

**State of Michigan
Department of Human Services**

**Child Fatality Reviews: 4/1/05-3/31/08
Quality Assurance Report**

Introduction

The state of Michigan Department of Human Services (DHS), is responsible for administering the state's child welfare program. The DHS mission includes a commitment to ensure that children and youths are safe; to promote, improve and sustain a higher quality of life while enhancing their well-being; and to have permanent and stable family lives. The DHS Children's Services Administration is responsible for planning, directing and coordinating statewide child welfare programs, including social services provided directly by DHS via statewide local offices and services provided by private child-placing agencies.

In 2006 a class-action lawsuit was filed alleging systemic failures in the Michigan child welfare system. A settlement agreement was signed July 3, 2008 and a final consent decree was entered on October 28, 2008. Since then, DHS has made significant strides to improve the quality of service to children and families in the child welfare system by reducing caseloads for its workers, moving more children to permanency, and reducing the number of children in out of home care, launching a continuous quality improvement system, increasing oversight of contracted providers, and developing extensive data reporting capabilities.

The consent decree requires DHS to ensure that qualified and competent individuals conduct a fatality review independent of the county in which the fatality occurred for each child who died while in the foster care custody of DHS. The fatality review process is overseen by the Office of Family Advocate.

The Child Welfare Quality Assurance (QA) Unit is responsible for analyzing results and incorporating the findings and recommendations from the reviews into relevant QA activities. The QA Unit has been established as a division of the Child Welfare Improvement Bureau in the Children's Services Administration to ensure the provision of service in accordance with DHS philosophy. The goal of the QA Unit is to ensure that children receive high quality services and achieve positive outcomes through improved service delivery, regular monitoring of case records and data trends, and improved implementation of policy.

This report is a summary of the completed fatality reviews concerning children who died during the three-year period ending March 31, 2008.

Process

The QA Unit's source material included child fatality reports completed by the Office of Family Advocate (OFA), the Michigan Public Health Institute - Citizen Review Panel (MPHI-CRP), and the Office of Children's Ombudsman (OCO). The OFA, MPHI-CRP and the OCO reviewers wrote an individual report for each child fatality.

The fatality review process was overseen by the OFA. The OFA director facilitated the reviews and ensured that a qualified reviewer conducted each review. The fatality reviews included a determination regarding whether there was a substantive finding of error in case handling that related to the child’s death. The reviewers examined relevant information, including the child’s foster care and adoption file, all Children’s Protective Services (CPS) complaints involving the child’s foster care home(s), the foster parents’ licensing file, police reports, medical, educational, and mental health documents, the child’s legal file, placement history, and all information related to the child death.

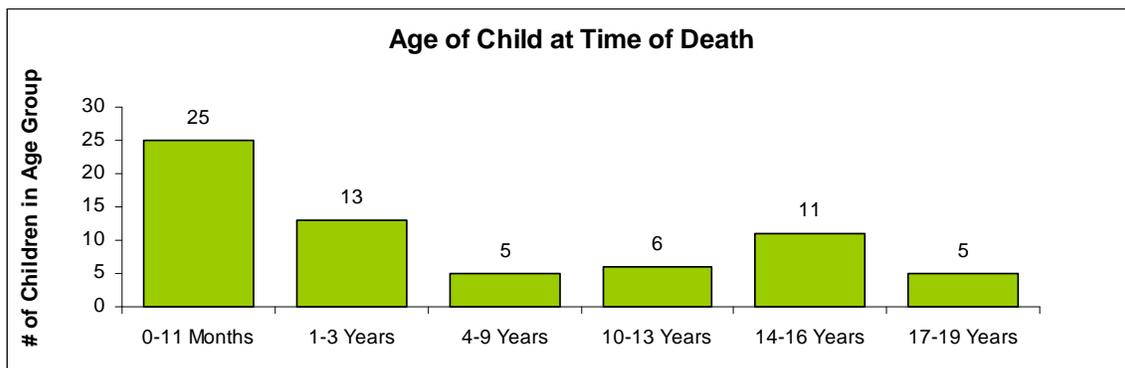
The Office of Family Advocate sent completed summaries to the QA Unit. The QA Unit reviewed the individual reports for each of the 65 child fatalities. Information from these reports was compiled and used for analysis. The Services Worker Support System (SWSS) was utilized by the QA Unit to expand the information from the fatality review summaries. Specific demographic data, such as the child’s age, race, gender, and living arrangement was derived from data obtained from SWSS.

