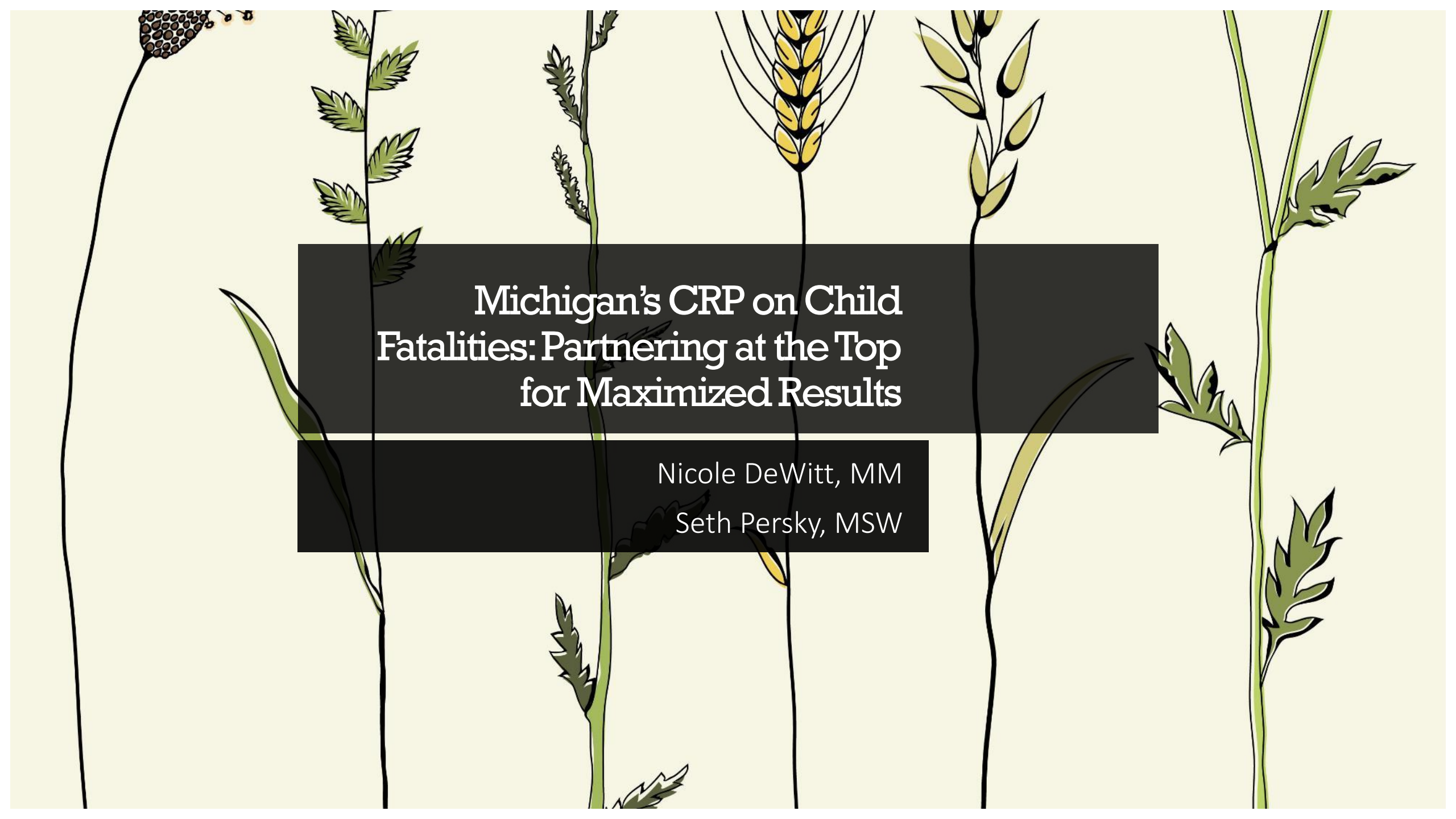

Michigan's CRP on Child Fatalities: Partnering at the Top for Maximized Results

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Hello From Michigan!

Nicole is the coordinator of Michigan's CRP on Child Fatalities. She is also a member of the National Citizen Review Panel Advisory Board. Nicole has a background in foster care and currently works for the non-profit agency Michigan Public Health Institute outside East Lansing, Michigan

Seth is the director of the Office of Family Advocate at the Michigan Department of Health and Human Service. He is a member of all three CRP's in Michigan and lives in Detroit, Michigan

MDHHS Michigan Department of Health and Human Services

Table Talk

1: Would you say that your state Department is very, somewhat, or not at all responsive to your CRP(s)?

