacted] Sr.'s other children who resided with their mother, [redacted] Law enforcement confirmed the well-being of the other children, who had no bruises or injuries.

CPS conducted an in-person interview with [redacted] at the hospital on February 27, 2021. [redacted] was informed of the physical abuse findings from the children's medical examination. The CPS investigation report documents due to [redacted] reaction and medical condition, further discussion could not occur, and CPS' interview had to end.

On March 1, 2021, the assigned lieutenant from Lincoln Park PD left a message for CPS regarding the LEN received, to discuss the case and the need for Kids Talk interviews. CPS spoke with a detective from Lincoln Park PD on March 4, 2021, and advised Kids Talk interviews were requested but not yet scheduled. CPS informed the detective they would provide the dates once they were scheduled.

The assigned CPS case manager spoke with [redacted] again on March 2, 2021, to discuss scheduling a home visit once [redacted] was out of the hospital. [redacted] remained hospitalized and did not know when she would be discharged. [redacted] told CPS she did not know what happened to her boys but that she also knew [redacted] Sr. would never do anything to them. [redacted] had to cancel multiple home visits planned with CPS due to additional medical issues that caused hospitalization.

CPS received photos of [redacted] and [redacted] injuries on March 5, 2021. These photos are documented to come from the children's aunt, [redacted] The OCA investigator observed these photos during the OCA investigation. The photos are poor quality and hard to determine which child is which, however, the bruising observed on the children is patterned and significant. Bruising is observed on a child's leg, buttocks, and abdomen area. There is also a photograph of a child's hand which appears swollen, and a child with a swollen shut black eye. These were the only photos taken by anyone during the investigation.

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[redacted]

Review of February 2021 CPS Investigation Cont.

On March 10, 2021, CPS attempted to speak with the doctor at Detroit Children's Hospital who examined [redacted] and [redacted] A message was left with another employee to have the doctor call CPS. CPS also contacted [redacted] Sr. on March 10th who denied any abuse occurring in he and [redacted] home. [redacted] Sr. then blamed the children's injuries on [redacted] mother (the children's grandmother), [redacted] Sr. agreed to be interviewed once [redacted] was out of the hospital.

Kids Talk forensic interviews were scheduled for March 18, 2021. CPS informed a Lincoln Park PD lieutenant of the interview, who advised CPS he would be present. [redacted] was also informed of the appointments for the children during a home visit on March 11, 2021. [redacted] agreed to transport the children to the interviews.

CPS conducted a home visit to [redacted] and [redacted] Sr.'s residence on March 16, 2021. [redacted] and [redacted] Sr. were interviewed again, this time in person, regarding the abuse allegations. Both denied any physical abuse. [redacted] did not believe [redacted] Sr., or her mother caused any injuries or harm to her children. [redacted] believed that [redacted] could have been involved stating she and [redacted] had not gotten along. [redacted] Sr. denied disciplining the children and told CPS he believed this whole thing was a "set up". [redacted] Sr. informed CPS that [redacted] was "accident prone", always getting hurt, and would hurt himself with toys when he was angry. [redacted] Sr.'s daughters, [redacted] and [redacted] were in his care, advising CPS that [redacted] (his daughter's mother) was struggling with substance abuse and was "on the run." CPS interviewed [redacted] and [redacted] separately and in a private setting. The girls made no disclosures of physical abuse or discipline in the home and told CPS they felt safe in the home with their dad and [redacted] None of the girls knew how [redacted] and [redacted] were injured. [redacted] and [redacted] were documented to be free of any visible injuries.

Kids Talk interviews were conducted with [redacted] and [redacted] on March 18, 2021. Prior to the interviews, the Lincoln Park lieutenant informed CPS [redacted] Sr. was arrested for unpaid parking tickets and was being held at the Lincoln Park police station until after the interviews. [redacted] was late arriving for the interviews and when asked questions, [redacted] could not provide the lieutenant with concrete answers regarding the timeline of events, regarding the bruising, when it was first observed, and when the children were taken to the hospital. [redacted] stated [redacted] cut ties with her when she began dating [redacted] Sr., that she did not approve of [redacted] Sr., and that she did not want her daughter with him. The Lincoln Park lieutenant told CPS he found this concerning and believed there could be possible coaching involved.