Results

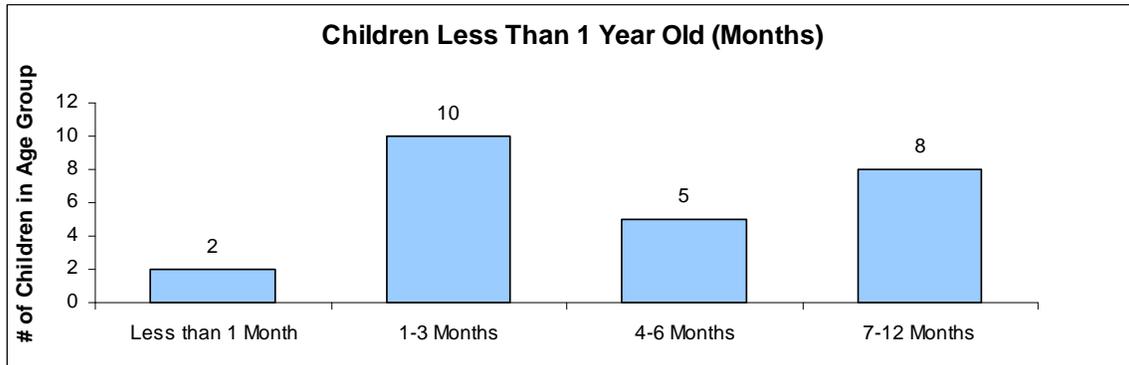
Child welfare stakeholders completed 65 fatality reviews for the backlog fatality review group identified in the consent decree. The OCO reviewed seven of these cases, MPHI-CRP reviewed 20 cases, and the OFA oversaw the review of the remaining 38 cases.

49.2 percent of the cases were under the direct responsibility of DHS and 50.8 percent were under the direct responsibility of private child placing agencies. 55.4 percent of the 65 children were male and 44.6 percent were female.

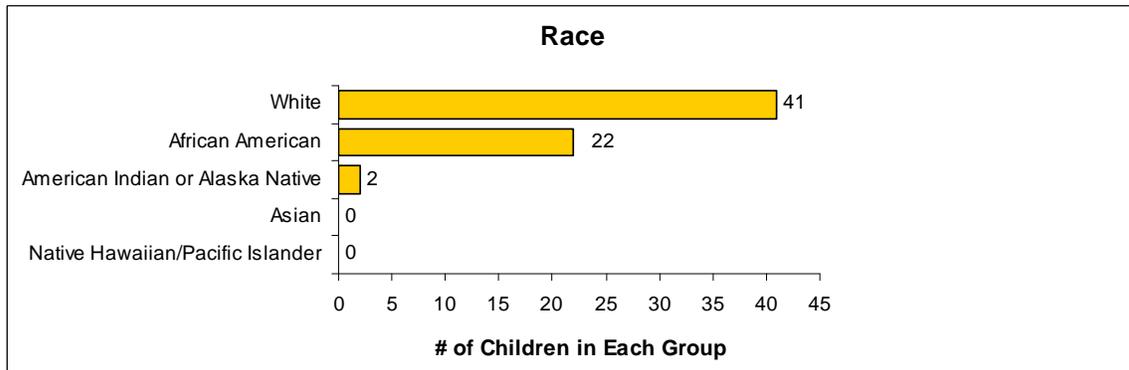
The average age of the children was 5.6 years when they died. 58.5 percent of the children who died were three years old or younger. Except for the age group from 14 to 16 years, there is a downward trend in the number of deaths as the children aged. The graph below illustrates the age of the children.