2: If you're in a responsive state, what have you done to successfully garner state support?

If you're in a somewhat or not at all responsive state, what have you tried to get your state to support you?

A little bit about the state of Michigan and CPS

Michigan Department of Health and Human Services. "Children's Protective Services: Comprehensive Report: (FY2019 Appropriation Act - Public Act 207 of 2018). March 2019

140,000-150,000

Approximate annual calls to our CPS intake hotline

96,084
Total reports of abuse or neglect assigned for investigation in 2018

4,432
Total number of cases with a Category I disposition

6,819
Total number of cases with a Category II disposition

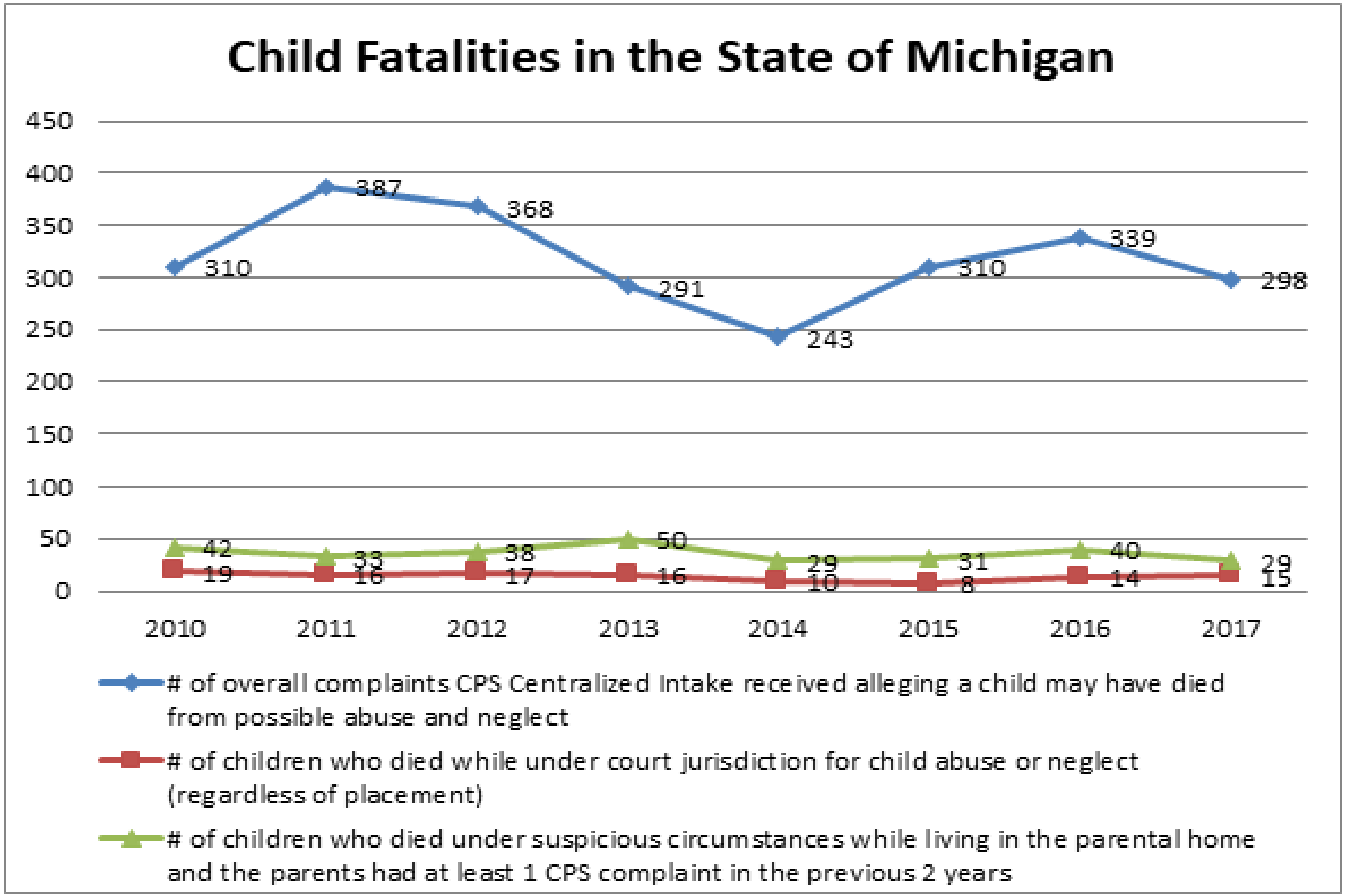
Removal occurs in less than 5% of all substantiated investigations.

