



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
OFFICE OF CHILDREN'S OMBUDSMAN
LANSING

RYAN SPEIDEL
DIRECTOR

Report of:
Findings and Recommendations
Regarding the Michigan Department of Health and Human Services involvement with
[REDACTED]
DOB: [REDACTED] DOD: 05/01/2020

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Date: 3-Dec-2020

Case No.: 2020-0036

Summary:

[REDACTED] died on 05/01/2020. 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 05/06/2020, the OCO opened an investigation into the handling of this matter by Lakeside Academy for Children (Lakeside Academy) and MDHHS pursuant to our statutory responsibilities.

The OCO reviewed confidential records and information that was in MiSACWIS, which includes but is not limited to service reports, medical records, social work contacts, investigative reports, incident reports, video recordings, facility policies, facility training materials, and court orders. The OCO also spoke with [REDACTED]' foster care worker and the worker's supervisor, a maltreatment-in-care (MIC) worker and her supervisor, a licensing investigator and her supervisor, a Sequel Youth and Family Services¹ employee, and numerous employees and managers of Michigan child caring institutions (CCI's).

¹ Sequel Youth and Family Services operated the Lakeside Academy facility in Kalamazoo.

The objective of this review was to identify areas for improvement in the child welfare system. By looking at how this family's case was handled by Lakeside Academy, and the involvement of staff, court personnel, 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.

Purpose, Scope & Summary of Investigation:

The purpose of this investigation was to determine whether [REDACTED]' placement at Lakeside Academy was in his best interest; whether Lakeside Academy staff members complied with law, administrative rule, DHHS policy, internal facility policy, and internal facility procedure concerning a restraint of [REDACTED] on 4/29/20 that resulted in his death; whether the assigned MIC unit complied with applicable law and policy when investigating this restraint; and whether there are systemic issues necessitating recommendations to improve practice regarding CCI's and the use of restraint techniques in CCI's.

The scope of the OCO investigation included [REDACTED]' foster care case, the MIC and licensing investigations concerning the 4/29/20 restraint, MIC and licensing investigations concerning Lakeside Academy resident discipline that occurred in the two years prior to [REDACTED]' death, MIC and licensing investigations at other CCI's in the two years prior to [REDACTED]' death, and the requirements for direct care workers in Michigan CCI's.

During this investigation, the OCO investigator:

- Obtained and reviewed [REDACTED]' medical records from Bronson Methodist Hospital, which treated [REDACTED] immediately prior to his death
- Obtained and reviewed the report of an autopsy conducted on [REDACTED]
- Reviewed case file documentation in MiSACWIS concerning [REDACTED] foster care case, [REDACTED]' adoption case, the MIC investigation concerning [REDACTED]' death, and the licensing special investigation concerning [REDACTED]' death and a previous restraint of [REDACTED] at Lakeside Academy
- Reviewed documentation in the Judicial Data Warehouse to confirm information describing the child protective proceeding involving [REDACTED] and his siblings and a delinquency proceeding involving [REDACTED]
- Interviewed [REDACTED]' foster care worker and her supervisor, the assigned MIC worker and her supervisor, and the assigned licensing investigator and her supervisor

- Obtained and reviewed video recordings of the restraint leading to [REDACTED]' death and a previous restraint of [REDACTED] at Lakeside Academy
- Obtained and reviewed internal Lakeside Academy policy concerning restraints and physical holds of residents at the facility and training materials used by Lakeside Academy to train staff on the use of restraints and physical holds
- Attempted to interview 11 former Lakeside Academy staff members involved in the 4/29/20 restraint of [REDACTED]
- Reviewed employment records of seven former Lakeside Academy staff members directly involved in the 4/29/20 restraint of [REDACTED]
- Reviewed law, policy, and documents describing restraint and positional asphyxia
- Reviewed 13 licensing special investigations and MIC investigations concerning Lakeside Academy staff that occurred in the two years prior to [REDACTED]' death
- Talled the number and general nature of licensing special investigations and MIC investigations that occurred in all Michigan non-secure CCI's during the two years prior to [REDACTED]' death
- Obtained starting pay rates and education and experience requirements for direct care workers at a majority of Michigan non-secure CCI's.



