STATE OF MICHIGAN
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GOVERNOR
OFFICE OF THE CHILD ADVOCATE
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Child Advocate Report of Findings and Recommendations

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Date: January 26, 2024

Case No.: 2021-0895

Child: [redacted]

DOB: February 10, 2010

DOD: November 22, 2021 (11 years)

Introduction:

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 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.

The OCA review included reading confidential records and information in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), service reports, medical records, social work contacts, and law enforcement reports. The OCA also interviewed MDHHS staff and medical professionals. 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 Berrien County MDHHS, and the involvement of MDHHS staff, physicians, 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 many cases investigated and managed by CPS, 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 eleven years old when he died on November 22, 2021. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatality. On December 14, 2021, the OCA opened an investigation into the administrative actions of CPS regarding [redacted]'s death. The following report summarizes the information and evidence found during the OCA investigation.

Family History and Background:

[redacted] and [redacted] are the birth parents of [redacted] and [redacted]. As mentioned above [redacted] was 11 at the time of his death and [redacted] was 13. A main issue in this case was [redacted]'s Type I diabetes which was diagnosed in 2018. [redacted] was eight years old when he developed diabetes.

This OCA investigation concentrated on interactions with CPS and [redacted]'s family from September 2020, and February 2021. Both investigations concerned [redacted]'s diabetes and the care that his parents were providing. As [redacted]'s death was directly related to his diabetes the OCA also reviewed the death investigation to determine if there was a correlation between past behaviors [redacted]'s parents presented when caring for his diabetes and CPS' interaction with the family concerning [redacted]'s care.

Review of September 2020 CPS investigation:

On September 12, 2020, [redacted] was brought to Helen DeVos Children's Hospital. When [redacted] arrived at the hospital, he was experiencing diabetic ketoacidosis[1]. [redacted] was admitted and treated for diabetic ketoacidosis. After two days of hospitalization, [redacted] was discharged on September 14, 2020. [redacted] was again brought to the hospital in diabetic ketoacidosis the following day, September 15, 2020. [redacted] was in the care of his father at the time of both hospitalizations. As a result of [redacted] being hospitalized twice in one week due to diabetic ketoacidosis, hospital staff had a concern about child abuse and neglect. A complaint was made to MDHHS Centralized Intake regarding the care or lack of care [redacted]'s father was providing. The reporting source also said they were made aware that [redacted]'s father, [redacted], had been physically abusive to [redacted] in the past. [redacted] had threatened to kill [redacted], [redacted], and their mother by setting their trailer on fire. The complaint was assigned to Berrien County CPS for investigation.

As part of the initial steps in their investigation, CPS spoke with the hospital social worker on September 17, 2020. The hospital social worker informed CPS that [redacted]'s diabetic ketoacidosis was "very avoidable". The hospital social worker further explained that diabetic ketoacidosis occurs when an individual with diabetes is "not getting enough insulin." CPS was told that according to [redacted], [redacted]'s father [redacted], "has limitations", and sometimes [redacted] would refuse to take his insulin. The hospital social worker explained that [redacted] told a hospital staff member that "his [[redacted]'s] dad will let him [[redacted]] do whatever he wants" adding that [redacted] also explained his father would threaten to kill him, his mother, and brother by setting the trailer on fire.

[1] Centers for Disease Control and Prevention: Diabetic ketoacidosis, or DKA, develops when your body doesn't have enough insulin to allow blood sugar into your cells for use as energy. Instead, your liver breaks down fat for fuel, a process that produces acids called ketones. When too many ketones are produced too fast, they can build up to dangerous levels in your body. DKA is a serious complication of diabetes that can be life-threatening.

The same day, September 17, 2020, CPS visited Helen DeVos Children's Hospital where CPS spoke with [redacted]'s mother. CPS also interviewed [redacted]. When CPS asked [redacted] why he was in the hospital, records show [redacted] explained …"I got sick and was puking and had to come back." [redacted] told CPS he ([redacted]) "…has to check his blood four times a day and that his dad is supposed to tell him but doesn't." [redacted] also told CPS his parents sometimes fight, and he has observed his mother hit his father. [redacted] again confirmed his dad gets upset and tells [redacted] he ([redacted]) will kill [redacted], [redacted] and [redacted].

According to the documented interview with [redacted], she informed CPS she did not know what happened to [redacted] because she was at work both times [redacted] became sick. [redacted] advised CPS [redacted] told her that he could take care of [redacted] on his own. [redacted] confirmed the threats [redacted] described and informed CPS that [redacted] had hit her in the past. CPS documented creating a safety plan with [redacted] to call 911 if [redacted] threatened anyone in the family again. [redacted] also agreed to have her sister or her mother babysit the children so they would receive the appropriate supervision.

Before leaving the hospital, CPS documented speaking with a nurse. The nurse told the case manager that if [redacted]'s blood sugar levels were stable, he would be discharged from the hospital (a second time) on September 17, or 18, 2020.

