

Michigan Citizen Review Panels 2007 Annual Report

Executive Summary – Recommendations and DHS Responses

Sections 106 (b)(2)(A)(X) and (c) of the Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5101 et seq.) requires the establishment of Citizen Review Panels in all states receiving CAPTA funding.

Purpose

The purpose of the Citizen Review Panels is to provide new opportunities for citizens to play an integral role in ensuring that States are meeting their goals of protecting children from abuse and neglect.

Number of Panels Required

Michigan was required to establish three panels by June 30, 1999.

The panels were established with membership from three existing citizen advisory committees: the Children’s Trust Fund, the Governor’s Task Force on Children’s Justice, and the State Child Death Review Team.

The panels are:

Citizen Review Panel for Prevention,
Citizen Review Panel for Children’s Protective Services, Foster Care and Adoption, and
Citizen Review Panel on Child Fatalities.

Reports

The panels must develop annual reports and make them available to the public. These reports are due March 31 of each year. The contents of the reports include the following:

1. A summary of the panel’s activities.
2. Findings and recommendations.

The Michigan Department of Human Services (DHS) must provide a written response to the findings and recommendations of the three panels.

Below are the recommendations of each of the panels. See the entire report for the 2007 activities, findings, and complete recommendations for each of the panels.

Citizen Review Panel for Prevention (The Children's Trust Fund)

Because the Citizen Review Panel for Prevention (CRPP) focused largely on rebuilding and orienting its panel of all-new members, the 2007 recommendations to DHS are relatively brief. In 2008, the panel will determine its focus area(s) and provide relevant information and recommendations.

The panel also felt that while past CPPP recommendations were valid, fiscal limitations have restricted the ability for DHS to successfully implement recommendations. In the future, the CRPP will strive to make its recommendations to DHS both meaningful and viable.

The 2007 CRPP recommendations to DHS are:

1. **Recommendation:** Provide the CRPP with a list of specific prevention initiatives and funding streams that are administered by or flow through DHS. The CRPP will use this information to help determine where prevention dollars are going, and where the biggest gaps in prevention services are. The information will also help inform the CRPP about specific prevention activities within DHS to evaluate.

DHS Response: DHS prevention services and funding streams are enumerated below. In addition to these services, the CTF provides a number of prevention programs.

Prevention funding streams administered by or flowing through DHS are:

1. Child Protection/Community Partners (CP/CP)

State legislated funding (TANF funds) specifically for services to:

- Category III Children's Protective Services cases which are confirmed and low to moderate risk.
- Category IV Children's Protective Services cases which are unconfirmed complaints.

See Attachment A for more information on CP/CP.

2. Strong Families/Safe Children (SF/SC)

Federal funds provided to states for mandatory family preservation, family support, time-limited reunification, and adoption promotion and support services.

These federal funds (Title IV-B, subpart 2 "Promoting Safe and Stable Families") are legislated for services to families with children at risk of child abuse and neglect or out-of-home placement:

- To keep children safe within their home (when appropriate) and prevent the unnecessary separation of families.
- To prevent child maltreatment.
- To promote family strength and stability.
- To return children in care to their families in a safe and timely manner.
- To provide permanent alternatives for children who cannot return home safely.
- To promote and support more adoptions out of the foster care system and help adoptive families maintain permanency.

See Attachment B for more information on SF/SC.

3. 0-3 Secondary Prevention Programs

The 0-3 Secondary Prevention programs are state legislated through DHS TANF funds and the Departments of Education (School Aid) and Community Health. The funds are administered through DHS by the Children’s Trust Fund to local entities to provide prevention services to families with 0-3 year olds who are at risk of abuse and/or neglect.

4. Infant Safe Sleep

CPS Program Office has been involved in the Infant Safe Sleep prevention effort that is not funded by prevention specific funding streams. CPS Program Office expended approximately \$23,000 of the Federal Child Abuse/Neglect allocation during FY 2007 on this project. Local DHS offices were provided DVDs on Infant Safe Sleep for use with clients, a Lobby Video consisting of various public service announcements (including the Infant Safe Sleep message) to be played in the lobbies of local DHS offices, DVD players, etc.

