STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR
OFFICE OF CHILDREN'S OMBUDSMAN
LANSING
RYAN SPEIDEL
CHILDREN'S OMBUDSMAN

Report of Findings and Recommendations Preamble

June 5, 2023

Office of Children's Ombudsman (OCO) Case No: CAS-02825-V7H4W6 (2018)

The attached report of findings and recommendations is being made public pursuant to the Children's Ombudsman Act.

The ombudsman shall not disclose information about an ongoing law enforcement or children's protective services investigation. The ombudsman may release the results of its investigation to a complainant or an individual not meeting the definition of the complainant if the ombudsman receives notification that releasing the results of its investigation is not related to and will not interfere with an ongoing law enforcement investigation or ongoing child protective services investigation.

In September 2019, the OCO was notified by the Ingham County Prosecutor's office that the results of the OCO investigation may interfere with the criminal case against Jessica Bice. On June 27, 2023, the Ingham County Prosecutor's office provided written notification that releasing the OCO report would not interfere with the criminal case.

A previous ombudsman authored the report of findings and recommendations. The report was not provided to MDHHS until a release was received and is now being made public as required under Michigan law.

As the children's ombudsman, I support the findings and recommendations made in this document.

Ryan J. Speidel
Children's Ombudsman

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Children's Ombudsman Report of 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: August 6, 2019

Case No.: CAS-02825-V7H4W6 (2018)

Child: [redacted]

DOB: August 28, 2011

DOD: August 17, 2018 (6 years old)

Summary:

[redacted] died on August 17, 2018. Pursuant to MCLA 722.627k, the Michigan Department of Health and Human Services (MDHHS) notified the Office of Children's Ombudsman (OCO) of the child fatality. On August 20, 2018, the OCO opened an investigation into the handling of Ingham County Children's Protective Services (CPS) and foster care (FC) cases pursuant to our statutory responsibilities.

The OCO reviewed confidential records and information in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), including but not limited to service reports, medical records, scene reenactment, and social work contacts. The OCO also spoke with MDHHS staff, [redacted]'s Lawyer-Guardian ad Litem, the Prosecuting Attorney, the law enforcement officer responsible for investigating [redacted]'s death, the Medical Examiner (ME), and medical personnel in [redacted]'s doctor's office.

The objective of this review was to identify areas for improvement in the child welfare system by looking at Ingham County's handling of this family's case and the involvement of staff, physicians, and law enforcement. This review reinforces the safety and well-being of a child is the shared responsibility of the family, community, and both law enforcement and medical personnel aiding children and families. It is not intended to place blame but to highlight areas of concern regarding the handling of this case and advocate for changes in the child welfare system on behalf of similarly situated children.

Family History:

[redacted] was born on August 28, 2011, and lived with his mother, [redacted] and father, [redacted] According to [redacted]'s medical records, he was diagnosed in June 2012 with multiple medical conditions, including infantilism, pediatric failure to thrive (FTT), and a myoneural disorder. In July of 2013, he was diagnosed with a congenital chromosomal disorder; in 2014, he was diagnosed with atopic dermatitis and allergic rhinitis. Ms. [redacted] committed suicide in June 2017.

After multiple unsuccessful threats and suicide attempts, [redacted] became the sole caregiver for [redacted]

In August 2017, Mr. [redacted] physically abused [redacted] and subsequently threatened suicide when faced with [redacted]'s removal. On August 8, 2017, [redacted] was removed from Mr. [redacted]'s care after a medical examination determined Mr. [redacted] physically abused [redacted] was placed with his paternal aunt, [redacted] and her six-year-old son [redacted] remained with Ms. [redacted] and [redacted] until August 17, 2018, when he died.

CPS Involvement with [redacted] prior to the Death of [redacted]

February 1, 2018, CPS Investigation:
A neglect complaint was made with allegations that Ms. [redacted] was physically neglecting [redacted] who was nonverbal with multiple impairments, by not properly cleaning and grooming him and not cleaning his wheelchair, which was covered in dried feces. It was also alleged that [redacted] had discharge from his ear and had an untreated rash on his face and buttocks. [redacted] was treated at Urgent Care for wax build-up in his left ear canal and a rash. The investigation allegations were unfounded, and he was released to Ms. [redacted] where he remained.