On September 23, 2020, CPS made a home visit with the family at their place of residence. [redacted], [redacted], and [redacted] were present for this visit. CPS interviewed [redacted]. Records show [redacted] told CPS when [redacted]'s blood sugar went up, he gave him insulin but for some reason his levels would not come down, so he took him to the hospital. The second time his levels were high, he also took him to the hospital. [redacted] informed CPS they now have a routine to check [redacted]'s sugar levels, explaining that before the hospitalization, [redacted] would argue with them about checking and would hide his monitor. [redacted] explained to CPS that [redacted] hiding his monitor and refusing to test his glucose was no longer a problem.

CPS also interviewed [redacted]. [redacted] confirmed his father and mother get into physical altercations and explained he is usually in another room when the fights happen. When [redacted] was asked about [redacted]'s diabetes, [redacted] told CPS that [redacted]'s blood sugar levels were high because [redacted] refused to check his levels. [redacted] said there is a routine in place to check [redacted]'s blood sugar levels, but [redacted] does not always follow it. [redacted] said that [redacted] is supposed to check his blood sugar levels at breakfast, lunch, dinner, and bedtime. [redacted] said it is his mother and father's responsibility to remind [redacted] to check his levels, but sometimes his father forgets or [redacted] refuses to check them.

On September 24, 2020, CPS received [redacted]'s medical records from Spectrum Health. Case records show CPS reviewed the medical records which confirmed [redacted]'s two recent hospitalizations for diabetic ketoacidosis. The medical records also indicate [redacted] needed to be educated about his diabetes to ensure proper management of the disease.

Between September 25, 2020, and September 28, 2020, CPS was informed by [redacted] that she was in the process of enrolling both [redacted] and [redacted] in virtual school. [redacted] told CPS [redacted] was doing a much better job of checking his blood sugar levels regularly. There is no documentation CPS was ever provided with or viewed [redacted]'s glucose logs.

CPS case files indicated that CPS requested and received [redacted]'s medical records from Southwestern Medical Clinic. CPS requested records from Southwestern Medical Clinic as this was [redacted]'s primary care physician. Documentation shows [redacted] was last seen on February 28, 2020, for congestion and that the records "did not note any concerns for [redacted]'s health."

On October 2, 2020, CPS confirmed with [redacted] and [redacted]'s school that they were enrolled in the

school's virtual program. CPS spoke with [redacted] and [redacted] again on October 28, 2020, asking them what they were doing to make sure [redacted] was checking his blood sugar levels. According to case records, [redacted] informed CPS that she and [redacted] were checking with [redacted] at breakfast, lunch, dinner, and bedtime to test his blood sugar levels. Records show [redacted] also had [redacted] test his sugar levels when he felt sick or got a headache. Both [redacted] and [redacted] agreed to continue to remind [redacted] to check his blood sugar level.

On October 28, 2020, CPS concluded the investigation as a Category IV with no preponderance of evidence found that [redacted] medically neglected [redacted]. The disposition states the "[v]ulnerable child policy was followed by talking to [redacted]'s parents, requesting and receiving medical records from Southwestern Medical Clinic and Helen Devos Children's Hospital." The disposition then goes on to state that a safety plan was established that consisted of [redacted] developing a "consistent schedule for checking his blood levels…"

During the OCA's investigation, the OCA investigator inquired about how MDHHS concluded a Category IV with no preponderance of evidence supporting medical neglect. The OCA learned CPS believed [redacted] was responsible enough to care for his diabetes and test his levels regularly himself. A safety plan was implemented to involve the parents more in ensuring [redacted] was testing his levels appropriately. This safety plan was never followed up on by CPS as the investigation was closed.

The OCA investigator was informed CPS chose not to speak to [redacted]'s endocrinologist (diabetes specialist) due to CPS already speaking with the parents, the hospital social worker, and obtaining [redacted]'s medical records. The MDHHS employees interviewed for this investigation informed the OCA investigator they believe the MDHHS vulnerable child policy should state the case manager must contact and speak with the child's doctor and specialist. The OCA investigator found that CPS did not speak to anyone about the parent's ability to meet [redacted]'s needs, or if [redacted] had any unmet needs. The OCA was informed the parents were not substantiated for medical neglect due to there being no history surrounding [redacted]'s diabetes not being met, and this investigation was treated more as a duty to educate the parents.

Review of the February 2021 CPS Investigation

On February 10, 2021, five months after [redacted]'s last hospitalization, Berrien County CPS was assigned an investigation concerning [redacted] and [redacted]. A mandated reporter from the children's school made a call to MDHHS Centralized Intake with concerns [redacted] was not getting the medical treatment he needed, advising his blood sugars were regularly over 200 and sometimes up to 400[2]. The mandated reporter said [redacted] and [redacted] were home a lot due to [redacted] working, and [redacted] was not checking [redacted]'s blood sugar levels as she should. The reporting source had additional concerns [redacted] and [redacted] had unaddressed mental health problems that included suicidal ideations.