[redacted] (age 4 at the time) was interviewed first. [redacted] is documented to "be walking around and would not sit in a chair." When the interviewer was attempting to get [redacted] to sit down, he randomly stated '[redacted] did it." He was asked what [redacted] did. The CPS report documents [redacted] then began motioning a punch and slapped his hands all over his body. [redacted] is documented to say, "all over." She asked who he did that to, and he responded with "his eye." The interviewer attempted to get more information from [redacted] however he did not answer any further questions and attempted to leave the room. The interview was then ended. The CPS report documents [redacted] (age 3 at the time) was interviewed next, but competency could not be established and two minutes after he entered the room, he was asking to leave.

Later the same day, (March 18, 2021), the Lincoln Park Lieutenant contacted CPS. The CPS report documents [redacted] Sr. was interviewed and the Lieutenant told CPS he believed everything that was said to him. The Lieutenant advised CPS [redacted] Sr. said he received a photo of the children from [redacted] after they were in her care without any marks. CPS was advised that during the interview, [redacted] Sr. agreed to take a polygraph adding he would pass the polygraph. The Lincoln Park Lieutenant told CPS that [redacted] Sr. was crying during the interview when he spoke about treating [redacted] and [redacted] as his own explaining he would not hurt them.

On March 24, 2021, the CPS specialist attempted, unsuccessfully, to make contact with the doctor at Children's Hospital who examined [redacted] and [redacted] on February 26, 2021. CPS left a message asking for a return phone call. There is no documentation CPS ever received a return phone call from the doctor. Interviews with MDHHS staff did not yield any additional evidence showing the doctor returned the phone call.

CPS was informed by the Lincoln Park Lieutenant on March 30, 2021, that [redacted] Sr. was scheduled for a polygraph, however, it was not believed he would come due to his lawyer advising him not to participate. On April 8, 2021, the Lincoln Park Lieutenant advised CPS that [redacted] Sr. did not attend the polygraph. The lieutenant also advised CPS there could be several relatives interfering with the investigation due to wanting more interactions with the mother and the children.

On April 13, 2021, CPS spoke with [redacted] and [redacted] Sr. via phone. CPS advised the parents a case would be opened, and services would need to be participated in. Both [redacted] Sr. and [redacted] agreed to participate in services. They agreed to a verbal safety plan of refraining from the use of physical discipline or excessive force with the children. The boys were then allowed to return to the care of [redacted] and [redacted] Sr.

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[redacted]

Review of February 2021 CPS Investigation Cont.

A referral to Families First of Michigan was made on April 19, 2021. Both [redacted] Sr. and [redacted] did not agree with an ongoing services case being open, however they verbally agreed to participate in the services provided by Families First.

The investigation resulted in a substantiation of physical abuse of [redacted] and [redacted] and was dispositioned as a Category II. [redacted] Sr. was identified as the abuser of [redacted] and [redacted] The CPS disposition summary documents law enforcement would move forward with requesting charges for [redacted] Sr. concerning physical abuse of [redacted] and [redacted] An ongoing services case was opened and transferred to CPS ongoing for monitoring of services provided.

Additional OCA Evidence: February 2021 CPS Investigation

During the OCA's investigation, the OCA investigator reviewed the medical records concerning [redacted] and [redacted] medical records note that [redacted] told medical staff at Children's Hospital his mother's boyfriend hit him. The medical records documented [redacted] had bruising all over his body and a bite mark on his right shoulder. Specifically, [redacted] had bruising on his left eye, multiple linear (patterned) bruising in different stages of healing on his back, abdomen, thighs, and a rash on his lower extremity. [redacted] was noted to have left periorbital ecchymosis[1], but his vision was intact. The medical documents show his left hand was swollen. [redacted] also had multiple scabs and lumps on his head. [redacted] was noted to have bruising on his legs, including pattern bruising over his left medial thigh. Both [redacted] and [redacted] medical records note suspected physical abuse. No photographs were taken at the hospital.