Michigan Statistics

From 2012-2017, the number of Michigan children experiencing child maltreatment increased from 33,394 to 38,064, and a yearly average of 70 children died from maltreatment.

Michigan's Victims of Child Abuse and Neglect, 2012-2017

	Number of Victims of Child Abuse and Neglect	Number of Deaths due to Child Abuse and Neglect
2012	33,394	63
2013	33,938	59
2014	30,705	76
2015	34,729	83
2016	37,293	85
2017	38,064	51


Child Fatalities in the State of Michigan
450
400
350
300
250
200
150
100
50
0
310
387
368
291
243
310
339
298
42
33
38
50
29
31
40
29
19
16
17
16
10
8
14
15
2010
2011
2012
2013
2014
2015
2016
2017
# of overall complaints CPS Centralized Intake received alleging a child may have died from possible abuse and neglect
# of children who died while under court jurisdiction for child abuse or neglect (regardless of placement)
# of children who died under suspicious circumstances while living in the parental home and the parents had at least 1 CPS complaint in the previous 2 years

The Lawsuit

In 2006, a lawsuit was filed against MDHHS by the advocacy group Children's Rights. The current version of our improvement plan, the Implementation, Sustainability and Exit Plan, was approved in U.S. District Court in February of 2016.

Over the last 10 years, practice and policy has changed significantly in the child welfare system due to the lawsuit. The Department welcomes input from committees such as the CRPCF.

Michigan has several state best practice protocols regarding the coordination of CPS investigations.

The protocols focus on multi-disciplinary coordination to ensure complete and thorough maltreatment investigations.

Players in the Sandbox

Statewide Local Child Death Review (CDR) Teams

MDHHS' Office of Family Advocate

Office of the Children's Ombudsman

CRP on Child Fatalities

- When it comes to fatalities, there are multiple child fatality review processes currently functioning in Michigan. Each has its own purpose, parameters, and limitations, but all emerged from the general mission of improving the state's systems that serve children most at risk.

- *What would make Michigan's CRPs stand out? What would make the state's Department support us even though so many other review processes exist?*

Let's Start with History: Michigan Child Death Review

Established in 1997 through a partnership between the MDHHS and MPHI, which still thrives today.

Purpose

The team meets to discuss the response/investigations in the children's deaths, service delivery to families and communities, and child death prevention efforts

National CDR Case Reporting System

Each county has a local coordinator with over 1,400 professional volunteer team members. During the meeting, team members bring their case-specific notes and openly share the history on the child. That data is entered into the national database.

Sustainability

MPHI works to ensure that CDR team membership remains stable so that key stakeholders are at each discussion and can share information freely.

Michigan's CRP on Child Fatalities

This CRP is charged with examining child fatality cases where a CPS referral was made at the time of the child's death and the family had previous interaction with the child protection system.

Risk Factors

The panel reviews these deaths to gain a better understanding of the risk factors present at the time of death.

State Policies and Practices

The panel examines how state policies and practices affected the response to the death.

Protection

The panel explores how the state can better protect other children from harm.

Membership

Panel membership must be composed of volunteers broadly representative of the state and community with a majority from outside the public welfare system.

Office of Children's Ombudsman

Investigator

Domestic Violence Prevention and Treatment Board

Director

Law Enforcement

Retired Detective

Michigan State University Chance at Childhood

Director

Helen DeVos Children's Hospital

Child Abuse Pediatrician

CPS and Family Preservation Programs

Program Manager

Office of Family Advocate

Director

State Court Administrative Office

Director

University of Michigan Dept. of Pathology

Medical Examiner (Chair)