May 23, 2018, CPS Investigation:
A physical abuse complaint was made with allegations that Ms. [redacted] was physically abusive to [redacted] who reportedly had bruises on his back that appeared to resemble finger marks. [redacted] was medically examined at the hospital on May 24, 2018, by Dr. [redacted] Dr. [redacted] could not determine if the marks on [redacted] were from physical abuse. During this encounter, [redacted] weighed 47 pounds. Seven days later, during a follow-up appointment with his primary doctor, Dr. [redacted] [redacted] weighed 40 pounds. Dr. [redacted] did not report any concerns that Ms. [redacted] was abusive or neglectful. The investigation was concluded with no findings of abuse and noted there were significant concerns about Ms. [redacted]'s mental health that were to be addressed through foster care case management.

CPS Investigation concerning the Death of [redacted]

August 17, 2018, CPS investigation
On August 17, 2018, a CPS complaint was made that [redacted] was found not breathing and after CPR was unsuccessful, [redacted] was transported to the hospital, where he was pronounced deceased. An autopsy was completed by Pathologist Patrick Hansma, DO. At the time of his death, [redacted] weighed 29 pounds. Dr. Hansma determined that [redacted]'s death was a result of blunt force trauma to the head and neck, adding a contributing factor of caregiver neglect. [redacted] was emaciated consistent with ongoing undernutrition and his manner of death was classified as a homicide.

According to Dr. Hansma, it would have taken a period of two to three months for [redacted]'s weight to decline from 47 lbs. to 29 lbs., and had medical care been sought for him on or about July 26, 2018, the malnutrition could have been treated. The August 17, 2018, investigation was concluded as a category I with a preponderance of evidence being found for failure to protect, improper supervision, medical neglect, physical abuse, and threatened harm. Ms. [redacted]'s son, [redacted] was initially placed in a licensed foster home and subsequently transitioned to the home of his father. [redacted]'s foster care case was closed after his father was granted full custody of [redacted] A petition was filed on May 16, 2019, requesting termination of Ms. [redacted]'s parental rights to [redacted]

On June 10, 2019, Ms. [redacted] was criminally charged with first degree child abuse and open murder for [redacted]'s death. [redacted] was convicted of child abuse first degree and homicide second degree on June 20, 2023.

Foster Care Involvement Prior to Death of [redacted]

When [redacted] entered foster care in August 2017, he had already been diagnosed with a medical condition that considered him a medically fragile child[1]. Due to this, the OCO report concentrates on the foster care case in the months leading up to [redacted]'s death.

[redacted]'s foster care case was assigned to four foster care workers over the 12-month period [redacted] was in care. The first foster care worker (FCW) was assigned from August 11, 2017, through February 27, 2018. [redacted]r's case was reassigned to a second FCW from February 27, 2018, through March 6, 2018, and then re-assigned back to the first FCW from March 6, 2018, through April 6, 2018. The third FCW was assigned [redacted]'s case from April 6, 2018, through April 17, 2018, a total of eleven days. [redacted]'s case was assigned to a fourth and final FCW on April 17, 2018. [redacted]'s case remained with the fourth FCW until [redacted] died.

When [redacted]'s most recent FCW was assigned case responsibility, the FCW had recently begun employment with the State of Michigan, finished the minimum amount of general case management training with the Child Welfare Training Institute (CWTI), and was assigned a position with Ingham County MDHHS.

On June 6, 2018, a Family Team Meeting (FTM) was convened at the agency to discuss whether Ms. [redacted] would be medically cleared by her doctor to become licensed, obtaining an educational planner for [redacted] to address issues between the school and the aunt, and respite care for the summer through Community Mental Health. During this FTM, Ms. [redacted] was documented to be emotional and defensive, raising concerns for her mental stability. According to interviews conducted by the OCO, the team decided to request a voluntary psychological evaluation and drug screens or request they be court ordered if [redacted] did not agree to the evaluation and testing.

