

## **Michigan Citizen Review Panels 2003 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.

Effective with the June 2003 amendments to the CAPTA legislation, panels were given additional responsibilities. They are

1. examine the practices as well as the policies and procedures of the State and local agencies to evaluate the extent to which the agencies are effectively discharging their child protection responsibilities.
2. provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community.
3. make recommendations to the State and public on improving the child protection services system at the State and local levels. The State Agency is required to respond in writing no later than six months after the panel recommendations are submitted.

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 2003.

# 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		

## **2003 Activities:**

- Participated with the Michigan Family Independence Agency Lines of Service (LOS) program to give input to help streamline services already provided by the state. The Citizen's Review Panel had members who actively participated on the teams and provided feedback to team on issues that the Panel had currently addressed. Examples of issue already addressed were: The transfer of Prevention Services from Services to the FIS program, a statewide definition of prevention, and services currently being duplicated across departments.
- 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. The definition was used in the FIA Program Improvement Plan submitted to the Federal Government in response to the federal audit.

- Developed a vision for where the CRPP would like to focus their attention. It was decided that they would like to take a look at actual prevention cases in the state and see exactly what services are being delivered to the state's prevention clientele.

### **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.

# Children's Trust Fund Citizen Review Panel

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Updated 03/2004

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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) 2003 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. Members from The Governor's Task Force on Children's Justice serve on the review panel for Children's Protective Services, Foster Care and Adoption.

## **Members:**

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

Jean Carl  
Susan C. Dobrich  
Kathy Kovalchik-Lacko  
Judy Labovitz  
Joseph Marshall  
Cheryl Matthews

Christine McPherson  
Ted Melinat  
JoAnn Monaghan  
JoAnne Nagy  
Pamela Gilbert O'Sullivan

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

## **2003 Activities:**

The Panel met four times. The Panel continued to focus on services to meet the emotional needs of children in out-of-home care. In 2002, The Panel identified two psychologists from Wayne State University with extensive experience in working with abused or neglected children. The Family Independence Agency (FIA) 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 was presented in June 2003. The Panel reviewed the recommendations, provided the report to FIA program staff and, after discussion, submitted a letter to the FIA Director supporting the recommendations and encouraging focused attention to implementing them.

The Panel reviewed the State's response to the Child and Family Services Review and provided input. The Panel will continue to monitor the State's development and implementation of the Program Improvement Plan.

Finally, the Panel developed its 2004 Work Plan. We will:

- Complete the 2003 Annual Report.
- Finalize recommendations to FIA on Screening, Assessment, and Treatment of Children in the child welfare system and monitor implementation of the recommendations.
- Develop methods for public outreach and comment as required by the CAPTA changes.
- Conduct case reviews to identify systemic issues in child welfare in cooperation with the other two citizen review panels.
- Provide oversight of the Child and Family Services Review Program Improvement Plan implementation.
- Review Michigan's compliance with the Indian Child Welfare Act.

### **Key Findings:**

The Child and Family Services Review confirmed that Michigan's policies and practices did not ensure that children's mental health needs were met as the Panel had determined in 2002. Despite seeming best efforts of staff in the Family Independence Agency and the Department of Community Health to reduce systemic barriers to effective service, the State's system of mental health and substance abuse treatment services for children and adults served by the child welfare system remains fragmented and "too little, too late".

### **Recommendations:**

After thorough review, the Panel recommended that FIA implement the following recommendations from the "Screening, Assessment, and Treatment of Children" Report by Douglas Barnett, PhD and Steven Ondersma, PhD. from Wayne State University:

"The information integrated within this report provides a clear mandate to the state. As is well known, Michigan has a direct responsibility to care for a large number of its most vulnerable citizens. There are numerous reasons to believe that the medical, mental, social, and educational needs of these children are great and are not being adequately identified and addressed, and conversely, that the strengths of these children are also not being adequately evaluated and capitalized upon. We propose the following recommendations to ensure that each foster child's strengths and needs are adequately and accurately identified and addressed. We organize recommendations to address this need into several sections: policy and funding, practice, and research.

#### **A. Policy and Funding**

According to our survey results, FIA-146 has been adopted as a standard procedure in the vast majority of foster care cases. Prior research has indicated that this form is part of a process that is associated with children having briefer stays in foster care (Wagner, Johnson, & Caskey, 2001). In these regards, FIA-146 and the Structured Decision Making process has proven to be an economical policy change that has likely benefited thousands of children in Michigan. However, numerous questions regarding the reliability, validity, and utility of FIA-146 remain. It is also unclear how frequently children receive referrals and services for the problems identified using FIA-146 and the rest of the current process.

