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GOVERNOR
OFFICE OF CHILDREN'S OMBUDSMAN
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Findings and Recommendations

Under state law a record of the Office of Children's Ombudsman's is confidential, is not subject to court subpoena, and is not discoverable in a legal proceeding. Additionally, a record of the Office of Children's Ombudsman's is exempt from disclosure under the Freedom of Information Act.

Date: October 12, 2023

Case No.: 2022-0076

Child: [redacted]

DOB: 03/05/2020

DOD: 05/03/2022

Summary:

The Office of Children's Ombudsman (OCO) is tasked with making recommendations to effect positive change in policy, procedure, and legislation. This is accomplished through independently investigating and reviewing actions of the Michigan Department of Health and Human Services (MDHHS), child placing agencies, or child caring institutions. The Children's Ombudsman Act, Public Act 204 of 1994, also requires the OCO ensure laws, rules, and policies pertaining to children's protective services (CPS), foster care, and adoption are being followed. The OCO is an autonomous entity, separate from the MDHHS.

The OCO review included reading confidential records and information in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), service reports, medical records, social work contacts, court documents, and law enforcement reports. The OCO also interviewed MDHHS staff and law enforcement personnel. Due to the confidentiality of OCO investigations, the OCO cannot disclose the identity of witnesses or complainants, or sources of statements and evidence.

The objective of this review is to identify areas for improvement in the child welfare system by looking at how CPS investigations involving [redacted] were handled by Wayne County CPS, and the involvement of staff, physicians, and law enforcement. This review reinforces that the safety and well-being of a child is the shared responsibility of the family, community, law enforcement and medical personnel aiding children and families. This report is not intended to place blame, but to highlight areas of concern regarding the handling of the investigations; inform policy, procedure, and practice of MDHHS and partners within the child welfare system; and to advocate for changes within it on behalf of similarly situated children.

On February 2, 2022, the OCO opened a full investigation following a complaint made to the Ombudsman expressing concern with statements made in the media that CPS failed [redacted] and his family. While the OCO was conducting its investigation into this complaint, [redacted] died on May 3, 2022. Pursuant to MCLA 722.627k, MDHHS did notify the OCO of the

child fatality. To provide context to the ombudsman's findings and recommendations, the following report summarizes the information and evidence found during the OCO investigation.

Background and History:

[redacted] and [redacted] are the birth parents of [redacted] and [redacted]. On January 1, 2022, [redacted] was arrested for the attempted murder of her children, [redacted], and [redacted] after she was found by the Inkster Police Department in the family's bathtub with the children. The children's throats had been cut and [redacted] was unresponsive. This led to both children being hospitalized and CPS became involved. CPS filed a termination of parental rights for both parents concerning the children. [redacted] became temporary court wards on January 7, 2022. [redacted] succumbed to his injuries on May 3, 2022.

The day after police found [redacted] and her children, January 2, 2022, statements were made to the media, by law enforcement, that CPS failed this family. The Inkster Police Department publicly stated [redacted] had a history of mental health problems, CPS had been involved with the family previously, and that CPS did not do enough to protect these children. A public complainant brought this case to the attention of the OCO asking if more could have been done on a systemic level in relation to law enforcement and mental health professionals' involvement.

The OCO investigation included reviews of the prior CPS history for the family, which included an investigation in 2018 and 2020. Both investigations surrounded concerns for [redacted]'s mental health.

Review of 2018 CPS Investigation:

December 12, 2018, was the first time CPS encountered the [redacted] family. A complaint was made to MDHHS centralized intake concerning improper supervision of [redacted] by [redacted]. [redacted] was six months old at the time of this complaint. Law Enforcement officers found [redacted] running down the street holding knives. During this incident, [redacted] was discovered in her car seat inside the family home and was taken to the police department. [redacted] became aggressive towards law enforcement and was petitioned to Garden City Hospital where she was sedated due to her aggressive behavior. CPS responded to the police station and assisted with making a safety plan for [redacted] to go home with maternal grandparents.

CPS conducted an interview with [redacted]'s father who is [redacted]'s husband, [redacted], at the police station. During this interview [redacted] informed CPS [redacted] was previously diagnosed with Bipolar, Post Traumatic Stress Disorder (PTSD), and Manic Depression. He informed CPS that [redacted] was not taking medications because she was breastfeeding [redacted]. [redacted] advised CPS [redacted] had been hospitalized in the past and was not involved in any counseling services. During this interview, [redacted] also informed CPS he was diagnosed with PTSD and depression. He advised receiving services at Psygenics Inc. and signed a release of information for CPS to speak with his counselor and psychiatrist. [redacted] agreed to allow [redacted] to stay with her maternal grandparents under a safety plan.

On December 13, 2018, CPS discovered that [redacted] was being transferred from Garden City Hospital to Behavioral Center of Michigan. The safety plan was also lifted on the 13th, and [redacted] was able to pick up [redacted] from the grandparents on December 14, 2018.

CPS' next contact was a home visit on December 21, 2018, where [redacted], [redacted] and [redacted] were present. [redacted] told CPS she was a good mother and denied that she would harm her child. [redacted] confirmed she was diagnosed with bipolar disorder with manic episodes, stating she has them once

per year. [redacted] advised she stopped taking her medications due to adverse side effects that they could have on [redacted] during breastfeeding. CPS asked her to schedule a counseling appointment and to inform her therapist and doctor of her concerns for side effects. [redacted] advised CPS she had been admitted to Stonecrest Behavioral Hospital for about four to five days after leaving Garden City Hospital. CPS did not develop a safety plan with the parents during this home visit.

