

Michigan Citizen Review Panels 2002 Annual Report

Federal legislation established the requirement for and parameters of the Citizen Review Panels. Those requirements are:

Legal Requirement:

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.

Expected Outcome:

It is expected that Citizen Review Panels will increase community awareness and ownership of child abuse and neglect issues, the strengths, weaknesses and challenges facing the child welfare service delivery system, and will promote creative problem solving.

Number of Panels Required:

Michigan is required to establish three Panels by June 30, 1999.

Panel Membership:

The Panels must be composed of volunteer members who are broadly representative of the State if they are State Panels, and of the community if they are Community Panels.

Federal guidelines recommend that Panel membership include a balance among children's attorneys, child advocates, CASA volunteers, parent/consumer representatives and health/mental health professionals who are familiar with the intricacies of the CPS system. The majority of the membership must include volunteer members from outside the public child welfare system.

Panel Requirements:

Each Citizen Review Panel must perform all of the following functions:

1. Evaluate the extent to which the State agency is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State Plan, as well as other criteria that the Panel considers important to ensure the protection of children. The review must incorporate examining the policies and procedures of State and local agencies.
2. Review the extent to which the State CPS system is coordinated with the foster care and adoption programs.

3. Review of child fatalities and near fatalities.
4. Federal law and regulation do not prescribe the depth of breadth of review of the above issues, which the Panels must conduct. Therefore, one Panel may choose to conduct in depth reviews of one of the prescribed functions and less extensive reviews of the other issues. Panels may also add issues.

The State must assure that the three Panels' combined review and input provide a holistic picture of the State's CPS system.

Frequency of Meetings:

Each Panel must meet no less frequently than every three months.

Panel Access to Case-Specific Information:

The State must provide each Citizen Review Panel with access to information on cases that the panel determines is necessary to carry out its functions under CAPTA.

Staff Assistance:

The State must provide staff assistance to the Panels for the performance of their duties upon request of the Panel.

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

Confidentiality:

Citizen Review Panel members are bound by the confidentiality restrictions of CAPTA. Specifically, members and staff of a Panel may not disclose identifying information about any specific child protection case (CPS and Foster Care cases) to any person or government official, and may not make public other information unless authorized by state statute to do so.

CAPTA requires states to establish civil sanctions for violations of these confidentiality restrictions.

Michigan established three panels in 1999 along with an Executive Steering Committee to coordinate the work of the three panels. In addition, there is an annual meeting of all panels.

The primary purpose of the annual meeting is to review the work of each panel, identify areas of mutual concern, and develop approaches to integrate review of those areas.

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 Protective Services, Foster Care and Adoption
- Citizen Review Panel on Child Fatalities.

This document summarizes the work of these Panels for 2002.

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

Purpose:

The United States Congress mandated that states receiving federal Child Abuse Prevention and Treatment Act funding establish a minimum of three Citizen Review Panels to assess and develop recommendations for the improvement of a state's child protection system. The Children's Trust Fund serves as the review panel for *Prevention* in the spring of 1999 the Children's Trust Fund Board accepted the responsibility of overseeing the Citizen Review Panel on Prevention. While focusing on the prevention of child abuse and neglect, the Children's Trust Fund Citizen Review Panel on Prevention (CRPP) will view prevention from a holistic approach noting that the *prevention of child abuse and neglect is a community responsibility*.

Members:

Candace Cowling	Mike Foley	Susan Fulton	Larry Burke
Sgt. Greg Jones	Richard Lively	Elizabeth O'Dell	Douglas Patterson
Kim Sanford	Paul Shaheen	Pat Sorenson	Mara Stein
Michele Strasz	Stephen Thomas Jr.	Susan Toman	Betty Wright
Deborah Strong	Shannon Stotenbur		

2002 Activities:

- Submitted recommendations to FIA regarding the CRPP findings surrounding the prevention transition from Children's Services to Family Independent Specialist. Recommendations were submitted and a response was received from FIA personnel.
- The finalized prevention definition created by the CRPP was sent to several State Departments such as Department of Community Health, Department of the State Police, Family Independence Agency, and the Department of Education. At this time, verbal acceptance has been given from the State Police and the Family Independence Agency.
- Developed a committee to look at current prevention program within FIA and will be convening focus groups with supervisors, workers, and clients surrounding this issue.