On February 11, 2021, CPS interviewed the reporting source and learned [redacted] and [redacted] had missed a "significant" amount of school. The reporting source also explained [redacted] and [redacted] were living with their aunt in Indiana. The mandated reporter informed CPS that [redacted]'s sugar levels were "sometimes at 400" and a staff member at the school tracked [redacted]'s sugar levels. CPS was advised [redacted] receives special education services for a learning disability and speech impairment.

On the same day, CPS made an unannounced visit to the family's home. Case file records show [redacted] refused to allow CPS into the home, advising she had not had time to clean. [redacted] also told

[2] According to the May Clinic the goal is to keep daytime blood sugar levels between 80 and 130 mg/dl, and after-meal numbers should be no higher than 180 mg/dl.

CPS the pipes were frozen, so the home had no water for about a week. CPS documented this was the reason why [redacted] and [redacted] were residing with their aunt, [redacted], in Indiana. [redacted] agreed CPS could come back to the home five days later, on February 16, 2020, to see the inside of the home. CPS informed [redacted] about the new complaint and the concerns. [redacted] confirmed [redacted] was diabetic, but said he had everything he needed to take care of it. The OCA could not find documentation in CPS records indicating they confirmed or reviewed what [redacted] used to care for his diabetes. The only documentation found by the OCA was [redacted] took "medications." [redacted] told CPS she is not regularly able to check [redacted]'s blood sugar every day because of her work schedule, but her sister was checking it. Case file records show [redacted] told CPS, that [redacted] and [redacted] only missed school when they were sick or when they were with their aunt. [redacted] also confirmed both boys had been depressed and expressed suicidal ideations. Records show [redacted] indicated she was taking [redacted] and [redacted] to their physician to address the suicidal comments. [redacted] admitted she had a domestic violence history with [redacted], advising CPS that [redacted] was not living in the family home and that he had not seen the children since November 2020.

[redacted] agreed to a safety plan of monitoring the children to avoid suicide attempts, giving [redacted] his diabetes medication, and monitoring [redacted]'s blood sugar level. The safety plan also indicated that [redacted] and [redacted] would continue to live with their aunt until the frozen pipes were repaired. Before CPS left the home, [redacted]'s sister, [redacted], arrived at the home without [redacted] and [redacted]. CPS spoke to [redacted] who explained [redacted] and [redacted] were at her home in Indiana. [redacted] agreed to the same safety plan as [redacted]. Following the home visit, the case manager requested Indiana CPS interview [redacted] and [redacted] at [redacted]'s.

As part of the CPS investigation, CPS contacted Southwestern Medical Clinic the following day, February 12, 2021. Clinic staff told CPS [redacted] was last seen a year ago on February 28, 2020. The clinic staff also told CPS [redacted] was last seen on April 3, 2020, for anxiety and he had been prescribed Zoloft. CPS was informed both [redacted] and [redacted] had an upcoming appointment on February 15, 2021, to help the family find therapy for the boys. The clinic staff explained there were no documented concerns about abuse and/or neglect in their records. The CPS report does not document any mention of [redacted]'s diabetes being discussed with the clinic staff.

CPS interviewed [redacted] via telephone on February 12, 2021. [redacted] confirmed he did not live in [redacted]'s home. CPS case records show [redacted] informed CPS that [redacted] checks his blood sugar four times a day and that [redacted] sometimes forgets. There is no documentation of how anyone else manages [redacted]'s diabetes or what he does if his sugar levels are too high or too low. Case file records show CPS also safety planned with [redacted] to "monitor [redacted]'s blood sugar when he can" and to monitor the boys to "prevent suicide attempts."

Indiana CPS notified Michigan CPS that they (Indiana CPS) had interviewed [redacted] ([redacted] and [redacted]'s aunt) and had verified the well-being of [redacted] and [redacted] on February 12, 2021. This was documented in an email. The email states [redacted] told Indiana CPS she was diabetic and was teaching [redacted] how to care for his diabetes and give himself his insulin shots. [redacted] confirmed that both boys had an appointment with Southwestern Medical Clinic for their depression on February 15, 2021. [redacted] told Indiana CPS both [redacted] and [redacted] were doing online schooling. A safety plan was established with [redacted] to "make sure" the children were in a "safe environment" and that she would "continue to meet their medical and mental needs." It is documented in the CPS investigation report, that Indiana CPS briefly spoke with [redacted] and [redacted] when at [redacted]'s home. The case file indicates [redacted] and [redacted] confirmed they don't go to school or do their schoolwork as they should. Records show [redacted] told Indiana CPS, that [redacted] was "helping him learn how to manage his [d]iabetes."

On February 22, 2021, CPS spoke with both [redacted] and [redacted] over the telephone. CPS safety

planned with both boys to "talk with someone if [they] feel the need to harm [themselves]" and to work on keeping their bedrooms clean.