On January 2, 2019, CPS spoke with [redacted] and again asked that [redacted] schedule an intake appointment to treat her mental health. On January 9, 2019, [redacted] informed CPS [redacted] scheduled an intake appointment with Psygenics Inc., and she can attend sessions with him to work on their communication skills. CPS called and spoke with [redacted]'s counselor, [redacted]. [redacted] was asked if [redacted] would be able to attend counseling sessions with [redacted] and [redacted] advised CPS that this was allowed. No further questions were inquired of [redacted] regarding [redacted], his treatment, or his compliance with his appointments.

CPS completed a Family Team Meeting (FTM) by phone with the parents. During this meeting a safety plan, in which [redacted] would attend the Psygenics Inc. intake appointment and take medications as prescribed, was agreed upon. CPS informed [redacted] that this was a serious matter and she needed to continue to address her mental health to avoid any future issues regarding child safety. The case was then concluded as a Category III Open/Close for a preponderance of evidence supporting improper supervision of [redacted] by [redacted]. CPS noted [redacted] had an upcoming counseling appointment for intake on February 11, 2019, and they provided the family with a community service pamphlet. The investigation was approved and closed on February 4, 2019.

During the OCO's review, the safety assessment for this CPS investigation noted that [redacted] was safe with no immediate harm factors identified. Based on the definitions, the OCO identified two immediate harm factors that could have been identified and explained. Number seven of the safety assessment, states "caretaker did not provide supervision necessary to protect the child from potentially serious harm." CPS' investigation found that [redacted] had left [redacted] alone in the home at six-months old, which is not providing the supervision necessary to protect her from potential serious harm. Number 14 of the safety assessment states "caretaker's emotional stability seriously affects their current ability to supervise, protect or care for the child." [redacted] had a mental health episode that left her unable to care for the child, resulting in her six-month old infant being left home alone.

The OCO's review of the risk assessment for the CPS investigation showed it was incorrectly scored, resulting in a low risk level. Question N1 of the risk assessment states: "current complaint and/or finding includes neglect" was marked 'no' and should have been marked 'yes' as improper supervision is neglect. In addition, CPS substantiated [redacted] for improper supervision, which is neglect. Question N6 states: "provides inadequate supervision of the child" was also scored 'no' and should have been marked yes. CPS found improper supervision as a six-month old child was left in the home alone, which is not appropriate for their safety, and could have resulted in harm to the child. Had these questions been answered appropriately, the risk level would have increased from low to moderate.

The risk assessment being scored low or moderate does not have an impact on this CPS investigation. The outcome would not have changed had the assessments been scored correctly. The inaccurate risk assessment score becomes important in future investigations as the accuracy of this assessment is relied upon to make future decisions. It is important that risk assessments are scored accurately as each investigation has the potential to impact future investigations.

Review of 2020 CPS Investigation:

The next time CPS became involved with the [redacted] family, was on May 17, 2020. [redacted] and [redacted] (father) now had a second child, [redacted] (child). [redacted], the couples first child was now two years old, and [redacted] d (child) was approximately two months old at the onset of this CPS case. The CPS investigation began due to concerns of improper supervision and physical neglect of [redacted] and [redacted] (child) by their parents. The concerns surrounded [redacted]'s mental health, noting she had schizophrenia and bipolar disorder, and had not been taking her medications. The complaint to MDHHS centralized intake stated two to three days prior to May 17, 2020, [redacted] had taken a pot of boiling hot water and poured it on her head. The complaint also stated [redacted] took a razor blade and used it to cut the back of her head. The same complaint stated [redacted] (father) did not call 911 when the incident occurred. [redacted]'s mother contacted 911 on May 17, 2020, after learning of the incident. EMS and law enforcement responded to the home, finding [redacted] in a catatonic state. She was transported to Garden City Hospital. [redacted] (father) refused to allow law enforcement officers to verify the safety of the children.

Due to the COVID-19 pandemic CPS spoke with [redacted] (father) via video chat on May 17, 2020. [redacted] confirmed [redacted] had a mental health episode and was transported to the hospital. He confirmed having the children in his care and allowed CPS to make face to face contact via video chat. CPS documented both children had no visible signs of abuse or neglect. [redacted] (father) advised he was not opposed to having CPS come to the home but due to COVID-19, he was not allowing anyone to enter. CPS made a safety plan surrounding safe sleep practices as [redacted] (child) during the video call. There is no documentation of a safety plan surrounding [redacted]'s mental health. It was noted in the CPS case file there was no safety plan needed due to [redacted] being admitted to the hospital.

From May 18, 2020, to May 27, 2020, CPS attempted contact with [redacted] (father) and [redacted], but were unsuccessful. CPS then contacted the Inkster Police Department to determine if any additional contact with the family had occurred and to inquire if Inkster police could complete a well-being check on the family. CPS did not document if law enforcement agreed to conduct a well-being check on the family or if one was completed. CPS continued attempting to contact the family via phone and in person from May 28, 2020, to May 30, 2020. These attempts were not successful.

During this timeframe CPS spoke with staff at Henry Ford Medical Center Pediatrics in Livonia. It was discovered there were no upcoming appointments for the family. CPS also learned the family was a no-show for their last scheduled appointment. Henry Ford Medical Center Pediatric staff informed CPS [redacted] (child) had never been seen at their facility and [redacted] had not been seen since October 11, 2019.