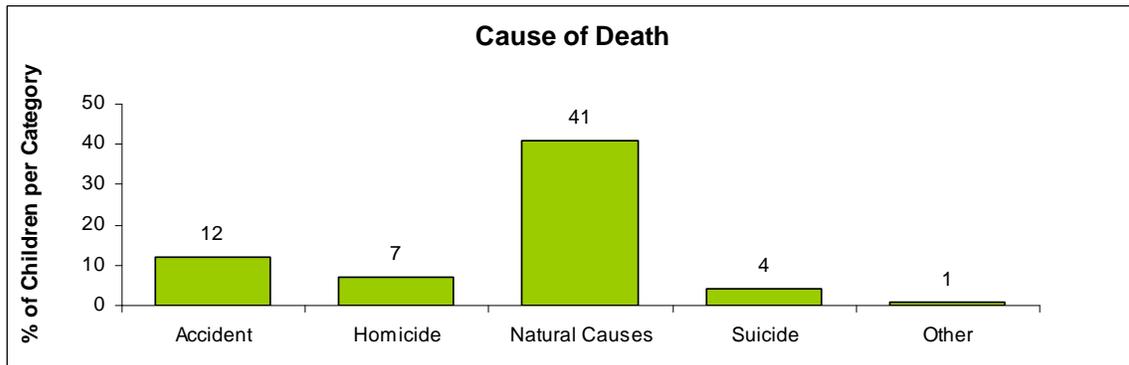
38.5 percent of the children who died while in care during this period were under the age of one. The graph below shows the age of these children in months.



63.1 percent of the children were white, 33.8 percent were African American, and 3.1 percent were American Indian or Alaska Native. The graph below shows the number of children in each group.



63.1 percent died of natural causes, 18.5 percent from accidents, 10.8 percent were homicides, and 6.2 percent were suicides. Two of the homicides were a direct result of caretaker abuse/neglect. The foster parents in these two cases were criminally prosecuted. One homicide had allegations of abuse/neglect where a perpetrator could not be identified. The one child listed in the "Other" category was severely impaired and died from malnutrition with an allegation of neglect against the caretaker. The graph below illustrates "cause of death".



The deaths occurred in 27 of Michigan's 83 counties. The table below shows the number of fatalities that occurred per county over the three-year period.

Children in Foster Care			
County Name	# of Fatalities	# of Active FC Cases (3/31/08)	Fatalities per 1000 Children
Berrien	1	409	2.4
Cass	1	130	7.7
Chippewa	1	57	17.5
Genesee	4	1,558	2.6
Ingham	4	760	5.3
Jackson	2	349	5.7
Kalamazoo	1	373	2.7
Kent	6	965	6.2
Lake	2	31	64.5
Lapeer	1	49	20.4
Lenawee	1	163	6.1
Macomb	2	1,232	1.6
Manistee	1	15	66.7
Marquette	1	70	14.3
Muskegon	2	413	4.8
Newaygo	1	80	12.5
Oakland	3	1,546	1.9
Ottawa	2	173	11.6
Roscommon	1	33	30.3
Saginaw	3	466	6.4
Shiawassee	1	60	16.7
St Joseph	1	154	6.5
Tuscola	1	85	11.8
Van Buren	2	142	14.1
Washtenaw	1	245	4.1
Wayne	18	5,945	3.0
Wexford	1	50	20.0
MI Totals	65	19,308	3.4