Key Findings:

There is a need to preserve the core value of prevention by:

- 1) Recognizing the work load restraints of those providing prevention services.
- 2) Ensuring that prevention services remain a voluntary program for clients.
- 3) Maintaining the nature of the relationship with a client that is common to prevention workers (non-threatening, working toward a more client based relationship).
- 4) Ensuring no time limits for clients needing prevention services.
- 5) Ensuring continuation of the traditional funding sources for prevention programs.

Recommendations:

- ❖ Need for increased emphasis on prevention.
 - ◆ The panel recommends utilizing a definition that is accepted and used by the entire human service field. The panel has created a definition that has been proposed to FIA.
 - ◆ Begin prior to birth before problems exist.
 - ◆ Need a single source within each county for prevention services or one body to oversee and coordinate prevention services throughout the community.
 - ◆ Assure adequacy of prevention services.
- ❖ Move the concept of prevention to a community responsibility.
- ❖ Need for connections within community plans or one community plan accepted by all agencies and programs (i.e. SF/SC, Wraparound, CPCP, and Permanency Prevention Plan).
- ❖ Need opportunities for workers to sustain knowledge and build ongoing learning.
 - ◆ Staff receives ongoing training, but is resistant to utilizing new knowledge and skills.
 - ◆ New staff requires ongoing support from experienced workers, in addition to supervision, as they utilize new knowledge and skills.
 - ◆ Need for refreshers and updates after training as well as specialized training.
 - ◆ Need for regular, ongoing supervision of workers to ensure new skills and knowledge are implemented and maintained.
- ❖ Need to evaluate the effectiveness of prevention services.
 - ◆ Determine appropriate outcomes and measurement tools.
- ❖ Emphasis on collaboration.
 - ◆ Needs to be part of culture.

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Updated 02/2003

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Michigan Citizen's Review Panel for Children's Protective Services, Foster Care and Adoption (The Governor's Task Force on Children's Justice) Annual Report

Purpose:

The United States Congress mandated that states receiving federal Child Abuse Prevention and Treatment Act funding establish a minimum of three Citizen Review Panels to assess and develop recommendations for the improvement of a state's child protection system. The Governor's Task Force on Children's Justice serves as the review panel for Children's Protective Services, Foster Care and Adoption.

Members:

Ernestine Moore, Co-chair
Gloria Gillespie, Co-chair

Jean Carl
Joseph Marshall
Cheryl Matthews
Teri Covington
Ted Melinat
Nancy Diehl
Christine McPherson

Susan C. Dobrich
JoAnne Nagy
Kathy Kovalchik-Lacko
Pamela O'Sullivan
Judy Labovitz
William Schikora

Staff to the Panel: Maria Candy, Henry Hofstra, and Mary Mehren.

2002 Activities:

The Panel met five times. The Panel continued to focus on services to meet the emotional needs of children in out-of-home care. We were concerned that children displaying “problem” behaviors were indiscriminately referred for counseling services and those with more severe emotional needs were experiencing several disruptions in placements. The meetings focused on reviewing the placement histories of approximately 75 children under the age of 12 years who had experienced multiple foster home and residential placements. After reviewing these cases and having presentations from a child psychiatrist and representative of Michigan’s children’s mental health system, the Panel concluded that the State needed to improve its policies and protocols for caseworker referrals for mental health evaluations and on-going counseling services. The Panel identified two psychologists from Wayne State University with extensive experience in working with abused or neglected children. The Family Independence Agency contracted with them to review and evaluate current FIA policies and practices and to recommend improvements. An interim report, Assessment and Treatment of Children in Foster Care, was presented to the Panel in October. The final report is expected in April 2003. Once the final report is received, the Panel will review the recommendations and work with FIA to implement the most promising.