Tobin Miller
Chief Investigator
Office of Children's Ombudsman
P.O. Box 30026
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Finding(s):

<u>Primary Agency of Focus:</u>	Lakeside for Children
<u>Secondary Agency(ies):</u>	N/A
<p>The OCO finds that Lakeside Academy staff violated Michigan Administrative Rules 400.4159 and 400.4142 and Lakeside Academy's internal policy governing the use of holds and restraints when restraining [REDACTED] on 4/29/20. This restraint was unwarranted, improperly executed, conducted without appropriate supervisory approval or oversight, and inconsistent with [REDACTED]' treatment plan. In addition, Lakeside Academy staff failed to obtain timely emergency medical care for [REDACTED] following the restraint.</p>	

<u>Primary Agency of Focus:</u>	Lakeside for Children
<u>Secondary Agency(ies):</u>	Children's Services Administration
<p>The OCO finds that a review of MIC substantiations and administrative rule violations concerning Lakeside Academy staff maltreatment of residents in the two years prior to [REDACTED]' death indicates a pattern of inappropriate use of restraint and assault to manage non-threatening behaviors.</p> <p>For example, the OCO reviewed confirmed allegations of Lakeside Academy staff members restraining a resident for over 30 minutes; dragging a resident across the floor for failing to respond to staff requests; challenging a resident to fight; pushing a resident into a brick wall because the staff member believed the resident was about to spit on him; yelling directly in a resident's face; and "backhanding" a resident in the face, in the presence of the resident's therapist, for calling the staff member a name.</p> <p>The OCO also finds that despite multiple rule violations concerning these and other incidents at Lakeside Academy, and despite the imposition of numerous corrective action plans as a result of the rule violations, the facility was still on regular license status at the time of [REDACTED]' death.</p>	

<u>Primary Agency of Focus:</u>	Lakeside for Children
<u>Secondary Agency(ies):</u>	N/A
<p>The Michigan Administrative Code for Child Care Institutions (CCIs) defines qualifications for direct care workers in Rule 121 (R 400.4120). The minimum qualification for a CCI direct care worker is "A direct care worker shall have completed high school or obtained a general equivalency diploma (GED)."</p>	

The OCO finds that of the seven employees most directly involved in the 4/29/20 restraint of [REDACTED], none had child welfare experience prior to being employed by Lakeside Academy. One of the seven employees holds a bachelor's degree in criminal justice, sociology, and anthropology; one has an associate degree in business and accounting; and five have high school diplomas.

Employment records from Lakeside Academy also show that the average number of months the seven employees had been employed by Lakeside Academy prior to 4/29/20 was approximately 12.

<u>Primary Agency of Focus:</u>	Children's Services Administration
<u>Secondary Agency(ies):</u>	N/A

The OCO finds that among 36 private non-secure CCI's that receive children under a Michigan court's jurisdiction for child abuse or neglect, the starting hourly pay rate for direct care workers ranges from a low of \$9.50 per hour to a high of \$18.77 per hour.

In addition, the OCO finds that among these 36 CCI's, the average starting rate of pay for direct care workers, including pay differentials for education and relevant experience, is approximately \$15.60 per hour.

<u>Primary Agency of Focus:</u>	Children's Services Administration
<u>Secondary Agency(ies):</u>	N/A

The OCO finds that MDHHS commissioned the Annie E. Casey Foundation's Child Welfare Strategy Group to review MDHHS' oversight of the safety and quality of Michigan CCI's. One of the recommendations from this review was to limit the number of residents at CCI's to 16.

The OCO reviewed publicly available² licensing special investigations and confidential MIC investigations occurring at non-secure CCI's within the two years preceding [REDACTED]' death. Based on this review, the OCO finds a correlation between the number of children housed within a non-secure CCI and the likelihood that the CCI was found responsible for a rule violation or a CCI employee was substantiated for staff assault of a resident or an improper restraint. Those CCI's with a violation or substantiation for a staff assault or improper restraint in the last two years (21 total CCI's) have an average of 40

² The OCO reviewed reports available on MDHHS' public website at <https://cwl-search.apps.lara.state.mi.us/>. Licensing special investigation reports and annual inspection reports are not generally available to the OCO via MiSACWIS.

residents. Those CCI's without such a violation within the last two years (31 total CCI's) have an average of 19 residents.