On May 31, 2020, CPS received a voice message from [redacted]. The CPS investigation report documents [redacted] stated she was still in the hospital; the children are being cared for by their father and are safe. [redacted] did not feel that "CPS was needed and does not understand why her [sic] child's father was being harassed while keeping the children safe." On the same day CPS conducted a home visit with a police officer from the Inkster Police Department. [redacted] (father) answered the door while holding his son ([redacted], child), and allowed [redacted] to come to the door to be seen by CPS. [redacted] (father) could not explain why he had not responded to CPS phone calls.

CPS attempted to obtain more information from [redacted]'s mother during the investigation, however, [redacted]'s mother refused to provide information, stating [redacted] was blaming her for CPS involvement. [redacted]'s mother advised she and [redacted] were not currently speaking.

CPS obtained medical records from Garden City Hospital for [redacted]. The medical records are documented to indicate [redacted] had risk factors of depression, psychosis, and schizophrenia; she was disheveled, had poor hygiene and was mumbling to herself. She was transferred to the burn unit at Detroit Medical Center due to second degree burns on her face, ear, and upper back. CPS made a collateral contact on June 10, 2020, with the inpatient social worker at Detroit Medical Center. The inpatient social worker advised CPS that [redacted] needed counseling and was referred to Hegira Health for outpatient services. The inpatient social worker did not believe [redacted] would harm her children and told CPS [redacted] promised to stop self-harming. CPS documented the social worker explained she did not have immediate concerns for the children but that the situation with [redacted] was "not perfect." CPS documented the social worker would not elaborate on what she meant by this statement but that the social worker emphasized [redacted] needed to get help.

CPS attempted contact with the family again on June 11, 2020. The family did not answer the door and law enforcement was requested to assist. Once law enforcement arrived, a white female, later identified as [redacted], opened the door, looked out and closed it. As CPS and police were about to leave the home, [redacted] (father) came to the window and said his children were fine. CPS asked for a good working phone number, to create a safety plan, and explained they wanted to verify the children were safe. [redacted] (father) brought [redacted] to the window, and she waved to CPS. [redacted] then began yelling at CPS that the baby was asleep, and they were not going to wake him up. The baby ([redacted], child) was not seen by CPS on this date. CPS documented they advised [redacted] (father) not to leave the children alone with [redacted] and that she needed to follow up with her mental health concerns. [redacted] (father) is documented telling CPS "[redacted] did not have mental health concerns", and he wanted CPS to leave. CPS again advised [redacted] (father) of his responsibility to make sure his children were safe, and he said he knew.

The investigation has no documented discussion with [redacted] about her follow up treatment to address her mental health. It is documented CPS sent a letter to [redacted] and [redacted] (father) on June 25, 2020, advising them the importance of providing safety and stability to the children and calling for assistance during a mental health episode. The report documents a community resource guide was included with each letter. The investigation was closed as a Category IV with no preponderance of evidence supporting physical neglect or improper supervision. The disposition documents the parents' refusal and lack of cooperation throughout the CPS investigation but that the children remained in the care of their father during the mental health episode. It was documented [redacted] was encouraged to follow through with mental health treatment.

During the OCO's review, the safety assessment was noted to mark number 15, "other" as yes with the explanation "based on past CPS and police intervention, the mother reportedly has a history of mental health concerns that may impact her ability to care for the children if she is the sole caregiver. The father has expressed to CPS that he is aware of the mother's needs, and he is present in the home and capable of providing daily care to his children. The family indicated they did not have a desire to cooperate with CPS or participate with any recommended services." To address this safety factor, CPS documented the use of "family resources, neighbors, and other individuals in the community as safety resources." CPS noted [redacted]'s mother was identified in medical records as a support for [redacted].

The contrary is documented when CPS answered the risk assessment question, N4 "Primary caretaker's social support, b. Limited or negative social support from relatives/friends/neighbors." CPS provided an explanation that [redacted] had limited social support as hospital records noted [redacted]'s support was her mother, however [redacted]'s mother informed CPS [redacted] had ended communication with her due to her hospitalization and CPS involvement.

In the safety assessment CPS could have marked question N14: "Caretaker(s) emotional stability seriously affects current ability to supervise, protect, or care for the child." [redacted] was diagnosed with psychosis, depression, anxiety, and schizophrenia. She had a mental health episode that involved pouring hot water on herself and cutting the back of her head with a razor blade. Her mental health status caused her to be hospitalized for inpatient treatment, leaving her unable to care, supervise or protect her children.

In review of the risk assessment, the OCO noted that CPS properly scored N7 pertaining to the primary caretaker currently having a mental health problem. CPS wrote '[redacted] has been diagnosed with psychosis, depression, anxiety, and schizophrenia. Due to the severe mental health [sic], [redacted] was referred to an outpatient program for continued care."

CPS scored "A10: All caretakers are motivated to improve parenting skills; b. Yes, caretakers are willing to participate in parenting skills program or other services to improve parenting or initiate appropriate services for parenting without referral by the department."

A10 should have been scored: "C. No, one or both caretakers need to improve parenting skills but refuse services." The parents were uncooperative with CPS and refused to participate in any services referred by the department. During CPS' last contact with [redacted] (father) and [redacted], [redacted] (father) stated "that [redacted] does not have mental health concerns." There is also no documented conversation with [redacted] regarding her mental health treatment or her willingness to participate in the outpatient services referred to her by the hospital. Both parents were uncooperative and told CPS to leave them alone.