CPS talked with [redacted] again about [redacted]'s diabetes on March 10, 2021. [redacted] told CPS that [redacted] knows how to take care of his diabetes and he learned how to do so from Helen DeVos Children's Hospital. She went over when [redacted] tests his blood sugar during the day with CPS. There is no documentation by CPS of any further details or actions regarding how [redacted]'s family provided care for [redacted]'s diabetes.

On March 11, 2021, CPS obtained medical records from Lakeland Healthcare for [redacted] and [redacted]. Lakeland Healthcare records were requested as this health system provided some healthcare for [redacted] and [redacted]. Through these records, CPS confirmed that [redacted] was taking medications for anxiety and [redacted] had several different insulin medications to treat his diabetes. CPS also followed up with [redacted] via phone regarding the boys' mental health needs, as [redacted] and [redacted] were back in her care. [redacted] told CPS she would be taking the children to a "Riverwood counselor" to address those needs. CPS attempted to safety plan with [redacted] regarding [redacted]'s diabetes, suggesting she have [redacted] make a chart or enter it on a calendar when he tests his blood sugar. [redacted] responded to CPS that [redacted] had a built-in alarm on his insulin pump to advise him when to check his blood sugar. She advised CPS the pump was connected to her cell phone via Bluetooth and agreed to verify [redacted]'s blood sugar results daily.

On March 15, 2021, CPS concluded the investigation as a Category IV finding no preponderance of evidence existed that [redacted] medically or physically neglected [redacted] or [redacted]. The CPS investigation report did not document the reason behind this disposition.

During the OCA's investigation, the OCA discovered CPS did not find a preponderance of evidence supporting medical neglect regarding [redacted]'s diabetes because [redacted] knew how to treat his diabetes, had taken a class, and the medical records obtained did not document a concern for abuse or neglect. Both [redacted] and [redacted] were enrolled in counseling services addressing their mental health needs, leading CPS to not make a finding of medical neglect. CPS believed [redacted] was mature enough and had the knowledge to care for his diabetes on his own.

CPS contacted several individuals who had some knowledge of [redacted]'s diabetic needs. However, CPS did not obtain definitive answers from any of the individuals on whether there was a concern for abuse or neglect relating to [redacted]'s diabetic needs, whether his parents were able to meet his diabetic needs, or whether [redacted] had any unmet needs related to his diabetes. Although CPS was aware that [redacted]'s school paraprofessional maintained a log of [redacted]'s glucose test results, CPS did not speak with the paraprofessional as this was overlooked.

The OCA investigator discovered CPS did not speak with any doctor treating [redacted] regarding his medical needs. The medical records showing [redacted] had diabetes were obtained by CPS which documented no concern for abuse or neglect. This was believed to be enough information along with what the family told CPS, to say [redacted]n's diabetic needs were being met. The OCA received evidence that indicates CPS was unaware [redacted] was being seen by an endocrinologist at Helen DeVos Children's Hospital for his diabetes care.

<u>Diabetes Type 1 Mellitus:</u>

The following information is provided to give context to the amount of responsibility placed on 11-year-old [redacted].

According to the National Institutes of Health (NIH) National Center for Biotechnology Information (NCBI), "Type 1 diabetes mellitus (T1D) is an autoimmune disease that leads to the destruction of insulin-producing pancreatic beta cells. Individuals with T1D require life-long insulin replacement with multiple daily insulin injections daily [sic], insulin pump therapy, or the use of an automated insulin delivery system. Without insulin, diabetic ketoacidosis (DKA) develops and is life-threatening. In addition to insulin therapy, glucose monitoring with (preferably) a continuous glucose monitor (CGM) and a blood glucose monitor if CGM is unavailable is recommended. Self-management education and support should include training on monitoring, insulin administration, ketone testing when indicated, nutrition including carbohydrate estimates, physical activity, ways of avoiding and treating hypoglycemia, and use of sick day rules. Psychosocial issues also need to be recognized and addressed."[3]

The NIH NCBI describes the care of T1D; "Self-management of T1D includes administering insulin multiple times daily with glucose monitoring and attention to food intake and physical activity every day, which is a considerable burden. Whereas newer technologies have helped people improve their glycemic control, they are costly, complex, and require education and training. Many people with diabetes fear hypoglycemia, hyperglycemia, and the development of complications, and depression, anxiety, and eating disorders can develop. The medical, education, training, psychological, and social challenges faced by people with T1D daily are best addressed by an interprofessional team that includes clinicians (MDs, DOs, NPs, and PAs), nurses (including diabetes nurse educators), pharmacists, dieticians, mental health professionals, social workers, podiatrists, and the use of community resources. Individualized treatment approaches, which can reduce the burden and further improve outcomes, are needed, and the interprofessional care model will yield the best possible patient outcomes."[4]

Review of CPS Investigation Regarding [redacted]'s Death, November 2021:

On November 19, 2021, [redacted] became ill and was vomiting. His blood sugar levels were between 300 and 400. On November 20, 2021, at 8:00 am, [redacted]'s blood sugar level reached 600. Medical attention was not sought for [redacted] until 8:30 pm that day, after [redacted] was found unconscious, with no pulse, and was blue. Medical professionals were able to resuscitate [redacted], and he was taken to the hospital where he was in critical condition. Law enforcement contacted MDHHS Centralized Intake on November 21, 2021. MDHHS Centralized Intake was also advised by law enforcement the home where [redacted] was found was "deplorable" with rats, bed bugs, and human and dog feces on the floor and in the beds. This was assigned to Berrien County CPS for investigation.