The Lincoln Park police report was also reviewed by the OCA investigator. The police report documents the case was transferred from Mott Children's Hospital Police, which is inaccurate. The Lincoln Park police report documents an interview with the maternal grandmother, [redacted] where it is documented [redacted] explained she took the boys to Mott Children's Hospital in Ann Arbor and then they were transferred to Detroit Children's Hospital. This is also inaccurate information. The OCA investigator confirmed the children were not seen at Mott Children's Hospital in Ann Arbor nor were the Mott Children's Hospital Police involved in this case.

According to the Lincoln Park police report [redacted] Sr. denied harming the children or causing any marks on the children, placing blame on [redacted] or [redacted] He also told law enforcement the boys play hard with one another. The Kids Talk interviews are also documented with no additional information from what was documented in the CPS report. The police report did not have any documented contact with [redacted] medical staff, or any other witnesses. The records included photographs that were the same photos CPS received from [redacted] during their investigation. The police report notes the investigation was turned over to the prosecutor on October 11, 2021 (approximately eight months after the incident occurred).

Review of April 2021 CPS Ongoing Services Case

The CPS ongoing case has one Updated Services Plan (USP), which is a closing report. The ongoing case was opened for the report period of April 17, 2021, to June 9, 2021.

A Family Team Meeting (FTM) was held with [redacted] and [redacted] Sr. by the CPS investigator on April 20, 2021. The case then transferred to an ongoing case manager on April 29, 2021. The assigned ongoing specialist contacted [redacted] on April 30, 2021, to arrange a home visit with the family that day. Due to the family having COVID-19, the home visit was completed virtually. [redacted] told the specialist that she had participated in a virtual visit with Families First as well. The specialist conducted another home visit with the family on May 13, 2021, and the children were documented to be free of injury. CPS documented going to the home but remaining outside and communicating with the family through the screen door and window due to COVID-19. [redacted] informed the specialist she was advised the services provided by Families First would be completed by the end of May. The USP documents, (during the report period of April 17, 2021, to June 9, 2021) that the case specialist advised [redacted] the ongoing services case would close after Families First services were completed.

According to documentation in the USP, CPS did not have contact with Families First until June 8, 2021. The USP documents CPS was informed [redacted] completed services provided by Families First on May 16, 2021, that sessions were held three times per week via zoom, and [redacted] was compliant. The USP also documents Families First had no additional concerns about the family.

[1] https://my.clevelandclinic.org/health/symptoms/raccoon-eyes

Case Number: 2023-0062

[redacted]

Review of April 2021 CPS Ongoing Services Case Cont.

The ongoing specialist held a closing FTM with [redacted] on June 8, 2021, documenting there were no additional safety concerns, and the case was safe to close due to [redacted] compliance with the services she was provided. [redacted] Sr. was not present for this FTM. Documentation shows that the case specialist spoke with [redacted] and observed the children through a window and door screen at their residence, due to [redacted] stating she had COVID-19. The children were documented to be free of visible marks and bruises. During this time, it was approved to conduct these evaluations virtually due to the COVID-19 pandemic.

The safety assessment completed by the CPS ongoing case manager scored the family as safe with services, with safety interventions of family resources, neighbors, and other individuals in the community, and use of community agencies or services as immediate safety resources. The risk assessment completed by the CPS ongoing case manager was not properly scored as the assessment documented [redacted] as the only caregiver in the home. [redacted] Sr. was also living in the home, was the father to one of the children living in the home and was considered a person responsible by law. The risk assessment statement regarding care providers is also inconsistent with the USP. The USP references both [redacted] and [redacted] Sr. regarding the family's income, employment, health, and stability, noting they were in a supportive relationship. In reviewing the "needs" section of the completed Family Assessment, ongoing needs were listed as parenting skills, stating [redacted] Sr. should continue to work on his parenting skills and to maintain adequate discipline techniques. [redacted] Sr. is the 'person responsible' listed for this goal, however, [redacted] Sr. never participated in the services provided to [redacted]

The ongoing services case was closed on June 15, 2021, without [redacted] Sr.'s participation.