CPS could have also then scored "A11 Primary caretaker views incident less seriously than the department." [redacted] was not taking responsibility for the incident, was refusing to speak to CPS about what happened, and [redacted] (father) stated [redacted] did not have any mental health concerns.

The OCO notes that this investigation was completed during the onset of the COVID-19 Pandemic. The OCO recognizes the barriers this created for CPS when working with families and addressing concerns of child abuse and neglect.

Additional Information:

Interview efforts were difficult for the OCO investigator due to the amount of time that expired between the 2018 CPS investigation and the OCO investigation. Additionally, some case managers are no longer employed with MDHHS and were unable to be located. Supervisors from both cases do not recall many details due to the long period of time since last interacting with these cases. MiSACWIS documentation is often the only evidence the OCO can rely on to draw conclusions about what actions were taken. The OCO found MiSACWIS documentation was lacking in several areas of the CPS investigations reviewed from 2018 and 2020.

Between June 2020 and January 2022 CPS did not have contact with the [redacted] family. During this 18-month period the Inkster Police Department responded to a call about domestic violence between [redacted] and [redacted] (father) where a child was involved. This occurred on March 13, 2019. The Inkster Police Department did not refer this incident to MDHHS Centralized Intake. Therefore, CPS was not involved.

Review of 2022 CPS investigation and [redacted]'s (child) death:

On January 1, 2022, and after 18 months of no interaction with the [redacted] family, CPS again became involved with the family. On January 1, 2022, law enforcement responded to the

[redacted] home to find [redacted] had stabbed and cut the throats of [redacted] and [redacted] (child). Both children were taken to Children's Hospital due to stab wounds and other injuries. [redacted] (child) had also been strangled and had to be intubated.

CPS spoke with medical staff and law enforcement during their investigation. CPS was informed [redacted] (child) was stabbed multiple times by his mother [redacted]. [redacted] (child) had to have surgery to repair his carotid arteries and was listed in critical condition as his injuries were life threatening. He also had multiple bruises to his neck, legs, face, arm, and hand. [redacted] had knife wounds to her neck and her face and was covered in bruises. [redacted] was released from the hospital and placed in the care of her maternal aunt, via a safety plan.

On the same day [redacted] (father) was involved in an unrelated car accident after he left the house on December 31, 2021, due to [redacted]'s erratic behavior. While being treated at the hospital [redacted] (father) was in a state of psychosis and was admitted to Pontiac General Hospital for mental health treatment. CPS interviewed [redacted] (father) in coordination with the Inkster Police Department. This is the first time [redacted] (father) was advised [redacted] harmed their children. [redacted] (father) told the interviewers [redacted] thought someone was coming through the windows or was watching the family. He left the home that evening at approximately 6 pm (December 31, 2021) to drive around and clear his head. [redacted] (father) explained [redacted] was "acting crazy and it threw him off his wagon."

CPS spoke with [redacted] at the jail after submitting a petition to the courts for removal of the children. [redacted] denied recalling what she did and told CPS, [redacted] (father) thought people were trying to kill him, and that he also had a nervous breakdown.

A preliminary hearing was held on February 8, 2022, regarding removal of the children from the home, suspending parenting time for both parents, and to order trauma assessments of the children. The petition also included a request for termination of parental rights for both children, listing both parents as respondents. This investigation was concluded as a Category I with a preponderance of evidence supporting threatened harm, physical abuse, and failure to protect. The CPS case manager documented no historical threatened harm was found; therefore, a threatened harm assessment was not completed. The safety and risk assessments appeared to be scored appropriately.

During the foster care case, [redacted]'s (child) condition continued to worsen. He was not able to breathe or eat without medical assistance and was experiencing seizures and brain hemorrhages. It was the opinion of medical providers that [redacted] would not recover from his injuries and would remain in a vegetative state. [redacted] (father) did not wish to give up on his son and continued life saving measures. [redacted] (child) was kept under life saving measures until his father made the decision to stop life support. [redacted] (child) succumbed to his injuries on May 3, 2022.

Additional Research:

During the OCO's investigation, additional research was made surrounding psychosis, assessing parental mental health, parental mental health's impact on children, and any additional steps that could be taken by CPS professionals when addressing these concerns.

Prior to researching the assessment of parental mental health and its impact on children, the OCO reviewed the definition of psychosis. The National Institute of Mental Health describes psychosis as a word used to "describe conditions that affect the mind, where there has been some loss of contact with reality. When someone becomes ill in this way it is called a psychotic episode. During a period of psychosis, a person's thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not. Symptoms of psychosis include delusions (false beliefs)

and hallucinations (seeing or hearing things that others do not see or hear)." Other symptoms include incoherent or nonsense speech, and behavior that is inappropriate for the situation. A person in a psychotic episode may also experience depression, anxiety, sleep problems, social withdrawal, lack of motivation, and difficulty functioning overall. A person in a psychotic episode may also "behave in confusing and unpredictable ways and may harm themselves or become threatening or violent towards others."[1]