The Panel participated in the Child and Family Services Review process with members serving on the work group to develop the self-assessment, being a team member for the on-site review, and advising in the program improvement plan process.

Finally, the Panel Co-chairs serve on The Foster Care Resource and Assignment Unit Committee. This Committee is developing a system for placement to ensure that children in need of residential or treatment foster care are timely placed in the most appropriate placement.

The goal is to reduce the number of placement disruptions resulting from inappropriate initial placements.

Key Findings:

The Panel found that, for the most part,

“Counseling services” were recommended for all children with behavioral problems.

There appeared to be no assessment as to whether or not other factors precipitated the behavioral problems nor if other services would be most beneficial to an individual child. Further, there was no discernment as to the type of counseling services that would be most beneficial. Children with severe emotional disturbances were not considered for residential treatment services until after they had disrupted in multiple “specialized foster home” placements.

Recommendations:

The Panel recommended that

- a complete review and assessment of the current policies and procedures for assessment and treatment of children in foster care be undertaken by outside experts.
- recommendations for improvement of the current policies and procedures by provided to the Panel for further discussion and recommendation to FIA.
- FIA Central Office review its current requirement for Central Office approval for residential placements for children under age 12 years and develop appropriate resources statewide to meet the needs of children with various degrees of need for mental health treatment, including residential care.

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Michigan Citizen's Review Panel for Child Fatalities (Child Death Review State Advisory Team) Annual Report

Purpose:

The United States Congress mandated that states receiving federal Child Abuse Prevention and Treatment Act funding establish a minimum of three Citizen Review Panels to assess and develop recommendations for the improvement of a state's child protection system. The Michigan Child Death Review State Advisory Team serves as the review panel for *Child Fatalities*. This panel meets quarterly to examine and review child fatalities due to neglect and/or abuse using several sources (FIA's Report of Minor's Death, MDCH's Vital Statistics, and the Child Death Review reports) to identify specific cases. Case-specific information is gathered on each fatality and the panel, subsequently reviews each death, compiling a list of issues or concerns. Based upon these reviews and the findings, the panel makes recommendations to the Michigan Family Independence Agency in the form of an annual report.

Members:

Chairperson: Vincent J. Palusci, M.D.

David Blocker
Teri Covington
Sandra Frank
Shirley Mann-Gray
Virginia R. Harmon
Douglas M. Paterson

Brian Hunter
Sgt. Gregory A. Jones
Joseph Marshall, M.D.
Margaret Penninger
Frank Vandervoort

Support Staff from MPHI: Heidi Hilliard Jean Kayitsinga
 Cheryl Niblo Sara Sharpley
 Jane Paterson

2002 Activities:

The Child Fatality Citizen Review Panel convened four times during the 2001 – 2002 fiscal year: March 27, June 14, August 26 and December 17. The focus of the panel this year was the child maltreatment deaths that occurred in 2000. As in the past, the cases to be reviewed were determined based upon data from the Family Independence Agency’s Report of Minor’s Death, the Child Death Review reports and the Michigan Department of Community Health’s vital statistics, specifying deaths of children 0 – 18 which resulted from child abuse and neglect. In addition, specific information on the determined deaths was requested from Prosecuting Attorneys, Law Enforcement and Medical Examiners. Panel activities included:

- ❑ Invited speakers:
 - Two FIA Children Protective Services workers enlightened the panel on the role of the CPS worker in their presentation entitled the “Structured Decision Making Process”
 - A Pediatric doctor, an expert on drug-exposed infants, who presented on “Mortality and Morbidity in Infants of Drug Dependent Mothers”
- ❑ Reviewing the cases of child fatalities due to abuse and neglect (a total of 91). In our ongoing endeavor to hone the review process we attempted several methods of group-review:
 - Dividing the some of the neglect cases (54) among small groups and then reconvening as a whole to discuss the findings;
 - Focusing the entire meeting on one, very complicated case (the members were provided a packet that included a detailed case abstraction, investigation history, newspaper articles and a date timeline of events);
 - Having a sub-group of the panel review all the abuse-related cases, charged with selecting cases for an in-depth review of the entire panel.
- ❑ The case review process continues to be a on-going topic as we attempt to develop protocols/guidelines by which to most effectively review the cases.