Additional OCA Evidence: April 2021 Ongoing Services Case

Interviews with MDHHS staff were conducted. Given the length of time from the OCA investigation and the 2021 CPS ongoing case, limited information was remembered by MDHHS staff. The OCA investigator was informed Families First did not know [redacted] Sr. was the one to be serviced and he may not have been on the service referral. The OCA investigator was unable to determine if any additional contact with the service provider was made and not documented as MDHHS staff could not recall. The ongoing services case concentrated on [redacted] and ignored [redacted] Sr.'s lack of participation. The OCA was informed during interviews the reason why the ongoing case was closed was due to [redacted] successful completion of services, she did not have any other needs, and she was not substantiated for child abuse or neglect.

The OCA investigator reviewed the Families First records for the services provided to [redacted] The records document both [redacted] and [redacted] Sr. were referred to participate in services due to concerns of physical abuse of [redacted] and [redacted] while in [redacted] Sr.'s care. The referral documented [redacted] Sr. was substantiated for physical abuse, and that neither parent was able to provide an explanation for how the injuries to [redacted] and [redacted] occurred. The records document the service provider was unable to fully complete [redacted] Sr.'s assessment as he was not present in the home during the initial assessment visits. The service provider's file documents that [redacted] Sr. was present for two of the interactions with the service provider, and his level of participation is unclear from the reviewed documentation. The final Families First report documents only 30 of the contracted 40 hours of intervention was able to be made with the family. The lack of full participation was identified as the family canceling or missing appointments, noting "there was no specific assistance provided to the family yet." It is documented [redacted] participated in services and made progress in learning new techniques for discipline and creating a routine schedule for the children, however, [redacted] Sr. did not participate, interact, or provide any input. The Families First termination report documents the family will continue to be monitored through the CPS ongoing case.

The OCA investigator interviewed Families First staff. Through these interviews it was confirmed [redacted] Sr. did not participate in services, even though [redacted] Sr. was referred to Families First to address parenting skills, specifically non-physical discipline techniques, creating structure and routine, how physical abuse can affect children, and proper supervision. The services provided by Families First occurred virtually due to the COVID-19 pandemic, and although he would be present in the background, [redacted] Sr. did not participate. Those interviewed acknowledged it was hard to determine whether or not [redacted] benefitted from the services due to the visits being virtual.

During the OCA's investigation, the OCA investigator spoke with Dr. [redacted] the Medical Director of the Child at Risk Evaluation (CARE) Team from Detroit Children's Hospital about the medical evaluations completed on [redacted] and [redacted] in 2021. Dr. [redacted] was familiar with the case as he was a treating specialist for [redacted] Jr. following [redacted] death.

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[redacted]

Additional OCA Evidence: April 2021 Ongoing Services Case

Dr. [redacted] was not consulted by CPS during the 2021 CPS investigation and was not involved in [redacted] or [redacted] examinations or treatment. Dr. [redacted] advised that after reviewing the medical records from the 2021 injuries, there was no doubt the injuries that [redacted] and [redacted] sustained were a result of physical abuse. He advised the documentation was clear that the children had several injuries indicative of child abuse. Dr. [redacted] further advised he considered the injuries significant because of the location of the bruising, explaining that the location of the bruising was not of typical childhood play and there was bruising all over their bodies. Dr. [redacted] advised that bruising in areas that you typically would not see, such as on the face, ears, and abdomen, can also indicate internal injury, and are significant. Dr. [redacted] expressed that Ten-4FACESp[1] could be a helpful tool to start considering significant bruising as serious physical harm/injury. Dr. [redacted] expressed the significance of CPS and/or law enforcement consulting with a medical child abuse expert when evaluating whether abuse or neglect has occurred. Dr. [redacted] reiterated that an expert should provide these medical assessments in cases involving physical abuse.