The OCO reviewed multiple studies and peer reviewed published journals including an abstract published in the National Institute of Health's National Library of Medicine titled 'Maternal mental illness and the safety and stability of maltreated children'. The abstract cites 'Child Abuse; The International Journal', which is the official publication of the International Society for Prevention of Child Abuse and Neglect[2]. The international journal describes how mental illness often negatively influences parenting behavior placing child safety at risk due to many different factors. As an example, depression elevates the risk of coercive or hostile parenting and corporal punishment. Additionally, the journal explains that mothers with schizophrenia are less responsive and emotionally involved with their children compared to depressed mothers and mothers without mental illness stating further, "Mental illness is associated with heightened risk of child maltreatment. Analysis of the National Institute for Mental Health's Epidemiologic Catchment Area survey demonstrated that maternal depression places children at risk for abuse (Chaffin, Kelleher, & Hollenberg, 1996). Others have found a similar association between maternal depression and maltreatment (Kotch et al., 1999, Sheppard, 1997, Windham et al., 2004). Children of parents with depression or schizophrenia are 2 times more likely to experience abuse than children of parents without mental illness; children of parents with antisocial behavior are 6 times more likely to experience abuse (Walsh, MacMillan, & Jamieson, 2002). Parents with undifferentiated mental illness are also 2 times more likely to abuse and neglect their children (Brown, Cohen, Johnson, & Salzinger, 1998). This maltreatment risk suggests that a high proportion of mothers entering the child welfare system have a mental disorder."[3]. The journal continues to describe various types of parental mental health issues and the negative impacts on child safety and wellbeing, stating clearly that "Mental illness is associated with heightened risk of child maltreatment", and an "increased likelihood of foster care placement".

The peer reviewed journal, "Parental mental health: disruptions to parenting and outcomes for children"[4], was also reviewed and speaks to the connection between parental mental health, maternal depression and how this affects children's mental health during their development. It also speaks to the impacts on children by disruptions in parenting relating to mental illness as "parental mental illness will in most cases impair parenting ability." It was found that the "age of the child will largely determine their vulnerability or resilience to different disruptions in parenting behavior, or in their relationships with their parents." The journal explains mental health problems are "frequently associated with other family or environmental factors, such as marital disharmony, conflict and domestic violence, separation or divorce, other stressful life events, poverty, severe economic deprivation, and social isolation." These associated factors are often by themselves correlated with negative impacts on children without an association with parental mental health, suggesting that "they should be viewed somewhat differently from other disruptions to parenting."

This journal explored modifying interventions to reduce or minimize the disruptions to parenting

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[1] U.S. Department of Health and Human Services. (n.d.). Understanding psychosis. National Institute of Mental Health. https://www.nimh.nih.gov/health/publications/understanding-psychosis
[2] Science Direct Journal, 2023, Child Abuse & Neglect. https://www.sciencedirect.com/journal/child-abuse-and-neglect
[3] Child Abuse & Neglect Volume 35, Issue 5, May 2011, Pages 309-318. https://www.sciencedirect.com/science/article/abs/pii/S0145213411000706?via%3Dihub
[4] Smith, M. (2004), Parental mental health: disruptions to parenting and outcomes for children. Child & Family Social Work, 9: 3-11. https://doi.org/10.1111/j.1365-2206.2004.00312.x

resulting from mental health problems in one or both parents. The journal suggests that parenting supports should be aimed at minimizing disruptions to parenting should be "initiated preventatively, when the mental health problems become apparent in the parent, and before they become apparent in the child."

The journal also explored injuries to children when parental mental health is present in mothers. It found that children were "significantly more likely to have sustained more serious injuries if their mothers were depressed or had a history of depression or treatment of a psychiatric disorder."

Additionally, during the OCO's research, the OCO found other states include specific questions on their safety assessments when discussing a parent's mental health. New York CPS policy[5] safety assessment asks:

"5. Parent(s)'/Caretaker(s)' apparent or diagnosed medical or mental health status or developmental disability negatively impacts his/her ability to supervise, protect, and/ or care for the child(ren).

- Parent(s)/Caretaker(s) exhibits behavior that seems out of touch with reality, fanatical, bizarre, and/or extremely irrational.

- Parent(s)/Caretaker(s) diagnosed mental illness does not appear to be controlled by prescribed medication or they have discontinued prescribed medication without medical oversight and the parent/caretaker's reasoning, ability to supervise and protect the child appear to be seriously impaired.

- The parent(s)/caretaker(s) lacks or fails to utilize the necessary supports related to his/her developmental disability, which has resulted in serious harm to the child or is likely to seriously harm the child in the very near future."

Ohio CPS has similar wording within their CPS safety assessment. Ohio's safety assessment[6] asks:

"7. Behavior(s) of any member of the family or any person having access to the child is symptomatic of mental or physical illness or disability that suggests the child is in immediate danger of serious harm."

The guidance for this question continues stating "This safety factor evaluates if behaviors of any member of the family or any person having access to the child(ren) are symptomatic of a mental or physical illness or disability to the extent that the child(ren) is in immediate danger of serious harm. The evaluation includes whether a caretaker acts out or exhibits distorted perception which seriously impedes his/her ability to parent the child(ren). This safety factor takes into account whether a physical or psychological illness or impairment is present and profoundly impacts the caretaker's ability to meet the basic needs of the child(ren). Also included is an evaluation of whether an intellectually impaired adult places the child(ren) in physical danger and/or is able to recognize and provide for the child(ren)'s basic needs."