2. **Recommendation:** Promote collaborative prevention efforts at both the community and state level.
 - In the 2006 report, the CRPP recommended that each DHS county office develop a Prevention Services delivery plan that connects with existing community plans and programs. DHS agreed and recommended that “local DHS offices assist in coordinating a multi-disciplinary prevention plan that is inclusive of all stakeholders the plan should include specific outcome criteria and a review process”. The DHS response also recommended that “the DHS Prevention Services delivery be strengthened and be included as an integral part of the Community Collaborative plan”.
 - **CRPP recommendation:** Develop and formalize the specific outcome criteria and review process. This could occur at the community level with input/objectives provided by DHS.

- **CRPP recommendation:** Identify how local DHS offices will develop or spearhead Prevention Services delivery plans with their local stakeholders, especially the Community Collaborative.
- **CRPP recommendation:** Provide direction to local offices and/or Community Collaboratives on how to accomplish this goal.

DHS Response: DHS currently coordinates prevention efforts at the local level as a statewide prevention plan has not yet been developed. Each local office director is part of the local Multipurpose Collaborative Body (MCB) which assists the community in directing resources to best meet the community needs. The local coordinator meets with the local DHS director and management staff to discuss the development and implementation of the Comprehensive Local Office Purchase Plan.

For a family to be eligible for prevention services, one or more of the following risk factors must be present:

- A history of child abuse/neglect.
- A documented substance abuse addiction for a parent.
- A serious mental disturbance for a parent.
- Child who is drug exposed and/or infant diagnosed with failure to thrive.
- Homelessness.
- History of domestic violence.
- Three or more Children’s Protective Services (CPS) complaints (including rejected complaints) or investigations.
- Family income that does not exceed 200% of the poverty guidelines.

An evaluation is being completed to determine if 85% of children who received prevention services were able to remain at home for at least one year after involvement with prevention services.

3. **Recommendation:** Provide the CRPP with updates on the efforts/advancements that have occurred to move local DHS offices/Community Collaboratives toward developing effective Prevention Services delivery plans.

DHS Response: DHS is identifying barriers to self sufficiency for all Family Independence Program clients as lack of self sufficiency can be a risk factor for child abuse and/or neglect. When applying for Family Independence Programs, clients must complete a Family Assessment screening tool which identifies strengths and barriers. These strengths and barriers are incorporated into the Family Support Services Plan. Direct Support Services are used to address barriers as needed. The 10 most requested services and barriers are identified and tracked for prevention services planning.

Due to budget constraints in fiscal year 2007, many prevention initiatives between DHS and the Community Collaboratives were substantially limited. Local DHS offices worked with the Community Collaboratives to maintain as many of the

core initiatives/services as the budget allowed. Subsequently, in fiscal year 2008, DHS was able to approve prevention services that were funded by the Strong Families/Safe Children allocation on a limited basis. (See Attachment C, L-Letter 08-030.) Each local DHS office, with their Community Collaborative, developed a plan for the distribution of available funds to address prevention services that met specific criteria.

**Citizen Review Panel for Children’s Protective Services, Foster Care and Adoption
(Governor’s Task Force on Children’s Justice)**

1. **Recommendation:** The panel recommends that DHS review and provide comment and pursue action on any proposed legislation that comes out of Justice Corrigan’s workgroup.

DHS Response: All program areas within DHS provide input on any proposed/pending legislation that impacts their respective programs.

2. **Recommendation:** DHS to maintain and update the mandated reporter web site.

DHS Response: DHS has implemented a DHS Web Team responsible for maintaining DHS Web sites and ensuring that all DHS Web sites are up-to-date. CPS Program Office is responsible for the mandated reporter Web site. It is reviewed quarterly and updated as needed.

3. **Recommendation:** DHS to maintain and update the Mandated Reporter’s Resource Guide.

DHS Response: The CPS Program Office is responsible for maintaining and updating the Mandated Reporter’s Resource Guide (DHS PUB 112). The guide is currently being reviewed for any needed updates.

4. **Recommendation:** The Mandated Reporter’s Resource Guide is currently only available electronically. The panel recommends that DHS make printed copies of this guide available.