Michigan Public Health Institute

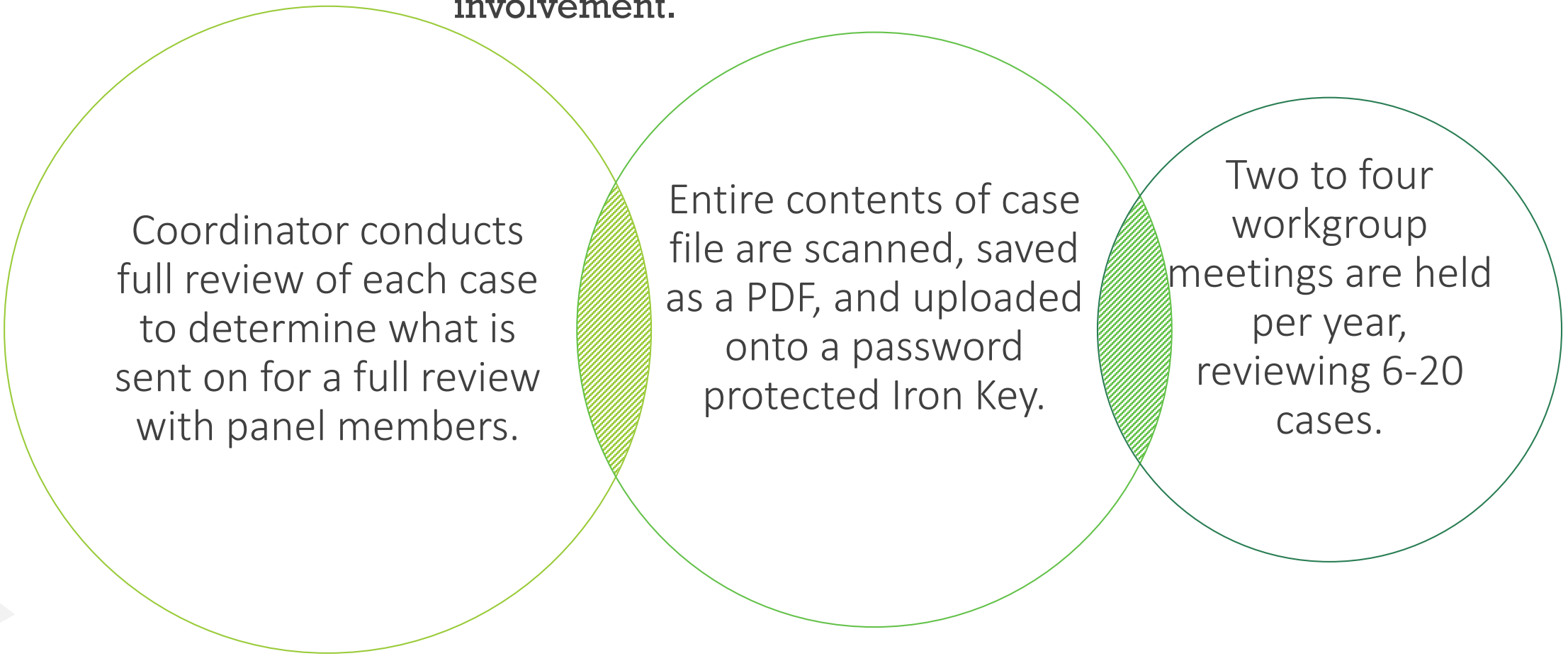
Coordinator/Facilitator

How CRP Helps

The reviews of specific cases are conducted, not to respond to any one specific case, but rather to develop recommendations based on the patterns or trends identified as common to the cases reviewed.

The Process

Case files are requested on previous year fatalities where there was a CPS referral at the time of death AND the family had previous CPS involvement.



Confidentiality

The panel was established by Public Act 220 of 1997 and functions under the authority of the Michigan Child Protection Act, Section 7. Section 7 requires the following:

All deliberations are confidential.

Members sign a confidentiality agreement at the beginning of every meeting.

Case specific information is confidential.

No participating member of the panel can discuss or disclose any case-specific information outside of the panel meeting.

Meetings are closed to the public.

The panel is not subject to either FOIA or the Open Meetings Act.

How to Ensure a Successful Workgroup Meeting

Environment

- Ensure confidentiality.
- Ensure comfortability.
- Ensure productivity.

Facilitation

The coordinator of this panel must be comfortable facilitating meetings.

Content Experts

- The coordinator should have an advanced understanding of child welfare.
- The members should be considered content experts in their field.