[1] TEN-4-FACESp stands for bruising to the Torso, Ears, Neck, Frenulum, Angle of the jaw, Cheeks, Eyelids or Subconjunctivae, "4" represents infants 4 months and younger with any bruise, anywhere, and "p" represents the presence of patterned bruising.

Review of CPS Investigation of [redacted] Death, January 2023

On January 22, 2023, [redacted] was pronounced deceased after 911 was called to the family home. [redacted] stated [redacted] had been sick the night prior and observed [redacted] sleeping with brown puss coming from his nose and mouth. She attempted to move [redacted] to the shower where he breathed deeply, snorted, and then stopped breathing. 911 was contacted and [redacted] was transported to the hospital where he was pronounced deceased. Reports indicate [redacted] entire body was covered in trauma, including deformities to his hip, left knee, skull, bruising all over his body, whip marks, and more linear bruises. His left toe was necrotic and falling off, with a full thickness slice between his toes, and puncture marks on his body. CPS complaints indicate [redacted] claimed the trauma to [redacted] was from his siblings beating him up. Due to multiple involved parties having concerns of [redacted] injuries and the mechanism of injury described by [redacted] multiple complaints were made to Centralized Intake for concerns of physical abuse.

On January 22, 2023, the CPS specialist conducted a visit to the hospital and interviewed [redacted] advised CPS [redacted] had been sick, stopped breathing, and she called 911. [redacted] acknowledged seeing the bruising on [redacted] but denied knowing where the bruising came from. When asked, [redacted] denied [redacted] Sr. hits the children. She informed the CPS investigator she had been "working up the courage to bring [redacted] to the hospital." A safety plan was created for the other children to be cared for by [redacted] the maternal grandmother.

CPS spoke with the doctor who examined [redacted] CPS was advised [redacted] had a deformation of the skull, swelling of his neck, fracture of his vertebrae C-7, bruising around his rectum, bruising all over his body, and it looked like he had been thrown to the ground. CPS was informed by the examining doctor, that he believed [redacted] died before January 22, 2023. [redacted] and [redacted] were evaluated at St. John Hospital. [redacted] had scratches on his forehead but no other obvious bruises. [redacted] was not able to provide any information about what happened to [redacted] [redacted] informed CPS that [redacted] had been sick lately, but he did not know what was wrong with him. He told CPS [redacted] had puss coming out of his toes, and this happens because [redacted] "pees on himself." He further said his mom and [redacted] Sr. had been giving [redacted] a blue pill crushed up in water for his toe. He believed the pills were his grandmother's. CPS relayed this information to law enforcement to add to the search warrant of [redacted] and [redacted] home.

CPS interviewed [redacted] on January 22, 2023. [redacted] is the mother of [redacted] Sr.'s other children. [redacted] explained [redacted] Sr. dropped off [redacted] Jr. and she was concerned with the number of marks on his body. [redacted] advised CPS her children told her ([redacted] that [redacted] Sr. hits the boys a lot. [redacted] agreed to take her children for physical abuse examinations at Detroit Children's Hospital. CPS learned [redacted] Jr. had been brought to the hospital by [redacted] Sr.'s sister, [redacted] [redacted] after she discovered injuries on [redacted] Jr. while at Mariah's home. [redacted] Jr. sustained cigarette burns, a descended abdomen, bruising on his hands and back, abrasions on his upper back, contusions to his chest, bruises on his right shoulder, limited motion in both of his hands, abrasions to his face, an abrasion on his left ear, red genitals, contusions on both lower legs, and his feet were frost bitten with a possible need for toe amputation. On January 23, 2023, Dr. [redacted] from the CARE team at Children's Hospital confirmed all the injuries to [redacted] Jr. were consistent with non-accidental trauma and were a result of abuse and neglect.