Recommendation(s):

<u>Primary Agency of Focus:</u>	Children's Services Administration
<u>Secondary Agency(ies):</u>	N/A
<p>The OCO recommends that MDHHS require a heightened response by Division of Child Welfare Licensing (DCWL) to statutory or administrative rule violations regarding restraint, staff physical abuse of a resident, or failure to comply with the mandated reporting provisions of the Child Protection Law (CPL) by a CCI. This heightened response could include the following:</p> <ul style="list-style-type: none"> • For a second or subsequent violation of law or administrative rule concerning restraint, staff physical abuse of a resident, or failure to report, issuing a provisional license to the CCI; and • For any violation of law or administrative rule concerning restraint, physical abuse of a resident, or failure to report, requiring DCWL to notify local DHHS offices of its findings to permit local offices to decide whether to seek re-placement of children under their care and supervision. 	

<u>Primary Agency of Focus:</u>	Children's Services Administration
<u>Secondary Agency(ies):</u>	
<p>The OCO recommends that MDHHS amend R 400.4121 to require either</p> <ol style="list-style-type: none"> a) A bachelor's degree in social sciences, human services, or a related field, or b) A minimum number of years of experience working with children before being employed in a CCI as a direct care worker. <p>This would encourage persons who plan a career working with children to apply for such jobs, reorient the nature of the position toward effective interaction with traumatized children and away from physical management of such children, and bring staff qualifications in line with the required qualifications for staff in other child welfare program areas.</p>	

<u>Primary Agency of Focus:</u>	Children's Services Administration
<u>Secondary Agency(ies):</u>	

The OCO recommends that MDHHS identify jobs within the state civil service that are substantially similar to the position of direct care worker at a private non-secure CCI. MDHHS should require by contract that pay rates for direct care workers within private non-secure CCI's be commensurate with the department's pay rates for substantially similar positions within the state civil service and include pay differentials for employees with relevant child welfare experience.

<u>Primary Agency of Focus:</u>	Children's Services Administration
<u>Secondary Agency(ies):</u>	
The OCO recommends that MDHHS add a requirement to Michigan Administrative Rule 400.4128; Rule 128, to require all direct care workers in CCI's, similar to the first aid training requirement, to take Parent Resources for Information, Development, and Education (PRIDE) training as required for foster parents.	

<u>Primary Agency of Focus:</u>	Michigan Legislature
<u>Secondary Agency(ies):</u>	
The OCO recommends that the Michigan Legislature amend the Child Care Organizations Act, MCL 722.111 et seq., to limit the number of children that a CCI may house within a self-contained unit of a facility to 19 residents or less.	

<u>Primary Agency of Focus:</u>	Michigan Legislature
<u>Secondary Agency(ies):</u>	
The OCO recommends that the Michigan Legislature appropriate sufficient funds to support the establishment, monitoring, and administrative costs of CCI's with smaller resident populations as recommended in this document.	



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STATE OF MICHIGAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

March 12, 2021

Ryan Speidel
Interim Children’s Ombudsman
Office of Children’s Ombudsman
The Arbaugh Building, Suite 103
401 S. Washington Square
Lansing, MI 48933

Dear Mr. Speidel:

The following is the Michigan Department of Health and Human Services (MDHHS) updated response to the recommendations from the Office of Children’s Ombudsman (OCO) Report of Findings and Recommendations regarding the care of [REDACTED] while in state custody.

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.

Recommendation(s):

Primary Agency of Focus:	Children's Services Agency
Secondary Agency(ies):	N/A
<p>The OCO recommends that MDHHS require a heightened response by DCWL to statutory or administrative rule violations regarding restraint, staff physical abuse of a resident, or failure to comply with the mandated reporting provisions of the Child Protection Law (CPL) by a CHILD CARING INSTITUTION. This heightened response could include the following:</p> <ul style="list-style-type: none"> • For a second or subsequent violation of law or administrative rule concerning restraint, staff physical abuse of a resident, or failure to report, issuing a provisional license to the CHILD CARING INSTITUTION; and • For any violation of law or administrative rule concerning restraint, physical abuse of a resident, or failure to report, requiring DCWL to notify local DHHS offices of its findings to permit local offices to decide whether to seek re-placement of children under their care and supervision. 	