Case Example

- Six-year-old black female in kindergarten
- Referral on death: Deceased child with multiple wounds at different stages of healing covering her entire body
- Family CPS hx: Multiple investigations for suspected physical abuse and improper supervision
- Cause of Death: Bilateral Bronchopneumonia Associated with Neglect and Abusive Injuries
- Manner of Death: Homicide

What We Learned

- Previous services referred during an open case described mom as “non-compliant.”
- Mom’s request for her name to be removed from Central Registry was granted after she rallied to participate for five weeks, no hearing required.
- Child was suspended from school after repeatedly stealing food from other students.
- Mom never brought child back to school after suspension and reported she was “home schooling.”
- Mom’s LTP was mentioned in previous CPS investigations but was never listed as a perpetrator.
- Decedent was seen by a dentist five days prior to death for swollen gums and a loose tooth.

Panel Findings

Failure by Mandated Reporters to make necessary referrals.

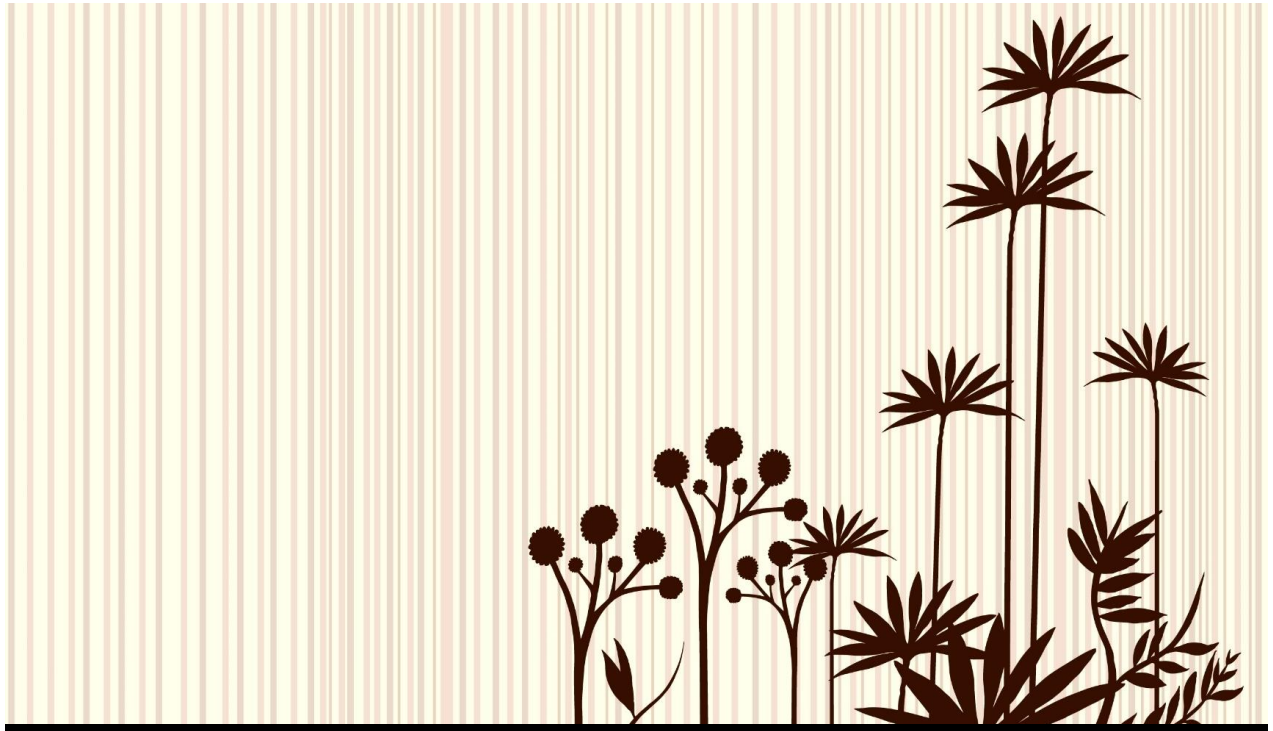
Removal of name off Central Registry was inappropriate.

No monitoring system in place for home school children.