DHS Response: The CPS Program Office will assess whether funding is available to cover the cost of printing the Mandated Reporter’s Resource Guide (DHS PUB 112). If funding is available, the CPS Program Office will request approval to print the guide for distribution.

In addition, DHS continues to work collaboratively with Michigan State University’s Chance at Childhood Program in the development of mandated reporter pamphlets for specific mandated reporter groups. The Chance at Childhood Program has pamphlets available for physicians, school personnel, clergy, social workers and nurses.

5. **Recommendation:** DHS provide training to mandated reporters regarding their obligation to report child abuse/neglect, including when and how to report.

DHS Response: DHS has a contract with the Prosecuting Attorneys Association of Michigan (PAAM) to provide regional training sessions to child welfare professionals on mandated reporting. Local DHS offices also provide mandated reporter training, as requested, to mandated reporters in their community.

Citizen Review Panel on Child Fatalities (State Child Death Review Team)

There were many recommendations that were made as a result of the Fatality CRP reviews. The top recommendations are highlighted below. These are the recommendations that address the most significant findings that the panel felt DHS should make a priority. A rationale is included in order to better explain why the panel chose these specific recommendations for DHS to focus on. The entire list of recommendations is contained in the full report (Attachment B).

Recommendations for the Michigan Department of Human Services

1. **Recommendation:** CPS/Foster Care workers should place greater emphasis on the developmental milestones and medical needs of children. CPS workers require training on child development and medical needs; including information specific to the treatment of complex and chronic medical conditions.

Rationale: Throughout the case reviews it was noted that many children with chronic medical conditions were not serviced appropriately. Their medical needs went unmet resulting in their eventual demise. CPS workers also did not request medical evaluations on children in 9 of the 24 cases when the child was not meeting the appropriate child development stages.

DHS Response: The Child Welfare Training Institute (CWTI) offers “Medical Findings” training to new workers and makes additional seats available for experienced workers who need a refresher. In the latter half of 2008, the University of Michigan Child Protection Team will offer advanced medical training to children’s services workers and supervisors.

CWTI offers “Engaging Children and Families” training in which the Child Development Wheel is presented and reviewed. Developmental concepts are interwoven throughout the CWTI new worker, with additional emphasis placed on developmental milestones and medical needs of children during the foster care Separation, Attachment and Loss (Entry Into Care) module and in the Child Assessment of Needs and Strengths module. In addition, CWTI has an Early Childhood Development package that was offered in 2007 and was made available to all services staff.

2. **Recommendation:** Training is needed for CPS workers such that if the manner of death is coded as Accident or Natural, culpability is not automatically removed.

Rationale: In many cases it was noted in the CPS investigation summary that the medical examiner ruled a death an Accident or Natural. This was used as justification for not substantiating abuse or neglect. There are many circumstances where a death can be a result of a natural disease process but the parents' neglect of their child's medical needs still played a role in the death. CPS still needs to complete a thorough investigation into a child's death regardless of the cause and manner of death, including but not limited to a review of the complete autopsy.

DHS Response: CWTI currently provides mandatory training for all CPS supervisors. A focus of that training is on how supervisors ensure that workers complete thorough investigations. In CWTI's committed effort to further address the complexities of the job and the types of cases DHS serves, greater emphasis will be placed on the issue regarding manner and cause of death not being the deciding factor in a CPS case disposition. Enhancements to CPS supervisory training are scheduled to be integrated into the training early in 2009.

In collaboration with the Michigan State Police (MSP), CWTI provides a mandatory training for all CPS workers and supervisors on Advanced Interviewing and Investigations. In 2009, the currently trained MSP Advanced Interview and Investigation training, in both concept and application, will be incorporated into the 8-week New Hire training.

CWTI will present a workshop based on a child death case scenario and missed clues at the 2008 Child Abuse and Neglect conference. In addition, in 2009, in collaboration with law enforcement and medical examiners, CWTI will develop/deliver advanced training that emphasizes the importance of thorough investigations and appropriate decision making in child death cases. CWTI recognizes the importance of completing thorough investigations and is in the beginning stages of developing an advanced worker investigation training, with emphasis on child death cases.