[5] New York State Child Protective Services Manual Chapter 6; https://ocfs.ny.gov/programs/cps/manual/2020/2020-CPS-Manual-Ch06-2020Mar.pdf
[6] Ohio Children's Protective Services Worker Manual, Assessing Safety; https://emanuals.jfs.ohio.gov/FamChild/CPSWM/Policy/Assessing-Safety.stm

Criminal Case Disposition:

According to the records of the Third Judicial Circuit Court of Michigan, on October 6, 2023, [redacted] was found not guilty of Homicide – Felony murder, Assault with intent to murder, and two counts of Child abuse – 1st Degree by reason of insanity.

Factual Findings:

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

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

The ombudsman believes their findings should be further considered by the department, and additional actions by MDHHS and other child welfare partners are necessary.

Findings:

1. The children's ombudsman finds the MDHHS CPS manual does not provide specific enough guidance to case managers regarding caretakers' and parents' mental health and its potential maltreatment of children in their care.

2. The children's ombudsman finds that the reviewed 2018 CPS investigation left questions unanswered surrounding [redacted] and [redacted]'s mental health. Additional contacts could have been made to determine if further services, support, or safety measures were needed.

    a. CPS did not put a safety plan into place when returning [redacted] to her father's custody. The children's ombudsman believes there could have been a safety plan put in place for father and [redacted] to help the father in the event [redacted] returns to the home and has another mental health experience that jeopardizes the health and safety of [redacted].

    b. CPS did not attempt any collateral contacts to determine if [redacted] completed her intake assessment and was treating her mental health appropriately.

        i. The children's ombudsman found [redacted] was a no show to two scheduled appointments at All Wellbeing Services in 2019 but was never actually seen by their agency.

    c. CPS did not obtain or review any mental health records or police reports.

    d. CPS did not obtain more information surrounding [redacted]'s mental health treatment, if he was compliant with services, or if there were any concerns for his parenting, when speaking with his counselor.

        i. During the OCO's investigation, it was discovered through requests for mental health records, that no records were able to be located for either [redacted] or [redacted] at Psygenics Inc. from 2018 to 2022.

ii. The children's ombudsman found that [redacted] was treated from April 4, 2018, to October 5, 2018, at the Team Wellness Center, for schizoaffective disorder, symptoms of depression and psychosis.

e. CPS did not properly score the safety and risk assessments.

3. The children's ombudsman finds CPS did not appropriately assess parental mental health during the 2020 CPS investigation.

   a. CPS did not interview [redacted] as [redacted] refused to cooperate with CPS.

   b. There is no evidence, written or verbal, that CPS asked questions of [redacted] regarding his ability to care for the children, or why he did not call for treatment of [redacted] when her episode of psychosis occurred. There is no evidence an adequate assessment of [redacted]'s ability to protect the children had taken place.

   c. There is no evidence of any attempted contact or documentation of attempted contact by CPS with outpatient services [redacted] was referred to upon her release from the hospital. Follow up with these service providers would have shed light on whether [redacted] had been attending follow up appointments and addressing her mental health needs.

      i. Through obtaining mental health and medical records, the OCO found that [redacted] was admitted voluntarily in April 2019 for her mental health. Records indicate she was treated for unspecified psychosis, rule or schizophrenia, and severe anxiety and depression.

      ii. [redacted] did participate in tele-health mental health treatment and medication reviews through Heigra Outpatient Services from June 15, 2020, to November 23, 2020.

   d. There is no evidence documenting communication between CPS and law enforcement occurred outside CPS requesting law enforcement assistance on home visits. If CPS had received the police reports and/or spoken with law enforcement about the family, or recent involvement with the family, perhaps CPS would have been informed of the domestic violence between [redacted] and [redacted] in 2019.

   e. CPS did not properly score the safety and risk assessments as the assessments contradicted one another.

   f. When documenting broad trends/patterns of any alleged or confirmed maltreatments, CPS stated "There is not a trend for the family, however there is a trend of improper supervision and threatened harm as it relates to [redacted]'s mental health."

   g. A threatened harm assessment did not occur surrounding [redacted]'s mental health as policy does not require one to occur.

4. The children's ombudsman finds staff within MDHHS do not believe CPS policy currently provides enough guidance and assistance on assessing parental mental health and its effects on child safety.

5. The children's ombudsman finds the COVID-19 pandemic further complicated matters in May 2020 due to delays with services being provided across the state and a lack of providers willing to accept new patients. Additionally, the OCO investigation found the amount of service providers who are available and willing to work with a family on an ongoing basis is lacking.

Recommendations:

In cases of parental mental health, particularly those with serious mental health diagnosis like psychosis and schizophrenia, incidents such as this tragic death of a child and injury to another, may not be 100% preventable, however, CPS can make amendments to policy to ensure that proper assessments and collateral contacts are being completed to help ensure families can remain safe together.

1. The children's ombudsman recommends MDHHS amend CPS policy 713-01, requiring caseworkers to make a collateral contact with mental health professionals when there is evidence of psychosis in a parent during a CPS investigation. This required contact would aid CPS in determining if mental health professionals believe the parent is compliant with treatment, services and if there is any concern for harm to the children.

2. The children's ombudsman recommends CPS policy manual define psychosis.

3. The children's ombudsman recommends MDHHS amend CPS policy 711-2 relating to threatened harm, expanding the definition of this to include the mental health of a parent. This can require a threatened harm assessment when the parent has history of mental health diagnosis in previous CPS investigations and the current case involves concerns relating to the parents' mental health and ability to meet the child's needs.