Consequently, the next step for Michigan involves improving the reliability, validity, utility, universality, and comprehensiveness of the screening, referral, and monitoring of the needs of children in foster care. This change is going to require changes to how FIA views their

charge of children in foster care. A comprehensive program that reaches all children in foster care is going to be expensive to develop and maintain. Although we also believe that many existing systems and procedures already in place to serve Michigan's children can be coordinated and integrated to more effectively serve children in foster care. Currently, the majority of children in foster care receives health coverage through Medicaid and therefore should be being followed through their program in Early and Periodic Screening, Diagnostic, and Treatment that should be monitoring children's physical health needs already. Moreover, Michigan's Department of Community Health offers a number of programs for children and families such as Wraparound Services and Permanency Planning Services that may already serve or be adapted to serve the needs of children in foster care (see [www.michigan.gov/mdch](http://www.michigan.gov/mdch) for more detail).

*Specific Recommendations regarding policy and funding:*

1. Set policies encouraging the screening of all children in foster care concerning physical health (including dental needs), mental health, education, and social needs. If compromises must be made, we strongly recommend starting with mental health given the literature and our survey, both of which indicate that this may be the most under-examined and addressed area among children in foster care.
2. Set policies that encourage cooperation across state departments of FIA, Community Health, & Education.
3. Set policies that marshal adequate resources to fund fully a screening and referral network around Michigan, including education of all stakeholders so that children can benefit maximally; evaluation to demonstrate and refine the program's utility.
4. Establish an atmosphere where research and evaluation are routine and welcome components of child welfare.

**B. Practice**

Many states around the nation have begun comprehensive screening and assessments for increasing larger numbers of children in foster care. Following a review of the research and best practices concerning the assessment and treatment of children in foster care, we recommend Michigan takes steps toward universal screening for the health, mental health, education, and social needs of children in foster care. We recommend such a network of screening and treatment centers be developed and maintained over the next 10 years to assure high quality care for children for which the state of Michigan have assumed responsibility. Ten years seems to be a realistic length of time given that no current system exists. This will provide enough time to establish such a system, refine it to run efficiently, educate stakeholders and the community, and develop adequate coverage for all of the various regions of the state

*Specific Recommendations for Practice:*

If a decision is made to design and implement a system for screening, referring, and monitoring treatment for children in foster care, we recommend that the following elements be addressed:

5. Standardized, reliable, and valid instruments must be utilized to screen at least four broad domains to yield a comprehensive and quantifiable profile of child well-being and needs.
6. Identified needs must be communicated to all relevant stakeholders such as the child, biological parents, foster parents, and in many cases select information may need to be shared with school to ensure a coordinated plan to improve child well-being. Foster care

specialists or their equivalents would be in the best position to see that relevant information is communicated and understood by all relevant parties including the child.

7. For all needs identified, particularly those of high priority, there must be trained professionals in place to provide treatment and service, and prepared to work with children in the child welfare system.
8. The state should have a policy of favoring evidence-based treatments where available.
9. Networks of providers of services, particularly mental health professionals need to be established, educated, nurtured, and coordinated to meet the complex needs of children in foster care.
10. Monitoring of referrals and treatment are necessary to help ensure the maximal efficacy of the implemented services.
11. Follow-up assessments are recommended before each case has its mandated annual review in court.
12. Establishment of a centralized database for research and evaluation, to improve the screening and referral networks with time.

### **C. Research**

This report is an initial step toward understanding the identification and treatment of health and well-being of children in foster care. Professional literatures were reviewed and relevant stakeholder groups were surveyed using a standardized telephone questionnaire. Although this is not a substitute for actual research on the needs of children in foster care, we feel that this report nonetheless identified ample evidence to justify the importance of initiating a demonstration screening, referral, and monitoring program for children in foster care. At the same time, there are many gaps in the knowledge base on children in foster care that only high quality research can answer. To examine the feasibility of a mass screening, and confirming that level of need is as high as estimated by research in other communities. Actual screenings of children in foster care can examine whether this information leads to greater improvement in health and well-being among children in foster care than if such a program was not available. Such studies also could examine and lead to improvements in the reliability, specificity, and validity of all instruments used to screen children.