3. **Recommendation:** CPS and Foster Care workers should be aware of and educated on environmental safety hazards including issues such as fire and water safety, child passenger safety and safe sleep.

Rationale: There were a number of deaths to children as a result of home safety issues going unnoticed during a CPS investigation. An example would be sleep related deaths. When CPS workers are in the home providing services or completing an investigation, the child's sleep environment should be

viewed as a potential risk to the child's safety. In many cases this was not done and the child died as a result of their sleep environment.

DHS Response: In the new worker training for CPS, CWTI facilitates a mock home environment where safety issues are identified and discussed. During new worker and program transfer training, CWTI provides literature on Infant Safe Sleep. In addition to the information CWTI provides on Infant Safe Sleep, as part of the DHS Infant Safe Sleep Initiative, each local office is to ensure all staff are knowledgeable about Infant Safe Sleep and that all staff promote the message properly. (See Attachment D, L-Letter 08-041.)

CWTI remains committed to providing training that will enhance a worker's ability to identify safety factors when making home calls. To that extent, by the second quarter of 2009, CWTI will collaborate with the Bureau of Child and Adult Licensing (BCAL) to identify how training can best ensure service workers are knowledgeable about, and focus on the safety factors that they should be aware of while in the home. BCAL was identified as a collaborative partner due to their experience/expertise in training licensing workers on how to complete a physical assessment of a person's home.

4. **Recommendation:** Supervision for CPS and Foster Care workers should be mandatory every thirty days to discuss the progress of their cases.

Rationale: The level of supervisory oversight in 63% of the cases reviewed by the panel did not follow CPS policy. In many cases reports were not signed by supervisors at all. Reports also were signed well after the disposition of the case was designated, not allowing for supervisory input into that decision. In addition, mandatory paperwork such as the 30-day exception documentation was not signed in a timely manner. Also, in 63% of the cases there was a lack of or no collateral contacts made. Supervisory oversight should ensure that these policies are followed.

DHS Response: In fiscal year 2008, DHS received an additional 31 million dollars to support the expansion of Child Welfare staffing and funding resources.

As part of the Governor's Child Welfare Improvement Plan, DHS gained 298 child welfare positions allowing more appropriate supervisor to staff ratios. When fully staffed, supervisors will be better able to allow sufficient time to meet with their staff on a regular basis.

DHS has, and continues to, mandate the CPS Supervisor Training. One goal of the CPS Supervisor Training is to improve the supervisory oversight of workers. As part of the training, CPS supervisors are provided with information on how to provide oversight to CPS workers. Some of the techniques taught are: what to cover in case conferences with individual staff, how to document and follow-up on issues, how to document what is covered in staff meetings, how to read cases

to ensure child safety and that thorough investigations are completed, among other topics.

As part of a lawsuit settlement, supervision for children's services staff will be mandated to occur on a monthly basis. In addition, the lawsuit mandates a children's services staff to supervisor ratio of 5 to 1.

5. **Recommendation:** DHS policy staff should work with local offices to create community resource guides utilized to educate on the available services to families.

Rationale: In many of the cases, the services were inadequate to address the needs of the family. It appeared the worker was unaware of referrals they could have provided to the family.

DHS Response: Most communities have already developed community resource guides, which are made available to DHS local offices. In addition, the 2-1-1 system, spearheaded by United Way, is a health and human services equivalent of 9-1-1 to give and get help to families who need services. A recent report to the Michigan legislature identified more than 700 toll-free telephone lines maintained by state agencies for public access to governmental services. Local DHS offices are coordinating with the 2-1-1 resource referral system as 2-1-1 is implemented statewide to allow for more extensive and up-to-date connections to community resources.

6. **Recommendation:** Specific trainings on the Structured Decision Making Tool, specifically the risk assessment and how to use it to accurately identify the needs of the family.

Rationale: In 18 of the 24 cases, the risk assessments were completed incorrectly which resulted in the wrong disposition in the investigation. It also resulted in inadequate services being provided to the family.