4. The children's ombudsman recommends CPS amend policy 713-11 pertaining to the threatened harm assessment. An amendment to require an assessment by the case manager when mental health is present in one or both caregivers and the prior history relates to concerns surrounding mental health. The threatened harm assessment would then require the worker to evaluate and assess the "severity of past behavior, length of time since past incident, evaluation of services, benefit from services (including if conditions have been rectified) and vulnerability of child(ren)." This information can aid CPS in comprehensively determining if threatened harm remains a factor for maltreatment and/or if CPS should request court involvement.

5. The OCO recommends CPS amend policy 713-11 to add a question to the safety assessment specifically surrounding parental mental health similar to those found in New York and Ohio CPS safety assessments.

Conclusion:

Pursuant to the Children's Ombudsman Act, MCL 722.903, the OCO respectfully submits this report of findings and recommendations.

It is important that the matters addressed in this report be further considered by MDHHS. If implemented, 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 respond to this report. The published report will include any statement of reasonable length made to the OCO by MDHHS in defense or mitigation of the action.

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

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

December 13, 2023

Ryan Speidel, Director
Office of Children's Ombudsman
111 S. Capitol Ave.
Lansing, MI 48933

Dear Mr. Speidel:

The following is the Michigan Department of Health and Human Services (MDHHS) response to the findings and recommendations from the Office of Children's Ombudsman (OCO) Report of Findings and Recommendations regarding [redacted].

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

Findings:

1. The children's ombudsman finds the MDHHS CPS manual does not provide specific enough guidance to case managers regarding caretakers' and parents' mental health and its potential maltreatment of children in their care.

   MDHHS Response to Finding 1: MDHHS agrees and will work with medical and mental health experts, other key stakeholders, and child welfare case managers and their supervisors to determine how to enhance CPS policy to offer more guidance to staff around assessing and responding to parents' and caregivers' mental health needs to help ensure child safety.

2. The children's ombudsman finds that the reviewed 2018 CPS investigation left questions unanswered surrounding [redacted] and [redacted]'s mental health. Additional contacts could have been made to determine if further services, support, or safety measures were needed.

   a. CPS did not put a safety plan into place when returning [redacted] to her father's custody. The children's ombudsman believes there could have been a safety plan put in place for father and [redacted] to help the father in the event [redacted] returns to the home and has another mental health experience that jeopardizes the health and safety of [redacted].

b. CPS did not attempt any collateral contacts to determine if [redacted] completed her intake assessment and was treating her mental health appropriately.

    i. The children's ombudsman found [redacted] was a no show to two scheduled appointments at All Wellbeing Services in 2019 but was never actually seen by their agency.

c. CPS did not obtain or review any mental health records or police reports.

d. CPS did not obtain more information surrounding [redacted]'s mental health treatment, if he was compliant with services, or if there were any concerns for his parenting, when speaking with his counselor.

    i. During the OCO's investigation, it was discovered through requests for mental health records, that no records were able to be located for either [redacted] or [redacted] at Psygenics Inc. from 2018 to 2022.

    ii. The children's ombudsman found that [redacted] was treated from April 4, 2018, to October 5, 2018, at the Team Wellness Center, for schizoaffective disorder, symptoms of depression and psychosis.

e. CPS did not properly score the safety and risk assessments.

MDHHS Response to Finding 2 a-e: Wayne County agrees with OCO findings 2 a-e. Wayne County acknowledges the importance of collateral contacts with mental health professionals in situations like the 2018 case. In 2023, in accordance with the MDHHS Keep Kids Safe Action Agenda, MDHHS implemented a critical case review process for cases with younger youth involved. In that process, upper management ensures collateral contacts are being made and risk is appropriately assessed.

3. The children's ombudsman finds CPS did not appropriately assess parental mental health during the 2020 CPS investigation.

    a. CPS did not interview [redacted] as [redacted] refused to cooperate with CPS.

    b. There is no evidence, written or verbal, that CPS asked questions of [redacted] regarding his ability to care for the children, or why he did not call for treatment of [redacted] when her episode of psychosis occurred. There is no evidence an adequate assessment of [redacted]'s ability to protect the children had taken place.

c. There is no evidence of any attempted contact or documentation of attempted contact by CPS with outpatient services [redacted] was referred to upon her release from the hospital. Follow up with these service providers would have shed light on whether [redacted] had been attending follow up appointments and addressing her mental health needs.

   i. Through obtaining mental health and medical records, the OCO found that [redacted] was admitted voluntarily in April 2019 for her mental health. Records indicate she was treated for unspecified psychosis, rule or schizophrenia, and severe anxiety and depression.

   ii. [redacted] did participate in tele-health mental health treatment and medication reviews through Heigra Outpatient Services from June 15, 2020, to November 23, 2020.

d. There is no evidence documenting communication between CPS and law enforcement occurred outside CPS requesting law enforcement assistance on home visits. If CPS had received the police reports and/or spoken with law enforcement about the family, or recent involvement with the family, perhaps CPS would have been informed of the domestic violence between [redacted] and [redacted] in 2019.

e. CPS did not properly score the safety and risk assessments as the assessments contradicted one another.

f. When documenting broad trends/patterns of any alleged or confirmed maltreatments, CPS stated “There is not a trend for the family, however there is a trend of improper supervision and threatened harm as it relates to [redacted]’s mental health.”

g. A threatened harm assessment did not occur surrounding [redacted]’s mental health as policy does not require one to occur.