CPS collaborated with law enforcement during this investigation and all the children participated in forensic interviews at Wayne County Children's Advocacy Center (CAC), Kids Talk CAC. Law enforcement provided CPS with 814 pages of text messages and Facebook messages between [redacted] Sr. and [redacted] These messages show ongoing maltreatment of the children by both [redacted] Sr. and [redacted] The text messages also showed [redacted] was forced to participate in the abuse of his younger siblings.

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[redacted]

Review of CPS Investigation of [redacted] Death, January 2023 Cont.

During the Kids Talk interviews, [redacted] did not disclose any abuse and again told the interviewer about [redacted] being sick and being given his grandmother's pills. [redacted] ([redacted] and [redacted] Sr.'s daughter) disclosed getting hit with an open hand by her dad, and with a stick by [redacted] described the stick as a kitchen utensil, like a spoon but bigger. She also advised getting hit by [redacted] with an open hand on the butt, and with a belt by her dad. [redacted] disclosed [redacted] would get hit by a belt a couple of times and she would see marks on his body. Her dad would use a belt and a cord on [redacted] would get hit on his butt and all over his body for "pooping on the floor, his bed, and stealing." She advised [redacted] would steal pop tarts, noodles, hot dogs, and all kinds of things. [redacted] said [redacted] also used a cord, a belt, and the same spoon she hits her with on [redacted] said [redacted] Jr. was also hit, she would hear both [redacted] and [redacted] Jr. scream, explaining that [redacted] Jr. also had bruising all over his body. [redacted] said [redacted] had been dead for two days as she heard her dad, [redacted] and aunt talking about it. [redacted] continued to describe the conditions of how [redacted] was treated, explaining that [redacted] and [redacted] Jr. would both get locked in the basement in a cold room in the house, with no blanket. During his forensic interview, [redacted] described similar abuse. [redacted] confirmed [redacted] Sr. would hit [redacted] and [redacted] Jr. [redacted] said before [redacted] died, he got in trouble. [redacted] explained [redacted] was hit with a belt or pipe by [redacted] Sr. and he had bruising all over his body.

On January 23, 2023, MDHHS filed a petition for removal of [redacted] and [redacted] Jr. from [redacted] and [redacted] Sr. with a request for termination of parental rights. A petition was later filed on February 09, 2023, for removal of [redacted] and [redacted] other children from the care of [redacted] requesting termination of her parental rights and [redacted] Sr.'s parental rights. All the children were placed in relative foster care placements.

During the CPS investigation regarding [redacted] death, CPS discovered that none of the boys were currently enrolled in school. [redacted] previously attended kindergarten but otherwise none of the boys had been in school.

This investigation was placed in a Category I Open/Close with a preponderance of evidence supporting physical abuse and physical neglect of [redacted] Jr., [redacted] and [redacted] by [redacted] Sr. and [redacted] A preponderance of evidence was also found for Failure to Protect [redacted] by his father, [redacted] and abandonment of [redacted] by his father [redacted] was also substantiated for medical neglect of [redacted] The CPS investigation was approved and closed by the supervisor on March 10, 2023.

[redacted] and [redacted] remain placed with relative caregivers. [redacted] Jr. is placed in a non-relative home.

[redacted] and [redacted] remain placed together with a relative caregiver. All of the children became state wards on May 15, 2024.

Shane Shelton Sr. and Valerie Hamilton were found guilty by a jury on homicide- felony murder, torture, two counts child abuse 1st degree, and conspiracy- legal act/illegal manner. On October 11, 2024, Shane Shelton Sr. and Valerie Hamilton were sentenced to life in prison.

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

Findings

1. The Child Advocate finds Shane Shelton Sr. and Valerie Hamilton were convicted of killing [redacted] Both were sentenced to life in prison on October 11, 2024.

2. The Child Advocate finds in the 2021 child abuse investigation neither CPS or law enforcement contacted a medical child abuse expert to confirm the injuries on [redacted] and [redacted] were a result of non-accidental trauma.

3. The Child Advocate finds CPS, the treating hospital, and law enforcement did not take photographs of the injuries to [redacted] and [redacted] during the 2021 CPS investigation. The photographs were provided by a relative and provide no evidentiary value.