On June 15, 2018, [redacted]'s final foster care worker, the foster care supervisor, and the licensing worker were notified that Ms. [redacted]'s doctor, Dr. [redacted] expressed specific and direct concerns about her mental instability, possible drug use, that she should not have a special need's child in her care, and could not recommend Ms. [redacted] for foster home licensure. Specifically, Dr. [redacted] did not believe Ms. [redacted] should have another child in her care, besides her own, especially a special needs child, that he feared neglect, and had concern for mental instability. These concerns were indicators of substantial risk of harm to a vulnerable child. Despite having reasonable knowledge that continued placement in Ms. [redacted]'s home presented a substantial risk to [redacted]'s safety and well-being, at the permanency planning hearing (PPH) on June 21, 2018, the FCW testified, given [redacted]'s special needs, it would be unlikely another foster home would be located for placement. This hearing continued placement with Ms. [redacted] The plan for permanency remained reunification with his father, his placement was maintained, and the request for a court order forcing Ms. [redacted]'s participation in services was denied.

In 2018, foster care policy FOM 722-03 stated that a placement change is required if the current placement is considered harmful or is no longer in the child's best interest. When presented with information that [redacted] a medically fragile child, was at substantial risk based on the mental instability, possible drug use, and a medical opinion Ms. [redacted] should not have a child with special needs in her care, no definitive action for replacement was implemented. [redacted] remained with Ms. [redacted] until he was found deceased.

On July 26, 2018, the FCW documented an unannounced home visit with Ms. [redacted] and [redacted] was visually observed in a diaper while sitting in his stroller. The FCW did not

[1] June 2018: Medically Fragile Children, per MDHHS protective services manual, are considered children with chronic health conditions. The 2018 MDHHS foster care manual refers to these children as children with chronic health conditions. Current manuals refer to medically fragile children as "vulnerable children". The term medically fragile was removed from policy after 2018.

document any concerns or indicators of child abuse or neglect and instructed Ms. [redacted] to seek medical attention for [redacted] if she thought it was necessary since she reported that [redacted] was depressed and not eating.

[redacted] died on August 17, 2018, and at the time of his death, he weighed 29 pounds. According to the ME, if medical attention had been sought for [redacted] on or after July 26, 2018, [redacted] could have been treated for starvation. [redacted]'s foster care case was closed in September 2018 due to his death.

Relevant Policy Violations for Review:

Regarding the foster care case from August 2017 to August 2018

- FOM 722-03, Placement Selection and Standards, Reasons for Placement Change was not initiated on or after Dr. [redacted] reported Ms. [redacted] should not have a special needs child in her care.
- FOM 722-06H, Case Contacts, conference with supervision missed in September of 2017, all social work contacts not entered timely, and no monthly contact with the licensing worker.
- FOM 801, Health Services for Children in Foster Care, Chronic Health Concerns policy not documented as required. There was no contact by the caseworkers with [redacted]'s doctors regarding information in his medical reports.

Findings:

1. The OCO finds when [redacted] entered foster care in August 2017, he had already been diagnosed with infantilism, pediatric FTT, myoneural disorder, congenital chromosomal disease, atopic dermatitis, and allergic rhinitis. These conditions made him a medically fragile/vulnerable child with multiple chronic conditions.

2. The OCO finds from August 2017 through August 2018, [redacted] had four foster care workers assigned to his case during five separate occasions. The length of time the foster care workers assigned to [redacted] was six months, seven days, thirty days, eleven days, and four-and-one-half months respectively.

3. The OCO finds that when [redacted]'s most recent FCW was assigned case responsibility, he had recently begun employment with the State of Michigan, finished the minimum amount of general case management training with CWTI and was assigned a position with Ingham County MDHHS.

4. The OCO finds between May 24, 2018, and his death on August 17, 2018, [redacted] had lost 38% of his body weight. One healthcare provider and the last foster care caseworker assigned to manage [redacted]'s case did not notice or express concern regarding the continued and extreme weight loss [redacted] at 6 years old, experienced before he died.

5. The OCO finds that Ingham County failed to comply with FOM 722-03. According to the May 2018 Maltreatment in Care (MIC) investigation report, the FCW, foster care supervisor, and licensing worker were notified on June 15, 2018, that Ms. [redacted]'s doctor, Dr. [redacted] expressed specific concerns about her mental instability, possible drug use, and that she should not have a special needs child in her care. Despite having reasonable knowledge that continued placement in Ms. [redacted]'s home presented a substantial risk to [redacted]'s safety and well-being, the FCW testified at the permanency planning hearing on June 21, 2018, it would be unlikely to find another foster home placement given [redacted]'s special needs. [redacted] remained in Ms. [redacted]'s care and custody, where he died without MDHHS initiating a change in placement.