On November 21, 2021, CPS spoke with a Michigan State Police (MSP) trooper. The trooper advised he responded to the family's home after [redacted] was found unresponsive, and it seemed like [redacted] was doing his own testing and administration of insulin. On the same day, [redacted] was seen by CPS at Helen DeVos Children's Hospital. CPS was informed by hospital staff [redacted] was not expected to recover and he would likely pass away. Medical staff advised CPS that [redacted] did not take any responsibility for [redacted]'s condition, stating [redacted] knew how to monitor his diabetes so this should not have happened.

On November 22, 2021, CPS spoke to the social worker at the hospital, advising CPS needed to know if [redacted]'s current "medical state is a result of the parent's failure to follow through with medical care." The social worker told CPS that [redacted]'s treating physician would likely not say this. CPS was also advised [redacted] was last seen by his primary endocrinologist on May 3, 2021. CPS contacted Southwestern Medical Clinic who advised [redacted] was last seen by the clinic on February 15, 2021.

[3] https://www.ncbi.nlm.nih.gov/books/NBK507713/
[4] https://www.ncbi.nlm.nih.gov/books/NBK507713/

Clinic staff informed CPS, that [redacted]'s parents had not called regarding any illness, and if they had, the parents would have been advised to take [redacted] to the emergency room. Later during the same day (November 22, 2021), CPS spoke with the hospital social worker again, who advised [redacted] was taken off life support and had died. CPS asked, "if medical doctors could state that the current medical state of [redacted] was a direct result of neglect." CPS was told "they could neither confirm nor deny" this.

On December 3, 2021, CPS interviewed [redacted] regarding the events that led up to [redacted] being found unresponsive. [redacted] stated on Thursday, November 18, 2021, [redacted] was not feeling well and when they checked his sugar levels it was reading 600. In response, [redacted] gave himself some insulin and went to sleep. [redacted] told CPS that the next day, Friday the 19th, [redacted] was still not feeling well, his sugar levels were still high, so he gave himself more insulin. [redacted] got home from work that day around 5:00 pm and [redacted] was still not feeling well. [redacted] advised she made dinner and shortly after eating, [redacted] threw up. [redacted] told CPS they checked his levels which were still high, so she gave [redacted] "medicine to try to get it lower" and he went to bed. CPS was informed by [redacted] that at 4:20 am on Saturday (November 20, 2021), [redacted] woke her up stating he was still not feeling well. [redacted] wanted her to stay home from work, but she told him she couldn't. [redacted] advised she went to work and ten minutes into her shift [redacted] called her telling her he wasn't feeling good. [redacted] told him to wake up his father and brother for assistance. [redacted] advised getting off work at 3:00 pm and [redacted] was still sick with high blood sugar levels. [redacted] told CPS she was taught by Helen DeVos Children's Hospital that if his levels were high, to up the dose of insulin until it came back down, so that is what they did. [redacted] then went back to bed. [redacted] told CPS she checked on him at 5 pm and he was still sleeping. She checked on him again at 7 pm and this is when he was found unresponsive. [redacted] told CPS she called her mother who told her to call 911, which is what she did.

After [redacted] passed away, [redacted] admitted to CPS [redacted] was last seen by his endocrinologist in February 2021, but he was supposed to be seen every three months. [redacted] informed CPS about the appointment in February stating [redacted]'s A1C[5] levels were high. CPS asked [redacted] if she had called any doctors regarding [redacted]'s condition over the past few days. She said she did not. When CPS asked why, [redacted] said because she had been trained by Helen DeVos Children's Hospital on what to do when [redacted]'s levels were high and that is what she did. CPS asked [redacted] if [redacted] was on any special type of diet due to his diabetes and she said he was not and could eat whatever he wanted.

On December 7, 2021, CPS spoke with the endocrinology department at Helen DeVos Children's Hospital. CPS was told [redacted] was supposed to be seen every three months and was a no-show for appointments in August and November 2021. Hospital staff advised CPS, they had sent letters and text messages to [redacted] reminding her of the appointments. CPS was told the only contact [redacted] had with the hospital since May 2021 was on September 6 when she called about getting a refill for [redacted]'s insulin. CPS asked if they would be able to read [redacted]'s insulin pump but was informed, they could not as the police had it.