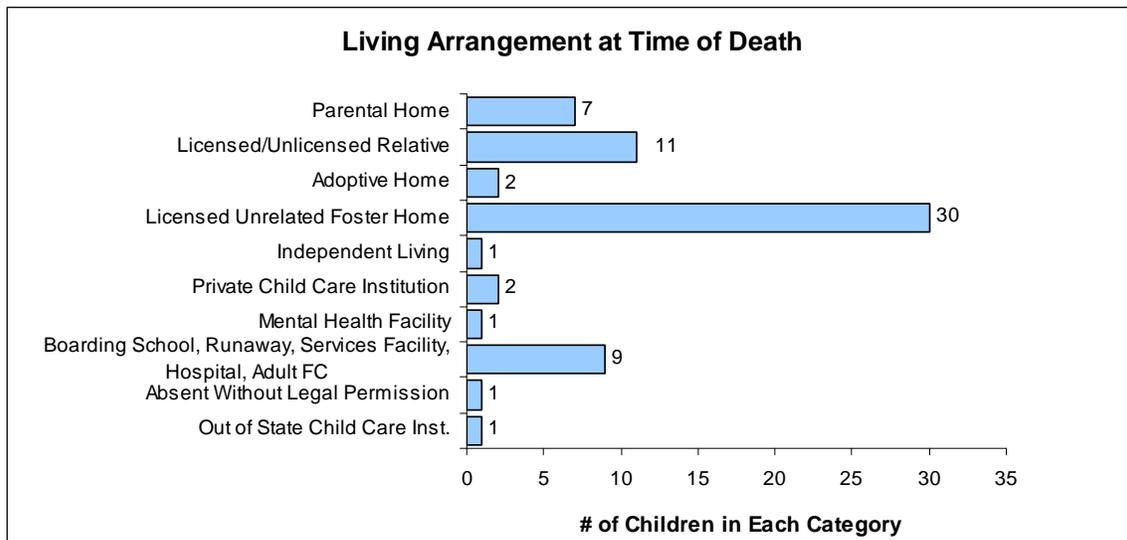
Over a similar three-year period from 2005-07, there were 5,301 fatalities¹ in the general population of 2,695,839 children 0-19 years old² in Michigan. Two fatalities per 1,000 children occurred in the state during that time period.

¹ The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org. These data are based on 3-year averages for 2005, 2006 and 2007.

² 2007 Est. Child Population. Population Division, U.S. Census Bureau, Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2000 to July 1, 2008, Release Date: May 14, 2009

Twenty nine children were born with significant medical issues. Of these, 18 died prior to their first birthday, five never left the hospital after birth. The cause of death for all but one of these 29 children was natural causes.

46.2 percent of the children were living in a licensed unrelated foster home when they died. 16.9 percent were living with a relative. 13.8 percent had a living arrangement of boarding school, services facility, hospital, or adult foster care. 10.8 percent resided in their parental home. The graph below illustrates the living arrangement of these children.



Findings

The Office of Family Advocate, the Office of Children’s Ombudsman and the Michigan Public Health Institute - Citizen Review Panel studied 65 fatalities and delivered findings where non-compliance with specific policies, laws or best practices were substantive. There were 41 findings, involving 23 separate children, which detailed an instance in which the supervising agency did not follow existing policy properly.

In 11 instances involving six children it was found that DHS CPS and children’s foster care, as well as private child placing agencies (CPA) “did not document adherence to the proper service level and contact standards.”

In eight instances involving four of the 65 children, CPS, private CPAs and the Bureau of Child and Adult Licensing (BCAL) did not “consistently or accurately document family history, potentially leading to an improper assessment of family functioning.” Reviewers noted both DHS and private CPA foster care staff failed to follow policies relating to children’s medical needs in seven summaries regarding seven separate children. In six examples the reviewer indicated that

“Decisions made were inconsistent with case facts and not in the best interest of the child(ren).” One individual case resulted in 28 separate findings related to foster care licensing, listing multiple instances in which DHS and private CPA licensing staff did not follow-up on corrective action plans. The following are specific findings from the reviews:

- CPS and/or licensing and/or CPA did not consistently or accurately document family history, potentially leading to an improper assessment of family functioning.
- CPS and FC did not document timely completion of service plans.
- CPS failed to notify licensing of complaints, as required by policy.
- Children’s services did not document adherence to the proper service level and contact standards.
- Supervisory oversight of cases was inadequate to ensure child safety and support quality casework.
- DHS/CPA FC did not obtain/maintain proper documentation of medical records as required.
- Decisions made were inconsistent with case facts and not in the best interests of the child(ren).
- Caregivers did not utilize Infant Safe Sleep practices for a child less than one year of age.
- DHS/CPA FC did not ensure that the child’s medical provider remained constant.
- Parent-Agency Agreement requirements not followed.
- Licensing report missing information, late, fail to follow policy/rules.
- Licensing failed to conduct Special Investigations when required by policy.
- Licensing failed to require a corrective action plan even where they found violations.
- Licensing failed to notify CPS of allegations of child abuse/neglect as required.
- Foster care staff did not follow absent without legal permission procedures to locate absent without legal permission wards as stated in policy.
- Foster Care did not follow policy regarding replacement of a foster child.
- DHS needs to review follow up when CPA is found in violation.
- There was no documentation of specific training/assessment that was provided to the foster parents/caregivers and their household or how the training related to meeting the child’s needs.
- CPA did not follow policy on records retention.

Quality Assurance Concerns

The quality assurance concerns noted by the reviewers revealed that, in 74 specific examples regarding 53 separate children, the case documentation was inadequate, untimely or missing. Reviewers designated the CPS Initial Service

Plan for 15 examples involving six children, while naming the Children's Foster Care (CFC) Updated Service Plan 17 times regarding 10 children. The case documentation did not demonstrate "adherence to the proper service level and contact standards" nine times involving seven children. The following are specific quality assurance concerns from the reviews:

- In the judgment of the reviewers, in seven instances, the CPS Initial Service Plan did not contain sufficient evidence to support the conclusion. In three instances, DHS listed a child differently in SWSS CPS and SWSS FAJ, resulting in the supervising agency obtaining an inadequate history. Seven foster care records did not contain a final report regarding the child's death. One CPS report included the name of the confidential source.
- The foster care record did not contain a final report indicating the cause and manner of death.
- Children's services/CPA did not follow the policy for reporting a child fatality.
- The CPS investigation summary did not contain all relevant evidence to support the conclusion.
- Licensing violations were not addressed by DHS or BCAL.
- There were no evaluation documented regarding the number of children in the home and the ability of the foster parents to meet the child's special needs.
- No documentation that a CPS investigation was conducted regarding the child's death, despite prior concerns regarding the child's care by the foster parents.
- CPS did not coordinate with law enforcement when required by policy.
- No documentation exists regarding attempts to license the relative as a foster parent.
- CPS named a confidential complaint source in an ISP.

Recommendations

The reviewers' recommendations covered a broad range that involved seven different administrative units. Many encouraged a review of policies to ensure consistency in application by all service providers, and with a number of specific issues named as needing clarification. Some reviewers recommended that a portion of six separate cases be re-assessed. Reviewers proposed new policies, ranging from issues relating to illegal immigrants to improved electronic searches and greater screening of new complaints and prospective foster parents.

Medical issues comprised the single largest category of recommendations. These ranged from specific instances of concern from individual reviews to broader issues relating to the medical passport.

Foster Care Program Office Recommendations:

- FC program office ensures policy timeframes are consistent for medical documentation.
- FC program office enhances policy regarding the foster care case record to delineate case record content requirements for private agencies and DHS during purchase of service cases.
- DHS create policy to require an agency to retain a foster home licensing record for *“not less than 10 years after closure.”*
- FC program office determines whether it is appropriate to allow foster parents to transport critically ill foster children to the emergency room rather than contact 911 for an ambulance.
- Foster PRIDE/Adopt PRIDE training begins immediately training Infant Safe Sleep practices as part of the curriculum for foster parents.
- Amend policy regarding the criminal record check – Law Enforcement Information Network (LEIN) to outline specific procedures for private CPA to coordinate responsibility for obtaining and documenting the criminal history and Central Registry check for purchase of services cases.