#### *Specific Recommendations for Research:*

There is a great need for clear data to guide policy and practice with respect to children in foster care. Two specific research needs that appear most crucial include:

13. Benchmarks are crucial as Michigan moves forward. A preliminary study should immediately be conducted on the reliability and validity of the current screening process for children in foster care in Michigan. This study should also evaluate the frequency with which identified needs receive a referral, the frequency with which referrals lead to treatment, and the rate at which treatment is successful. These data will serve as crucial benchmarks with which to track the health and welfare of children in foster care, as well as the efficiency with which the foster care system is recognizing and addressing the same.
14. Financial considerations are also key. A preliminary study should compare health outcomes in children identified using current, standard procedures, children given only a modified screening battery, and children given comprehensive assessments. Such a study could examine the extent to which information beyond the screening can contribute to the child's well-being, and thus the extent to which additional expenditures lead to actual gains in child well-being."

Given changes at the Director level in the Family Independence Agency, the report and recommendations were transmitted in February 2004. The Panel will remain vigilant to ensure that these recommendations are implemented or alternatives developed to achieve the same objectives.

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# Michigan Citizen's Review Panel on Child Fatalities 2003 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.

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Teri Covington  
Sandra Frank  
Shirley Mann-Gray  
Virginia R. Harmon  
Nancy Stimson  
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Jacqueline Wood

Support Staff from MPFI:

Heidi Hilliard  
Lynda Meade  
Jane Paterson

Jean Kayitsinga  
Sara Rich  
Lori Corteville

## **2003 Activities:**

The Child Fatality Citizen Review Panel convened five times during the 2002 – 2003 fiscal year: March 25, May 9, July 29, October 6 and December 5. The focus of the panel this year was the child maltreatment deaths that occurred in 2001. 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:

- Reviewing the cases of child fatalities due to abuse and neglect (30 abuse and 35 neglect, for a total of 65). The previous year we had instituted a review process, whereby a sub-group of the panel reviewed all the abuse and neglect-related cases. Based upon that process, cases (12 abuse and 8 neglect) were selected for an in-depth review by the entire panel.
- An FIA representative from the FIA's Office of the Director attended the final meeting of 2003 to discuss the Agency's response and/or action taken to our previous years Findings and Recommendations.
- Although the workgroup selection method has been met with success, the case review process continues to be an on-going topic as we attempt to develop protocols/guidelines by which to most effectively review the cases.
- The panel reviewed and discussed the federal CAPTA changes, and will continue to address compliance with these changes.

## **Key Findings:**

Fatality Citizen Review Panel: 2004 Findings and Recommendations

### **FINDINGS:**

#### **Summary**

The Fatality CRP team identified concerns in 52 of the 65 maltreatment deaths reviewed, in the multiple systems, ranging from: (1) those responsible for the identification and reporting of suspected abuse and neglect; (2) investigation, assessment and the provision of services by FIA; and (3) problems with court petition and adjudication. Bolded items were noted in our previous reports and were again noted this year.

#### **I. IDENTIFICATION, REPORTING AND FOLLOW-UP:**

- **Failure among medical professionals to diagnose and report suspected abuse and neglect.**
- **Poor medical follow-up by families and medical professionals after hospitalization.**
- **Failure on the part of mental health professionals to recognize risk to children.**
  
- Unaddressed mental health needs lead to the death of a child.

- Failure among law enforcement to recognize and report suspected abuse and neglect.
- Failure on the part of law enforcement to recognize imminent danger and take protective custody of the child.
- Failure on part of Medical Examiner to correctly classify cause or manner of child's death, based on lack of autopsy, unacceptable autopsy or inaccurate conclusions.