Key Findings:

IDENTIFICATION, REPORTING AND FOLLOW-UP:

1. Failure among medical professionals to diagnose and report suspected abuse and neglect.
2. Poor medical follow-up by families and medical professionals after hospitalization.
3. Failure among pathology professionals to fully conduct an acceptable autopsy that would allow identification of maltreatment injuries
4. Failure to refer cases for autopsy because a child has a previous medical condition, despite suspected additional inflicted injuries.

INVESTIGATION, ASSESSMENT AND THE PROVISION OF SERVICES BY FIA:

5. Inappropriate screening-out of complaints and delay in acceptance of complaints and case assignment This was also discussed by county workers who noted that some county FIA offices rotate the intake function, potentially compromising the intake and disposition of the initial complaint.
6. Failure to provide feedback to medical providers when they failed to identify child abuse or medical neglect

7. Incomplete and insufficient investigation by FIA staff. This was also discussed by county workers who noted that caseloads were sometimes too high to allow thorough investigation.
8. Unacceptable time lapses between assignment and contact with families.
9. Supervisor to sign off on child abuse/neglect assessments within an appropriate timeframe.
10. Failure to contact mandated reporters (law enforcement, medical) during the investigation; insufficient review of previous FIA history. Poor communication among law enforcement, courts and FIA results in the whole picture of the child and family's condition not being adequately evaluated.
11. Failure to perform complete investigations regarding medically fragile babies because it is believed the child 'will die anyway'.
12. Inaccurate assessment and improper coding of the five-tiered system. This was also discussed by county workers who noted that the high number of cases also had the potential to compromise worker oversight in these assessments by supervisors.
13. Failure to comply with FIA policy that requires that positive drug screens on newborns result in automatic finding of a preponderance of the evidence for failure to protect
14. Failure to make a finding that there is a preponderance of the evidence for abuse or neglect complaints when otherwise indicated only because parents are not at home when workers attempt a visit.
15. Failure to place all caregivers (perpetrator and non-involved) on Central Registry when warranted, i.e. Live-together partners (LTP).
16. FIA worker must enforce policy to assess well-being of child(ren) in the home, recognizing a sick child or verifying that a sleeping child is well. (Based on a reviewed case where the child was dead at the time of a visitation by the CPS worker).
17. Modify level of risk determination when evidence of reasonable cause to believe caregiver is dishonest in responses, fails to follow care recommendations and / or there is a known impact of prior criminal history on current investigation.
18. Failure to recognize and respond to parents' communications that they do not want the pregnancy or child/children.
19. Safety Assessment completed incorrectly or not at all.
20. Risk Assessment completed incorrectly or not at all.
21. Totality of case inaccessible to the caseworker, including timelines, substantiations and unsubstantiations.
22. Protocol to assure cooperation between FIA and CIS.
23. Foster Care should give consideration to the number of children placed in a foster care setting, especially in homes specializing in children with special or medical needs.

COMMUNICATION WITH LAW ENFORCEMENT:

24. Notify law enforcement and follow up for abuse and neglect injury; Law Enforcement ability to interview suspects will be valuable to FIA investigation.
25. Criminal history check in order to determine impact of prior criminal history on current investigation (addressed in FIA safety initiatives LEIN policy)

COURT PETITION AND ADJUDICATION:

26. Petition not filed with the court by FIA because workers believe the court will not certify or accept their petitions, despite there being adequate reason.

27. Courts, investigators and child attorneys are not always accessing the complete FIA file information, leading to inaccurate decision-making.
28. Courts sometimes inappropriately return children to an abusive family, disregarding CPS recommendations.
29. Courts denied information provided by FIA.
30. Child Welfare agency should aggressively pursue patterns of practice by the court, which ignore the facts of a case presented as a matter of record.
31. To assure effective protection of minors, Child Welfare agency must assume legal representation of workers in legal proceedings.