Recommendation:

The OCO recommends MDHHS implement units within the Children's Services Agency that specialize in the handling of foster care cases involving vulnerable children. The OCO recommends that caseworkers assigned to vulnerable children's cases have a pre-determined minimum amount of case management experience, more specialized training, and a reduced number of cases. This may allow a case manager to service a vulnerable child more appropriately; document and ensure all their needs are being met; make the required contacts with medical professionals; identify and address all needs of the child and caregiver; document and accurately report all concerns of a child's placement to the court; and act upon information received which indicates a child's safety and wellbeing is at substantial risk in their current placement.

Furthermore, the OCO recommends that employees who staff the specialized unit have the proper experience and training to address the specific needs of children who are more vulnerable to child abuse and neglect.

Conclusion:

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

It is important that the matters addressed in this report be further considered by MDHHS. If implemented, the recommendation can effectuate positive change and 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

November 28, 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] [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 OCO finds when [redacted] entered foster care in August 2017, he had already been diagnosed with infantilism, pediatric FTT, myoneural disorder, congenital chromosomal disease, atopic dermatitis, and allergic rhinitis. These conditions made him a medically fragile/vulnerable child with multiple chronic conditions.

MDHHS Response to Finding 1: Agree.

2. The OCO finds from August 2017 through August 2018, [redacted] had four foster care workers assigned to his case during five separate occasions. The length of time the foster care workers assigned to [redacted] [redacted] was six months, seven days, thirty days, eleven days, and four-and-one-half months respectively.

MDHHS Response to Finding 2: Agree.

3. The OCO finds that when [redacted]s most recent FCW was assigned case responsibility, he had recently begun employment with the State of Michigan, finished the minimum amount of general case management training with CWTI and was assigned a position with Ingham County MDHHS.

MDHHS Response to Finding 3: Agree.

4. The OCO finds between May 24, 2018, and his death on August 17, 2018, [redacted] had lost 38% of his body weight. One healthcare provider and the last foster care caseworker assigned to manage [redacted]'s case did not notice or express concern regarding the continued and extreme weight loss [redacted] at 6 years old, experienced before he died.

MDHHS Response to Finding 4: Agree.

5. The OCO finds that Ingham County failed to comply with FOM 722-03. According to the May 2018 Maltreatment in Care (MIC) investigation report, the FCW, foster care supervisor, and licensing worker were notified on June 15, 2018, that Ms. [redacted]'s doctor, Dr. [redacted] expressed specific concerns about her mental instability, possible drug use, and that she should not have a special needs child in her care. Despite having reasonable knowledge that continued placement in Ms. [redacted]'s home presented a substantial risk to [redacted]'s safety and well-being, the FCW testified at the permanency planning hearing on June 21, 2018, it would be unlikely to find another foster home placement given [redacted]'s special needs. [redacted] remained in Ms. [redacted]'s care and custody, where he died without MDHHS initiating a change in placement.

MDHHS Response to Finding 5: Agree.

Recommendation:

The OCO recommends MDHHS implement units within the Children's Services Agency that specialize in the handling of foster care cases involving vulnerable children. The OCO recommends that caseworkers assigned to vulnerable children's cases have a pre-determined minimum amount of case management experience, more specialized training, and a reduced number of cases. This may allow a case manager to service a vulnerable child more appropriately; document and ensure all their needs are being met; make the required contacts with medical professionals; identify and address all needs of the child and caregiver; document and accurately report all concerns of a child's placement to the court; and act upon information received which indicates a child's safety and wellbeing is at substantial risk in their current placement.

Furthermore, the OCO recommends that employees who staff the specialized unit have the proper experience and training to address the specific needs of children who are more vulnerable to child abuse and neglect.

MDHHS Response to Recommendation: Agree, improvements are needed related to vulnerable children's cases, and this is currently being assessed, enhanced, and redesigned pertaining to how child welfare professionals, including supervisors and specialists, are trained initially upon hiring into child welfare and continuously throughout their careers to improve interactions with children and families and strengthen teaming and engagement approaches.

Conclusion:

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

It is important that the matters addressed in this report be further considered by MDHHS. If implemented, the recommendation can effectuate positive change and 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.

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