MDHHS Response to Finding 3 a-g: Agree.

4. The children’s ombudsman finds staff within MDHHS do not believe CPS policy currently provides enough guidance and assistance on assessing parental mental health and its effects on child safety.

MDHHS Response to Finding 4: MDHHS agrees and will work with medical and mental health experts, other key stakeholders, and child welfare case

managers and their supervisors to determine how to enhance CPS policy to offer more guidance to staff around assessing and responding to parents' and caregivers' mental health needs to help ensure child safety.

5. The children's ombudsman finds the COVID-19 pandemic further complicated matters in May 2020 due to delays with services being provided across the state and a lack of providers willing to accept new patients. Additionally, the OCO investigation found the amount of service providers who are available and willing to work with a family on an ongoing basis is lacking.

   MDHHS Response to Finding 5: While MDHHS acknowledges the COVID-19 pandemic impacted most aspects of child welfare, including service provision, the department provided detailed practice guidance to staff at the very onset to help ensure child safety and meet the needs of children and families despite health concerns for staff, children, families, and service providers.

   MDHHS consistently seeks to expand mental health services and access for children and families and offer other prevention services and support.

   MDHHS reviewed and offered flexibilities post pandemic to decrease administrative burdens and increase behavioral health workforce. In March 2022, MDHHS created the Bureau of Children's Coordinated Health, Policy, and Supports, dedicated to addressing behavioral health needs of Michigan's children, youth, and their families. The Bureau is structured to support work related to children's behavioral health policy analysis and modification, expansion of access to services, data collection and continuous quality improvement, provision of evidence-based practices, partnership expansion with other child-serving agencies and organizations, and implementation of technical assistance and consultation for youth and families experiencing complex behavioral health challenges in the public mental health system.

   The Bureau of Children's Coordinated Health, Policy, and Supports also serves as the primary entity for development and management of Medicaid-funded home and community-based services for children, youth, and their families; implementation of a standard assessment process to determine eligibility and obtain access to behavioral health services; establishment of a public-facing dashboard to support transparency and decision making pertaining to specialty behavioral health services; and expansion of training and initiatives focused on growing the behavioral health workforce.

   Additional information regarding the bureau can be found at: Bureau of Children's Coordinated Health Policy & Supports (michigan.gov).

Recommendations:
In cases of parental mental health, particularly those with serious mental health diagnosis like psychosis and schizophrenia, incidents such as this tragic death of a child and injury to another, may not be 100% preventable, however, CPS can make amendments to policy to ensure that proper assessments and collateral contacts are being completed to help ensure families can remain safe together.

1. The children's ombudsman recommends MDHHS amend CPS policy 713-01, requiring caseworkers to make a collateral contact with mental health professionals when there is evidence of psychosis in a parent during a CPS investigation. This required contact would aid CPS in determining if mental health professionals believe the parent is compliant with treatment, services and if there is any concern for harm to the children.

   MDHHS Response to Recommendation 1: Current CPS policy does recommend case managers make collateral contacts to thoroughly assess child safety during an investigation, including contact with mental health providers. However, MDHHS will work with medical and mental health experts and other key stakeholders to determine when specific collateral contacts should be required based on the unique circumstances of a case to better assess a parents' and caregivers' mental health and the potential impact on safety. MDHHS is proactively working to identify behavioral health services across the state to better connect families to services.

2. The children's ombudsman recommends CPS policy manual define psychosis.

   MDHHS Response to Recommendation 2: MDHHS agrees and will work with mental health experts to define psychosis in CPS policy.

3. The children's ombudsman recommends MDHHS amend CPS policy 711-2 relating to threatened harm, expanding the definition of this to include the mental health of a parent. This can require a threatened harm assessment when the parent has history of mental health diagnosis in previous CPS investigations and the current case involves concerns relating to the parents' mental health and ability to meet the child's needs.

   MDHHS Response to Recommendation 3: MDHHS agrees and will review the current threatened harm assessment with medical and mental health experts, other key stakeholders, and child welfare case managers and their supervisors to determine how best to utilize the assessment in cases involving a parent or caregiver's mental health to ensure the safety and well-being of children. Policy will be updated to reflect any recommendations.

4. The children's ombudsman recommends CPS amend policy 713-11 pertaining to the threatened harm assessment. An amendment to require an assessment by the case manager when mental health is present in one or both caregivers and the prior history relates to concerns surrounding mental health. The threatened harm assessment would then require the worker to evaluate and assess the "severity of past behavior, length of time since past incident, evaluation of services, benefit from services (including if conditions have been rectified) and vulnerability of child(ren)." This information can aid CPS in comprehensively determining if threatened harm remains a factor for maltreatment and/or if CPS should request court involvement.

   MDHHS Response to Recommendation 4: MDHHS agrees and will review the current threatened harm assessment with medical and mental health experts, other key stakeholders, and child welfare case managers and their supervisors to determine how best to utilize the assessment in cases involving a parent or caregiver's mental health to ensure the safety and well-being of children. Policy will be updated to reflect any recommendations.

5. The OCO recommends CPS amend policy 713-11 to add a question to the safety assessment specifically surrounding parental mental health similar to those found in New York and Ohio CPS safety assessments.

   MDHHS Response to Recommendation 5: MDHHS is actively revising the department's safety assessment in partnership with Evident Change and will consider this recommendation during development. CPS policy will be amended to reflect the questions and other assessment items within the revised safety assessment upon completion.

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