Annual Report Recommendations

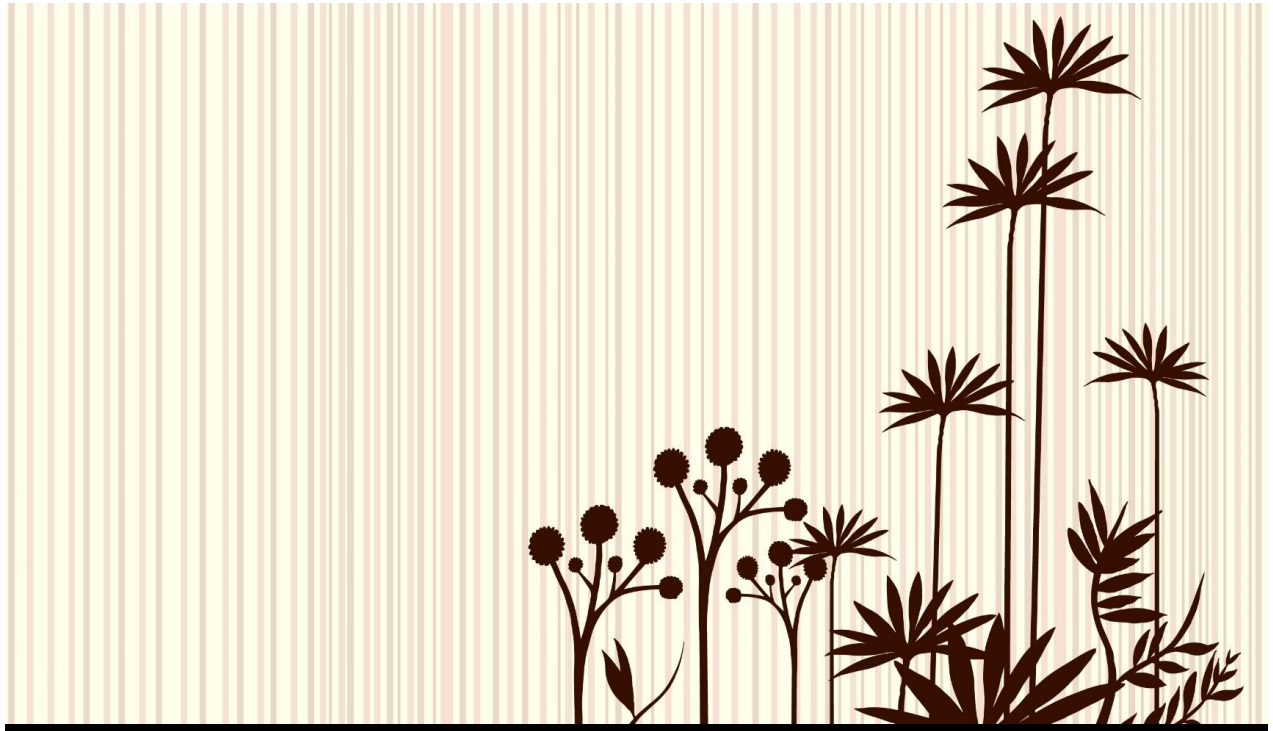
A multidisciplinary team (i.e: MDHHS, schools, court, mental health, public health) should study repeated neglect cases (typically related to hygiene and safety concerns in the home) to determine what underlying circumstances may exist and explore alternatives for servicing these families.

Rationale: The panel reviewed many cases that documented repeated environmental neglect referrals for families who thrived when in-home services were provided, but whose living environment would revert to its original condition once the services were no longer in place. The panel found that although living in such conditions as the norm is likely a marker for other more basic underlying risk factors (unmet mental health needs, chronic substance abuse, lack of social supports), often the physical condition of the home is the only factor focused on in the case, leaving the more primary risk factors unaddressed. A multidisciplinary team convened to more closely examine the nuances of these cases may lead to improved policy and prevention efforts.