[redacted] was interviewed by CPS on December 10, 2021. [redacted] also confirmed the series of events between November 18, 2021, and November 20, 2021, previously described by [redacted]. CPS asked [redacted] if he or [redacted] ever called a doctor about [redacted]'s condition while he was sick. [redacted] informed CPS they did not contact a doctor. CPS asked [redacted] if he was aware [redacted] needed to be

[5] According to the Centers for Disease Control, the A1C test is or hemoglobin A1C, or HbA1c test, is a blood test that measures an individual's average blood sugar levels over the past 3 months and is also the main test to help you and your health care team manage your diabetes. Additionally, higher A1C levels are linked to diabetes complications, so reaching and maintaining your individual A1C goal is important if you have diabetes.

seen every three months by the endocrinologist. [redacted] denied knowing this and denied ever seeing any letters or anything else from the endocrinologist about [redacted] having appointments.

On January 4, 2022, CPS learned from [redacted]'s death certificate that the cause of his death was multi-organ failure and cardiac arrest from an unclear etiology. Contributing factors to his death were his diabetes and obesity. His manner of death was listed as natural. CPS documented receiving [redacted]'s autopsy report on March 1, 2022, and noted the findings suggest "bronchopneumonia as the etiology for demise, complicated by underlying diabetes."

CPS tried to speak with [redacted]'s endocrinologist on March 2, 2022. They were told that "doctors do not normally call or talk to anyone on the phone." When CPS told her they needed to speak with the doctor regarding the death of one of his patients, they took CPS' information for a return call. There is no documentation CPS ever spoke with [redacted]'s endocrinologist.

The investigation was concluded as a Category II, with a preponderance of evidence supporting improper supervision, physical neglect, and threatened harm to [redacted] and [redacted] by their parents. This finding was based on the "deplorable" conditions of the family home. CPS did not find a preponderance of evidence to support the medical neglect of [redacted] by his parents. CPS documented this finding because "no medical documentation [was] found that failing to attend [missed doctor's] appointments or seeking medical treatment before [redacted]'s death was a result of his death." The investigation conclusion documented CPS tried to speak with doctors about [redacted]'s death, and whether the parents' failure to attend doctors' appointments and seek medical attention when [redacted] was sick contributed to his death, but the doctors were non-cooperative. The investigation was opened for monitoring and the family was referred to Families First services and psychological evaluations.

During the OCA's investigation, the OCA investigator was told CPS did not substantiate the parents' medical neglect of [redacted] as no doctor could inform CPS that medical neglect was involved in his death. The OCA was able to confirm that CPS did not speak with [redacted]'s endocrinologist.

The OCA obtained [redacted]'s medical records from his endocrinologist. These medical records show several missed appointments, and that [redacted] had not been seen by his endocrinologist since May 2, 2021. [redacted] was due to be seen in August 2021 but did not show up for the appointment, and the family did not respond to calls or letters regarding rescheduling the appointment. The OCA was provided information that [redacted]'s A1C levels were typically between 10 and 12, meaning [redacted] and his parents were non-compliant with treating his diabetes, and were not following the instructions provided by the endocrinologist's office.

The OCA was informed by [redacted]'s endocrinologist that the family was mostly compliant with appointments, however, [redacted]'s AIC levels show his family was not compliant with treating his diabetes. The OCA was informed that had CPS called to ask about [redacted]'s care in the investigations before his death, CPS would have been provided the same information. The OCA was further informed that the parents not calling regarding [redacted] being ill was neglectful of his medical needs. It was explained that part of the sick day rules, due to diabetes, was to reach out to the doctor whenever [redacted] was sick. The OCA was informed there was no record of [redacted]'s parents ever contacting [redacted]'s endocrinologist's office regarding his illness. After [redacted]'s death, the endocrinologist attempted to call CPS back but received no response. If CPS had spoken with the endocrinologist, CPS would have been informed the parents were neglectful of [redacted]'s medical needs.

The OCA was provided with "Sick Day Rules" for every family of a child with diabetes. These rules were provided by [redacted]'s endocrinologist's office. The rules state the emergency on-call number

should be contacted if the child has ketones; if the child has vomiting or is unable to eat/drink normally; the child has symptoms of ketoacidosis, high blood sugar plus nausea, abdominal pain, drowsiness, confusion, deep rapid breathing or fruity breath; the child's blood sugar is running high or low (especially if no appetite during illness); adding the parent will need to help with insulin dosing, and to call before the usual dose or if you have questions or concerns.

CPS Policy Manual Research:

The OCA reviewed historical policy concerning children with medical conditions as part of this OCA investigation. In prior years, CPS policy referred to children with medical conditions as medically fragile children. Policy language shifted over the years, as detailed below, and now refers to children with medical conditions as vulnerable children. An overview of these changes is summarized below.

CPS policy, PSM 713-04 Medical Examination and Assessment, dated May 1, 2016, identifies that medically fragile children "are particularly vulnerable to abuse and neglect; therefore, a worker's observation of a medically fragile child is not sufficient to determine whether the child's special needs are being met."