Children’s Protective Services Program Office Recommendations:

- Enhance electronic search measures and expand initial CPS clearance at intake to include a search to confirm licensure of foster parents.

Field Operations Recommendations:

- DHS develop a plan to ensure policy related to a foster child’s medical passport is fully complied with, including, but not limited to:
 - Medical examinations must be completed and documented every 14 months.
 - Medical passport must be completed and maintained.
 - The child's medical provider must be consistent while the child is in foster care.
 - The supervising agency will obtain and document all recommended follow-up medical care on the medical passport, the Child Assessment of Needs and Strengths and the Updated Service Plan.
- DHS develop and implement a case management system to ensure record retention requirements are met.
- DHS develop procedures for case closure including steps to ensure case records have complete documentation prior to filing a case record for retention.

Child Welfare Contract Compliance Unit Recommendations:

- Review the nurse/medical program in practice, if one exists, at private CPA and if applicable, determine if it is an appropriate medical resource for foster children.
- Ensure that contracts include the requirement for a CPA licensed to accept placement of special needs children to have a plan to ensure workers are trained in the specialized care of children's needs prior to assigning such a case to the worker.
- Ensure training and competence of purchase of services agencies in medical passport issues and requirements.

Adoption Program Office Recommendation:

- Policy should emphasize an accurate assessment of the needs of all children in the home and the parents' ability to meet them.

Child Welfare Training Institute Recommendations:

- Develop specific training for adoption workers to identify and evaluate potential risk and safety factors when completing adoptive family assessments.
- Develop training curriculum in conjunction with the new DHS medical director for workers assigned to cases involving medically fragile children.

Bureau of Children and Adult Licensing Recommendations:

- Licensing Rules be amended to require all foster parents to receive training on Infant Safe Sleep practices and require Infant Safe Sleep practices for all children age one or under, unless a physician's written documentation grants an exception.
- Develop a process to ensure that a CPA is not licensed to accept placement of special needs children without employees trained in the specialized care required to meet the children's needs.
- Identify whether current rules and policies governing retention, storage, and access of foster home licensing files enable child placing agencies to consistently comply with licensing rule 400.12310(3) (c) regarding the assessment of previous licenses, criminal convictions and substantiated child abuse or neglect for any member of the household in the initial evaluation.
- Child placing agency rule 400.12310 (3) (c) be amended and policy require that the initial evaluation to include an assessment of all CPS complaints and investigations, whether substantiated or not.
- DHS and BCAL determine whether sufficient resources exist to ensure child placing agencies are consistently in compliance with licensing rules regarding assessments in the initial evaluation.
Licensing rules: 400.12310(3) - (4).

- Identify/implement as needed, safety measures/oversight procedures to increase the likelihood that child-placing agencies respond as required when CPS informs them that it received a complaint about a licensed foster home.
- Day care licensing and foster home licensing should be consistent in regards to water safety.

Conclusion

Child fatalities are most prevalent among the youngest children involved in the child welfare system. Over 60 percent of these fatalities are the result of natural causes. This preliminary review indicates a need for improved case management, training, supervisory oversight and policy revision.

County specific training needs will be identified and training will be provided to improve documentation and policy compliance. Child fatality risk issues that are county specific will be addressed by the QA Unit and quality committees within individual counties.

It is important to note that many of these findings and recommendations involve multiple departments and/or agencies, that child abuse/neglect cases have increased in complexity, and there is a need for more resources and improved collaboration between all parties.

These reviews have yielded information that will enhance our ability to ensure the safety of children in our care. Outcome data will be quantified to determine cause, identify gaps, trends or commonalities and, when needed, address practice or systemic deficiencies. The results of this analysis will be shared with the DHS Quality Council and Children's Cabinet and utilized in the CQI process.