MDHHS Response

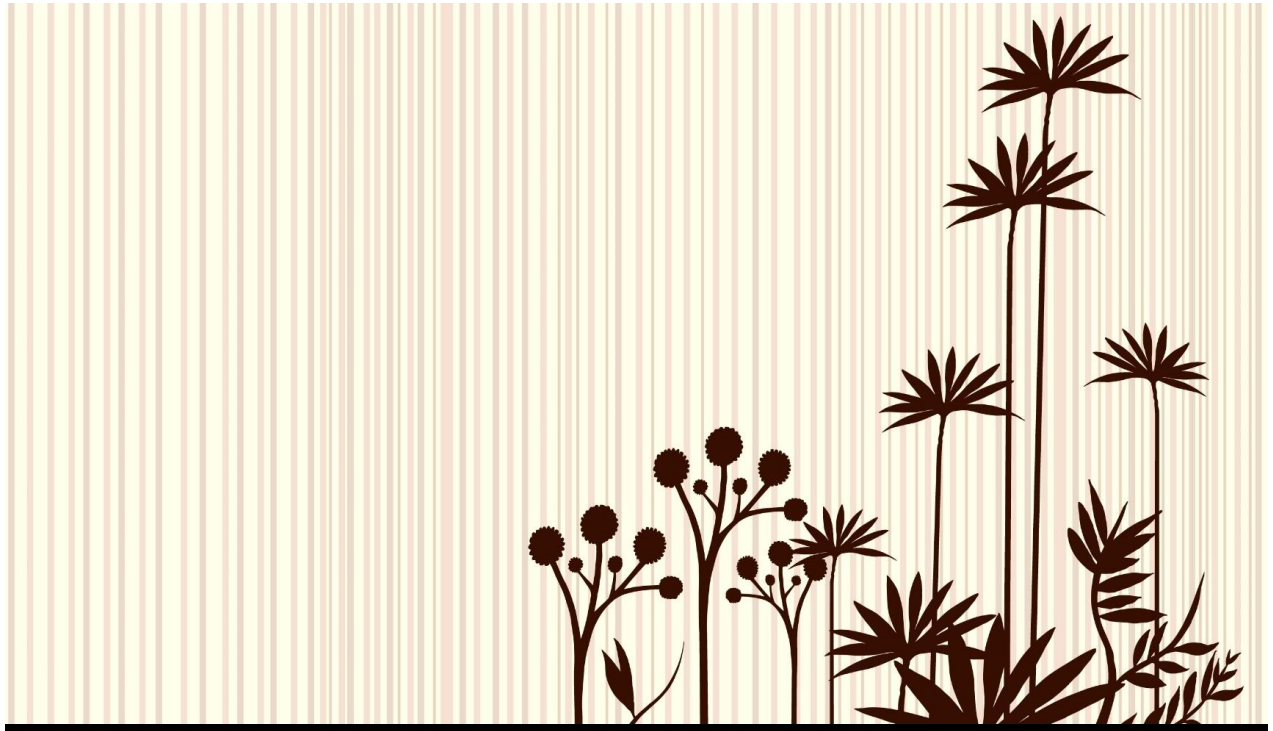
MDHHS agrees that an assessment of these types of neglect cases and unaddressed risk factors could assist in the development of improved policy, practices, and more adequate training for staff. This recommendation will be brought to the SOFAC Safety sub-team for discussion. The Safety sub-team will request participation from a Child Fatality Committee member to assist in providing a coordinated recommendation to the executive SOFAC Committee following discussion.



Annual Report Recommendations

Revise the state model child abuse protocol to include a medical neglect section that provides workers with enhanced guidance beyond word-for-word policy, including options for different ways to engage medical experts in case consultation.

Rationale: The panel noted multiple cases where complex medical issues on the part of the child hindered good case investigation and response. Therefore, the panel suggests that the department utilize the Medical Advisory Committee to assist in establishing more explicit guidance for medical neglect on the revised Safety and Risk Assessment tool. The questions to engage with experts should be specific to the child's medical needs. For example, some questions to ask a doctor of a child who has diabetes could be, "What is the targeted A1C level for this child?" "Has this child maintained their targeted A1C level?" "If not, why and what are your concerns?" The lack of this level of specificity can add to the risk for the child victim.



MDHHS Response

MDHHS agrees with this recommendation. The Governor's Task Force on Child Abuse and Neglect (GTFCAN) is responsible for updating this publication, and therefore MDHHS will recommend these revisions be considered at the next quarterly meeting. MDHHS will also be a part of the revision committee and report back to this CRP regarding the revisions and any additional feedback received from the GTFCAN.

Accomplishments

Improvement in joint investigation protocols.

Changes in CPS policy.

Changes in CPS worker and supervisor training practices.

Improved data systems.

Other Wins

Other improvements to the child welfare system have been implemented over the years not as a result of one specific recommendation, but rather further in-depth knowledge gained internally based on the CRPCF process.

Birth Match

Threatened Harm

Based on the idea of "anticipatory" harm; upheld by Michigan Supreme Court.

Generated by hospitals

Computer systems match daily.

Substantiations

Substantiating on a birth match investigation requires the dep't to file for termination.

Q & A

Thank You

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