This 2016 CPS policy further explains that regardless of the allegations, "when investigating complaints which include a child who is physically or developmentally disabled or has a chronic medical and/or mental health condition, the worker is required to make collateral contacts with medical, school and other community resources who are knowledgeable about the child's needs." The purpose of these contacts is to assist in evaluating potential safety and risk factors in the home. If these collateral contacts do not assist in determining if the child's needs are being met, then a "medical examination is required." Additionally, the policy states that "when an allegation is made that a medically fragile child's needs are not being met by the caregiver, contact with the child's primary doctor to evaluate the child's care is required." The CPS investigation report must then document the assessment of the caregiver's ability to meet the needs both physical and medical of the child.

CPS policy PSM 713-04 Medical Examination and Assessment was changed on May 1, 2018. The medically fragile children section was updated. The policy continued to state that observation alone of a medically fragile child is insufficient when determining if the child's needs are being met. The policy states "A caseworker must contact the child's primary care physician when it is alleged that a medically fragile child has unmet medical, health or safety needs."

The 2018 policy stated that collateral contacts are required in investigations involving a medically fragile child if the child meets any of the following criteria:

- Physically disabled.
- Developmentally disabled.
- Inability to verbally express themselves.
- Has a chronic medical condition.
- Has a diagnosed or reported mental health condition.

Policy details that after case assignment, the caseworker must make the collateral contacts as soon as possible to assess the child's needs. These collateral contacts include:

- Medical professionals, such as, primary care physician.
- A school or day care if enrolled.
- Other community resources knowledgeable of the child's needs.

PSM 713-04 continues to state that if the collateral contacts do not enable the caseworker to determine whether the child has been abused or neglected, "a medical examination is **required**." The caseworker must document the caretaker's ability to meet the needs of the medically fragile child in social work contacts in MiSACWIS.

CPS policy PSM 713-04 Medical Examination and Assessment was again changed on August 1, 2019. This policy switched from medically fragile children to vulnerable children. The policy states that "children may be at a greater risk of abuse or neglect based on various factors including age, developmental ability, physical health or mental health considerations."

After August 1, 2019, CPS policy outlines that…
"A child is considered a vulnerable child if they are:

- Diagnosed with a physical or developmental disability
- Have a chronic health condition such as asthma or diabetes.
- Diagnosed or reported to have mental health concerns.
- Under the age of two.

When an allegation involves a vulnerable child, the caseworker must **contact one or more individuals with knowledge of the child's needs**. Caseworkers should also obtain and document the following information:

- Concerns regarding potential child abuse or neglect.
- The caregiver's ability to meet the needs of the child.
- If the child has any unmet medical, mental health, or safety needs."

The August 1, 2019, policy change removed the requirement for a medical examination if the caseworker was unable to obtain an assessment of the caregiver's ability to meet the child's needs from collateral contacts made. The 2019 policy change also eliminated the need to contact medical professionals, changing the wording to, “contact one or more individuals with knowledge of the child’s needs”, as bolded above.

Effective August 1, 2023, the policy surrounding vulnerable children was moved to PSM 713-01 CPS Investigation- General Instructions. This section of policy considers a child a vulnerable child if one of the following factors is true:

- **“Age 0-5 years.** Any child in the household five years of age or younger. Children in this age range are considered more vulnerable because they are less verbal and less able to protect themselves from harm...”
- **“Significant diagnosed or suspected medical or mental health concern.** Any child in the household has a diagnosed or suspected medical or mental health concern that significantly impairs the child’s ability to protect themselves from harm, or a diagnosis may not yet be confirmed, but preliminary indications are present, and testing/evaluation is in process OR the child is on a waitlist for evaluation. Examples include, but are not limited to, severe asthma, severe depression, and medically fragile (for example, requires assistive devices to sustain life).”
- **“Not readily visible in the community.** The child is isolated or less visible within the community (for example, the child may not have routine contact with people outside the household, and/or the child may not attend a public or private school and/or is not routinely involved in other activities within the community). Children who are less visible in their community are more likely to have signs of abuse/neglect go unnoticed or unreported, and they are less able to reach out to others for assistance.”

- **"Diminished developmental/cognitive capacity.** Any child in the household has diminished developmental/cognitive capacity that affects their ability to communicate verbally or to care for and protect themself from harm (for example, cannot communicate or defend themself, cannot get out of the house in an emergency if left unattended)."
- **"Diminished physical capacity**. Any child in the household has a physical condition/disability that affects their ability to protect themselves from harm (for example cannot run away or defend themself, cannot get out of the house in an emergency situation if left unattended.)"

This policy continues to state "When a child has been identified as vulnerable based on the above factors, **the case manager must contact one or more individuals**, excluding the perpetrator, with knowledge of the child's needs. Case managers should also obtain and document the following in a social work contact:

- Concerns regarding potential child abuse and/or neglect
- The caregiver's ability to meet the needs of the child.
- If the child has any unmet medical, mental health, or safety needs."