4. The Child Advocate finds the Lincoln Park police report concerning the 2021 incident documents the wrong hospital and wrong prior police agency. Additionally, law enforcement did not interview the mother, the paternal aunt, or the medical professional who examined the children.

5. The Child Advocate finds a warrant packet was sent to the Wayne County Prosecutor's Office in 2021 by Lincoln Park Police Department. This warrant packet was reviewed by the Wayne County prosecutor's office and the case was returned to Lincoln Park Police Department for further investigation. The Wayne County prosecutor requested Lincoln Park Police Department gather medical records of the abused children.

6. The Child Advocate finds the 2021 CPS ongoing services case did not ensure the substantiated perpetrator, [redacted] Sr., participated in services to address the identified needs.

7. The Child Advocate finds that closing Category II cases due to lack of cooperation from families or perpetrators is not supported by law or policy, potentially endangering children. The Child Advocate also recognizes that it is impossible to determine if [redacted] death could have been avoided had the case remained open and [redacted] Sr. received the required services and participated in them.

a. The child advocate's case statistics indicate that in 75% of category II cases that are closed without the abusers participating in or benefiting from services, the result is a child's death.

8. The Child Advocate finds that in the 2021 investigation, although CPS and law enforcement had contact with one another, a joint multidisciplinary team (MDT) investigation did not occur.

a. Law enforcement was unaware of the outcome of the CPS investigation.
b. The CPS ongoing services case was closed without knowing if charges were issued against [redacted] Sr.

9. The Child Advocate finds that the [redacted] children were purportedly homeschooled and thus had limited or no exposure to mandated reporters of child abuse.

10. The Child Advocate finds prior recommendations were made to MDHHS and the legislature to amend policy and law regarding the use of multi-disciplinary teams, however the recommended changes have not been made.

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[redacted]

Recommendations

1. The Child Advocate recommends MDHHS add a question to the risk assessment and the vulnerable child assessment surrounding Ten-4FACESp to help identify cases where children have injuries and help ensure proper medical examinations are completed.

2. The Child Advocate recommends MDHHS require a medical assessment within 24 hours if a child presents with injuries in the locations identified in Ten-4FACESp, and that the case specialist have direct contact with the medical provider who examines the child(ren).

3. The Child Advocate recommends that the legislature allocate funding to establish statewide regional child abuse medical centers. These centers would be required for the MDHHS and placing agency foster care (PAFCs) to utilize for medical examinations when injuries are identified in children. The purpose of these centers is to assist CPS in directing children to the appropriate facilities for their examinations. Furthermore, it will ensure that these examinations are conducted under the guidance of a specialist, specifically a Child Abuse Pediatrician, who is trained to accurately diagnose and manage injuries. Additionally, the centers will facilitate follow-up discussions and findings with CPS workers, enhancing collaboration and care for affected children.

4. The Child Advocate continues to recommend county prosecuting attorneys, or their designee, conduct regular MDT meetings to increase communication among members.

The OCA has seen positive outcomes when the MDT is actively involved in case-by-case decision-making to facilitate and support the work of its members. The MDT can include members of law enforcement, medical personnel, mental health personnel, and Child Advocacy Centers.

5. The Child Advocate recommends the Michigan Legislature amend Child Protection Law, MCL 722.628(6), to require that, as the lead criminal investigators, law enforcement be added to the MDT, along with the prosecuting attorney and the department.

6. The Child Advocate recommends the Michigan Legislature provide funding for MDHHS liaisons to the MDT for each county MDHHS office.

7. The Child Advocate recommends MDHHS create positions that are solely responsible for MDT Liaison duties, which can include but are not limited to, serving as a bridge between MDT members, assisting the MDT leader in facilitating monthly MDT case review meetings, collaboration with MDHHS central office on policy changes, and actively participate in serious abuse and neglect investigations as an advisor to the MDT. Serious investigations include, but are not limited to, when a child presents with abnormal or suspicious bruising or injury, severe injury, sexual assault, or death.

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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