Recommendations:

Identification, Reporting, and Follow-up

1. Ensure adequate training for mandatory reporters in the identification and reporting of child abuse and neglect and ensure use of death investigation protocols and need for autopsy.
2. Enhance existing training on medical neglect by FIA for mandatory reporters.
3. Ensure that particular mandated reporters, including Medical Examiners, primary care providers, emergency department staff and emergency medical personnel have opportunities to attend training on child abuse and neglect.
4. Require Medical Examiners to allocate a certain proportion of their required continuing medical education hours to issues related to medical examiner work and pediatric forensic pathology.
5. Provide support and encouragement for all counties to hire and/or train medical examiner investigators.

Investigation, Assessment and the Provision of Services by FIA

1. Time lapses between complaint and case assignment, communication breakdowns and inadequate risk assessments suggest the lack of experience of workers and poor morale. While we believe high quality work is being done within FIA, a high turnover rate of CPS workers has been identified which contributes to our challenge of keeping trained and experienced CPS workers. Programs should be designed to retain, encourage, reward and promote good workers and to move those not up to the task to other less challenging positions within FIA.
2. During case review, the Fatality CRP members often sensed fragmentation among FIA divisions and services, resulting from CPS workers being pulled in multiple directions and unable to focus on the needs of the child or children in question. This could be addressed by increasing staff numbers, thereby decreasing caseload per caseworker, allowing more attention and investigation research per given case.
3. Train workers to recognize and react to serious indicators of abuse regardless of previous assessment findings.
4. Train workers to obtain, review and understand medical records, especially for infants.
5. Ensure compliance with the recently adopted FIA policy "CFP 713-11 CPS Risk Assessment Overrides" to provide improved supervisor oversight on all assessments.
6. Ensure careful agency review and monitoring of all worker investigations and referrals for investigation.
7. Consider putting in place a standard of timeliness for the supervisor to review and approve all cases with a risk assessment within 24 hours, thereby enhancing compliance

with FIA Policy “CFP 71309 Time Frame for Completion of Field Investigation” requiring completion within 30 days.

8. Cases should not be found to lack a preponderance of the evidence solely on the basis that a family cannot be located. If no contact can be made after 30 days, policy should be followed to assign the case to Category V “Unable to Locate” with adequate documentation showing the worker’s “due diligence” in seeking to make contact, as required in FIA Policy CFP 713-8.
9. Consider implementing a policy that requires acceptance of a complaint for investigation when a predetermined number of uninvestigated or unsubstantiated complaints had already been received regarding the child or family.
10. Improve current compliance with CFP 712-8, which, we believe, indicates that all cases must be registered on the local FIA client information system within 24 hours of receipt of complaint.
11. FIA should examine cases of child fatalities in which there were numerous prior screen-outs or were assigned for investigation and closed with “No preponderance” to determine how policy changes can avoid omissions.
12. Enhance training opportunities for law enforcement, court and FIA personnel around the implementation of joint investigation protocols.
13. Ensure compliance with FIA procedures that require criminal history checks on all caretakers involved with the child.
14. Review FIA standards of investigation to ensure that the investigators have met their obligation of ‘due diligence’ in conducting a full investigation.
15. Improve morale and training of workers. New CPS workers entering the Child Welfare Institute should be identified as CPS workers so that they can more directly focus on CPS during their training. Focus energy on persons who want to do CPS work. Screen these people ahead of time to ensure that they want to be doing CPS. Explore selective certification for CPS workers.

Court Petition and Adjudication

1. Review FIA policy regarding court petitions and procedures for FIA staff to appeal petition non-acceptance.
2. County FIA offices should designate individual workers for court appearances and/or establish practices to assure conveyance of all information to the court, investigators and the child’s attorney.
3. Review FIA policy regarding procedures for FIA staff to appeal inaccurate and/or potentially dangerous court adjudication.

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