MDHHS Response to Recommendation: MDHHS intensified its response to rule violations by requiring the MDHHS Division of Child Welfare Licensing, prior to determining adverse action, to conduct a comprehensive review of a Child Caring Institution’s serious and safety-related violations for the previous twenty-four months. The goal is to identify patterns and trends that may necessitate a corrective action plan or other intervention to address concerns that impact child safety and wellbeing.

Effective 7/16/20, MDHHS issued Emergency Rules for Child Caring Institutions restricting dangerous types of restraints and limiting use of restraints when necessary to prevent serious injury to the child or injury to others.

Effective 7/24/20, MDHHS licensing consultants began making unannounced visits to Child Caring Institutions – quarterly to all Child Caring Institutions, monthly when a first provisional license is recommended, and weekly when a second provisional license is recommended.

Additionally, the Department implemented weekly Child Caring Institution status meetings to identify concerns that impact child safety and require immediate action, such as caseworker verification of safety and wellbeing, implementation of safety plans, review of staffing sufficiency, additional investigation by Children’s Protective Services Maltreatment in Care unit or licensing, technical assistance by licensing and/or program offices, and temporary suspension of new referrals to the facility. Participation at the weekly meetings includes, among others, the Bureau of Out-of-Home Services director, the Division of Child Welfare Licensing director or designee, the Maltreatment in Care director, the Juvenile Justice Programs director, the manager of the Regional Placement Unit, and the respective managers of foster care and juvenile justice program offices. The Division of Child Welfare Licensing also holds conference calls with the caseworker in the local office after every restraint of a child on their caseload. The Division of Child Welfare Licensing seriously considers issuing a provisional license to Child Caring Institutions that have more than one serious restraint violation.

After the tragedy at Lakeside, MDHHS asked national experts to help guide reform of its use of residential services and improve safety for children receiving residential services. National experts issued a report containing recommendations to improve oversight of safety and quality of care to children receiving residential services and their families, including moving towards restraint-free programs. In September 2020, Michigan convened a 6-month steering committee to implement the recommendations in the report. The steering committee is set to conclude its work at the end of March 2021.

Finally, MDHHS has implemented a series of trainings for Child Caring Institutions focused on implementation of best practices to prevent and safely reduce the use of restraints; additional technical assistance is planned in 2021.

<u>Primary Agency of Focus:</u>	Children's Services Agency
<u>Secondary Agency(ies):</u>	
The OCO recommends that MDHHS amend R 400.4121 to require either a) A bachelor's degree in social sciences, human services, or a related field, or	

- b) A minimum number of years of experience working with children before being employed in a CHILD CARING INSTITUTION as a direct care worker.

This would encourage persons who plan a career working with children to apply for such jobs, reorient the nature of the position toward effective interaction with traumatized children and away from physical management of such children, and bring staff qualifications in line with the required qualifications for staff in other child welfare program areas.

MDHHS Response to Recommendation: MDHHS recognizes the important role Child Caring Institution direct care staff have in working with children who have experienced trauma and their families. Draft revisions to the licensing rules, that are expected to take effect in Fall 2021, enhance the amount and types of training newly hired and existing staff will receive when employed at a Child Caring Institution. Under the draft revised rules, staff are required to complete 50 hours of training in their first year of hire, and 25 hours annually thereafter. Staff will select from over 30 annual training topics as identified in Michigan Administrative Code R400.4128 and the Child Protection Law including, but not limited to, topics related to working as part of a team, understanding and defusing challenging behaviors, relationship building with the family, crisis intervention, suicide prevention, grief and loss for foster children, and other topics which will enhance staff skill and ability to deliver effective services and intervention with youth and their families.

Primary Agency of Focus:	Children's Services Agency
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Secondary Agency(ies):	
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The OCO recommends that MDHHS identify jobs within the state civil service that are substantially similar to the position of direct care worker at a private non-secure CHILD CARING INSTITUTION. MDHHS should require by contract that pay rates for direct care workers within private non-secure CHILD CARING INSTITUTION's be commensurate with the department's pay rates for substantially similar positions within the state civil service and include pay differentials for employees with relevant child welfare experience.