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 current policy surrounding Vulnerable Children is insufficient.

    a. In 2021 at the time of [redacted]'s death, the policy surrounding vulnerable children was in PSM 713-04 Medical Examination and Assessment.
    b. In 2023, the policy concerning vulnerable children was changed and moved to PSM 713-01.
    c. Currently, and in the investigations leading up to [redacted]'s death, CPS is only required to "**contact one or more individuals"** who are familiar with the child's condition.
    d. Current policy eliminates the requirement to speak with a medical provider… (…is not sufficient enough to protect our most vulnerable children.; …does not provide adequate information to keep children safe.;) and may leave a "vulnerable" child without the protection sought by Children's Protective Services.

2. The Child Advocate finds that [redacted] and [redacted] are responsible for medically neglecting [redacted] concerning his diabetic needs.

Recommendation(s):

1. The Child Advocate recommends MDHHS amend PSM 713-01 surrounding vulnerable children, to state the case manager **must contact and speak with the physician or medical personnel who are treating the vulnerable child's medical condition (or, who are the most knowledgeable about the medical condition…)**.

   This policy change would allow the case manager to ask a treating physician questions about whether or not the child's medical needs are being met, and if there are concerns for abuse and/or neglect.

2. The Child Advocate recommends that MDHHS change the disposition of the November 2021 CPS investigation concerning [redacted]'s death, to include medical neglect by his parents, because of failing to treat [redacted]'s diabetic needs.

Conclusion:

Under the authority provided to the Child Advocate in Michigan Law, 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. These recommendations may effectuate positive change and can improve the lives of similarly situated children involved in Michigan's child welfare system.

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

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

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

April 2, 2024

Ryan Speidel, Director
Office of Child Advocate
111 S. Capitol Avenue
Lansing, Michigan 48933

Dear Mr. Speidel:

The following is the Michigan Department of Health and Human Services (MDHHS) response to the findings and recommendations from the Office of Child Advocate (OCA) Report of Findings and Recommendations regarding [redacted].

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

Findings:

1. The Child Advocate finds current policy surrounding Vulnerable Children is insufficient.

    a. In 2021 at the time of [redacted]'s death, the policy surrounding vulnerable children was in PSM 713-04 Medical Examination and Assessment.
    b. In 2023, the policy concerning vulnerable children was changed and moved to PSM 713-01.
    c. Currently, and in the investigations leading up to [redacted]'s death, CPS is only required to "contact one or more individuals" who are familiar with the child's condition.
    d. Current policy eliminates the requirement to speak with a medical provider… (…is not sufficient enough to protect our most vulnerable children.; …does not provide adequate information to keep children safe. ;) and may leave a "vulnerable" child without the protection sought by Children's Protective Services.

MDHHS Response to Finding 1: Agree.

2. The Child Advocate finds that [redacted] and [redacted] are responsible for medically neglecting [redacted] concerning his diabetic needs.

MDHHS Response to Finding 2: Agree. Based on the information obtained by the Office of Child Advocate, a finding of medical neglect is appropriate.

Recommendation(s):

1. The Child Advocate recommends MDHHS amend PSM 713-01 surrounding vulnerable children, to state the case manager must contact and speak with the physician or medical personnel who are treating the vulnerable child's medical condition (or, who are the most knowledgeable about the medical condition…).

   This policy change would allow the case manager to ask a treating physician's questions about whether or not the child's medical needs are being met, and if there are concerns for abuse and/or neglect.

MDHHS Response to Recommendation 1: The vulnerable child policy was modified in 2019 from requiring contact with a medical professional to complete the assessment to contacting one or more individuals, excluding the perpetrator, with knowledge of the child's needs. This policy change was informed by feedback from medical providers and others, indicating the requirement was overwhelming and not achieving the intended outcome. While contacting a medical professional to complete the vulnerable child assessment is appropriate in the referenced case, there may be children considered vulnerable, who do not have a medical condition or require ongoing medical care outside of routine well-child visits. Contacting a medical professional in these cases may not provide the best insight into how well a parent or caregiver is meeting a child's needs and may inadvertently inundate medical providers and their offices, and unintentionally compromise child safety.

The Department recognizes there may be an opportunity to enhance this policy further for vulnerable children, specifically who have a significant or diagnosed medical condition, and will explore the requirement for CPS to make efforts to contact the treating provider for children who meet this criterion as part of the vulnerable child assessment. Any enhancements to this policy will be informed by medical professionals, child welfare staff and their supervisors, and other key stakeholders to help ensure the intended outcome is achieved.

2. The Child Advocate recommends that MDHHS change the disposition of the November 2021 CPS investigation concerning [redacted] [redacted]'s death, to include medical neglect by his parents, because of failing to treat [redacted]'s diabetic needs.

MDHHS Response to Recommendation 2: Agree. DHHS will amend the original investigation to reflect the new disposition.

Thank you for the opportunity to respond to this Report of Findings and Recommendations. If you have questions or concerns, please feel free to contact me.

Sincerely,

Demetrius Starling
Senior Deputy Director
Children's Services Administration