DHS Response: The CWTI training provided to new workers and those transferring to a different program extensively covers the proper use of Structured Decision Making (SDM) tools. Proper use and scoring is accomplished through use of definitions, discussion and case practice. Upon request from the field, CWTI provides local office refresher training on the use of SDM tools.

Below are recommendations that the panel made for other departments. Although the CAPTA legislation only requires that recommendations are made to DHS, the panel feels that multidisciplinary change is required to protect children. Thus, we have highlighted recommendations below for other state departments.

Recommendations for Law Enforcement

1. Training is needed for law enforcement such that if the manner of death is coded as Accident or Natural, culpability is not automatically removed.

Rationale: In many cases it is noted that law enforcement did not pursue further investigation in the case because the medical examiner ruled the manner as Accident or Natural. An accidental death is not automatically free of criminal culpability.

2. Law enforcement should receive mandated reporter training, using the state developed training materials, on how to recognize the signs of child maltreatment and how to make a report to DHS.

Rationale: Law enforcement failed to follow statute and report suspected child abuse and neglect to Child Protective Services.

Recommendations for Michigan Department of Education

1. Chronic truancy should result in a referral to the appropriate authorities or an investigation by school officials. Resources for truancy officers and school resource officers could be utilized to enforce this policy. Schools could also explore the possibility of having their computer systems flag chronic attendance problems with their students.

Rationale: Chronic truancy can at times be a sign or symptom of child maltreatment. It can not only be a sign of chronic neglect it can be a sign of physical abuse that the parent wishes to conceal from the school. A well-being check should be completed in these cases to ensure the safety of the child.

Recommendations for Medical Professionals

1. Hospital social workers should complete a safety assessment when a person under the age of 16 gives birth, to evaluate for the family's needs and risk for the newborn.

Rationale: Teenage mothers under the age of 16 should undergo a social work assessment to determine any risks the family might have. In some cases a teen mother has been unprepared to care for her newborn, resulting in risks to the child's health and safety.

2. Mandate a toxicology screen for cold and cough medications by medical examiners in cases of sudden unexpected child deaths under the age of three.

Rationale: Toxicology screens done at autopsy across the state vary in the substances they screen for. Medications contained in cold and cough medications are very dangerous for young children and can easily result in overdose. These deaths can often be mistaken for sleep related infant deaths. Thus this screening will help to better identify these cases and prevent future deaths.

3. Medical professionals should receive mandated reporter training, using the state developed training materials, on how to recognize the signs of child maltreatment and how to report suspected child abuse and neglect to Child Protective Services.

Rationale: In six of the 24 cases reviewed by the panel, medical professionals failed to make the statutorily required referrals to Child Protective Services.

4. Medical Examiners should consider using Undetermined as a manner of death in cases where medical neglect or other negligence could have played a role in the child's death in order to assist in the prosecution of such offenders.

Rationale: In many cases law enforcement, prosecutors and child protective services workers determine their course of action based on the manner of death determined by the medical examiner.

5. The panel supports the Michigan Association of Medical Examiners' creation of a peer review process in order to address the inconsistencies across the state in how medical examiners report cause and manner of death.

Rationale: All aspects of the medical community have a peer review process in order to maintain quality standards. Medical examiners in the state of Michigan do not have any oversight or peer review process. As a result there can be inconsistencies in the ways in which similar types of deaths are determined. This results in adverse outcomes in court cases as well as in targeting prevention initiatives.

Recommendations for the Courts

1. Prosecutors should charge mandated reporters for failure to report when there is suspected child abuse or neglect.

Rationale: In eight of the cases that underwent a full case review, mandated reporters failed to make the appropriate referrals to CPS. If professionals do not carry out their legally mandated duty to report, child abuse and neglect goes untreated and in these cases resulted in the child's death.

2. Training is needed for prosecutors such that if the manner of death is coded as Accident or Natural, culpability is not automatically removed.

Rationale: In many cases it was determined that a perpetrator would not face prosecution because the medical examiner ruled a death as an accident or as natural. There are many circumstances where a death can be a result of a natural disease process but the parents' neglect of their child's medical needs still played a role in the death. Prosecutors need to complete a thorough investigation into a child's death regardless of cause and manner.