MDHHS Response to Recommendation: Beginning in December 2020, MDHHS began working with Public Consulting Group and residential service providers to identify comparable market rates for similar positions and identify salary benchmarks commensurate with job duties and expectations. The next meeting among MDHHS, Public Sector Consulting Group and residential providers is scheduled for March 17, with additional meetings scheduled to occur in April and May. This work will be factored into actuarially sound rate recommendations for Child Caring Institutions.

Primary Agency of Focus:	Children's Services Agency
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Secondary Agency(ies):	
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The OCO recommends that MDHHS add a requirement to Michigan Administrative Rule 400.4128; Rule 128, to require all direct care workers in CHILD CARING INSTITUTION's, similar to the first aid training requirement, to take Parent Resources for Information, Development, and Education (PRIDE) training as required for foster parents.

MDHHS Response to Recommendation: While Parent Resources for Information, Development, and Education (PRIDE) training is geared toward the placement of children with foster parents and relatives, Child Caring Institution contracts require orientation for all new staff that include topics identified in Michigan Administrative Code R400.4128 and the Child Protection Law. Current draft rule revisions will require additional annual training in over 30 areas related to staff providing effective treatment for children and families involved at Child Caring Institutions.

Additionally, all staff will receive annual trauma-focused program training to maintain a trauma-informed milieu and treatment environment. In 2020 and 2021, all Child Caring Institutions were invited to participate in the Six Core Strategies training, delivered by national experts in congregate care system reform. The training included five three-hour training sessions on strategies they should take to reduce the use of restraints, seclusion, and other coercive practices. The training focused on ways that Child Caring Institutions can promote permanency, family-driven, youth-guided and trauma-informed care, cultural and linguistic competence, strength/resiliency-based and individualized care.

A workgroup has drafted rule revisions that will require all Child Caring Institutions to develop agency-based and child specific crisis prevention and intervention strategies that are strength-based and non-coercive. These plans will be used to support staff and assist children in self-regulation, social skills, and healing.

Primary Agency of Focus:	Michigan Legislature
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Secondary Agency(ies):	
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The OCO recommends that the Michigan Legislature amend the Child Care Organizations Act, MCL 722.111 et seq., to limit the number of children that a CHILD CARING INSTITUTION may house within a self-contained unit of a facility to 19 residents or less.

MDHHS Response to Recommendation: As part of the Child Caring Institution Steering Committee convened from September 2020 through March 2021, a workgroup analyzed and carefully considered modifying the Licensing Rules for Child Caring Institutions to limit residential program size to a capacity of 16 youth or less. The workgroup recommended updates be made to licensing rules, contracts, programs, and oversight focus on factors that improve safety and positive outcomes for children and their families such as engagement with families, reducing lengths of stay, prevention of restraint/seclusion use, workforce support and development, urgency toward permanency, use of data for program improvement, post-discharge supports, trauma-responsive interventions and organizational oversight.

The workgroup recommended, and the Steering Committee agreed, not to modify the licensing rules, or contracts, for residential services to limit bed capacity. The decision was based on the following: 1) insufficient data, research, or consistent approach in other locations, 2) current Michigan data does not support this recommendation and 3) evidence to establish a correlation between bed capacity and safety/outcomes research suggests that positive outcomes are linked to factors such as family engagement, staff training, and adherence to evidence-based practices.

As MDHHS implements Qualified Residential Treatment Programs under the Family First Prevention Services Act, its contractual requirements and residential treatment programs will

implement trauma-informed treatment models, staff professional competencies, licensed nursing, and intensive aftercare support to sustain each youth and family success in the community.

<u>Primary Agency of Focus:</u>	Michigan Legislature
<u>Secondary Agency(ies):</u>	

The OCO recommends that the Michigan Legislature appropriate sufficient funds to support the establishment, monitoring, and administrative costs of CHILD CARING INSTITUTION's with smaller resident populations as recommended in this document.

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,



Stacie Bladen
Interim Executive Director
Children's Services Agency