## **II. INVESTIGATION, ASSESSMENT AND THE PROVISION OF SERVICES BY FIA:**

- **Inappropriate screening-out of complaints and delay in acceptance of complaints and case assignment.**
- **Incomplete and insufficient complaint investigations by FIA staff. ("Incomplete" refers to concluded investigations, but no supervisory sign-off; "insufficient" refers to the apparent omission of required tasks).**
- **Unacceptable (does not comply with current law) time lapses between assignment and contact with families.**
- **Failure of CPS supervisor to sign off on child abuse/neglect assessments and/or properly review the case materials, in accordance with established procedures.**
- **Poor communication among law enforcement and FIA and failure to perform joint investigation resulted in the whole picture of the child and family's condition not being properly investigated.**
- **Failure to perform complete investigations regarding medically fragile children because it is believed the child 'will die anyway'.**
- **Inaccurate assessment and improper coding of the five-tiered system.**
- **Failure to properly investigate for abuse or neglect complaints when otherwise indicated (only because parents are not at home when workers attempt a visit) and there is no documented evidence of due diligence.**
- **Failure of worker to properly assess well-being of child(ren) in the home and/or recognize imminent danger and take protective custody (including a previously reviewed case where the child was dead at the time of a visit by the CPS worker).**
- **Failure to recognize and respond to parents' repeated and clear indications that they do not want the pregnancy or child/children.**
- **Safety Assessment completed incorrectly or not at all.**
- **Risk Assessment completed incorrectly or not at all.**
- **Totality of case inaccessible to the caseworker, including timelines, substantiations and unfounded reports.**
- **Failure to cooperate with and/or coordinate investigations with Consumer and Industry Services ).**
- **Failure to assess the effects of Domestic Violence on the accuracy of the investigation and the steps needed to protect the child.**
- **Failure of worker to report important elements of the investigation to their supervisor, leading to improper supervision.**
- **Failure to assess the appropriateness of the setting and to give consideration to the total number of children placed in foster care in a single home, especially in homes specializing in children with special or medical needs.**
- **Failure to make required finding of preponderance of evidence with positive toxicology results in newborns and/or remove subsequent children after multiple removals for prior drug-exposed infants.**
- **Improperly returning a child to a home that had lost its foster care license.**

- **LEIN/criminal history check was not done; if done, was not complete.**
- CPS workers did not utilize multidisciplinary teams to see the entirety of the case and enlist the best services for families.
- Workers appear to have inadequate resources such as lack of supervision of foster care placements and daycare settings. Workers are not meeting minimal requirements for licensing investigation, frequency of contact or number of children present.
- Workers appear to lack experience in understanding families, leading to their inability to provide effective service. Prevention services provided are not the correct services to meet identified needs.
- Interstate communication is poor, resulting in workers not receiving entire client history.
- FIA agencies and contractors appear to have discrepant information in their files regarding the same event and miss opportunities to reach consensus and intervene, such as with private foster care agencies.

### **III. COURT PETITION AND ADJUDICATION:**

- **Failure to file a petition to terminate parental rights for siblings following the death of a child, when the parents are at fault.**
- **Courts, investigators and child's lawyer Guardian ad Litem did not access the complete FIA file information, leading to inaccurate decision-making.**
- **Courts inappropriately returned children to an abusive family, disregarding CPS recommendations.**
- **Courts were not provided important information known by FIA.**
- **Guardian ad Litem did not meet standards for client contact and/or representation.**

### **RECOMMENDATIONS:**

#### Summary

The Fatality CRP team had 22 Recommendations, 17 of which reflected continuing concerns from prior years. Bolded items were noted in our previous reports and were again noted this year, with FIA's feedback immediately following the bolded Recommendation.

1. **FIA should aggressively pursue practice by the court that ignores the facts of a case presented as a matter of record and review policy regarding court petitions and procedures for FIA staff to appeal petition non-acceptance.** The FIA agreed with this recommendation and noted their new policy for workers where FIA does not agree with decisions of the prosecuting attorney or court, implemented 10/1/2003.
2. **To ensure effective protection of minors, Child Welfare agency must assure legal representation of workers in legal proceedings and have access to on-going legal consultation. Consider working with the court system to develop training specific to CPS workers.** The FIA agreed with this recommendation and noted contracts in place with individual county prosecutors and steps that will be taken by the CPS Line of Service Team to assure legal representation for child welfare staff. Training was to be provided, joint investigation protocols were to be followed, the Child Welfare Institute was to be revised and the training process lengthened.

3. **Implement peer oversight of judges as a tool of accountability.** The FIA agreed with this recommendation but noted this would have to be developed through the State Court Administrators Office.
4. **Develop a policy about returning child to a home that has lost its Foster Care license.** The FIA agreed with this recommendation, citing current policy allowing children to return to kinship care despite having lost a foster care license.
5. **Information Technology improvements to assure access to the complete profile of an individual/family to further assist in the current investigation.** The FIA agreed with this recommendation, mentioning the new SWSS-CPS system under development for 6/5/2004.
6. **Risk Assessment and Safety Assessment: The committee recommends timely and effective assessments of these critical factors. We highly recommend that FIA re-visit their application of these actuarial tools and the potential for a more practical, fact-based system germane to child safety and well-being in Michigan.** The FIA agreed with this recommendation, citing current policy. Peer review has been used to monitor their application. The tools have been reviewed by NCCD.
7. **Better collaboration and cooperation between CPS workers and Law Enforcement, thereby strengthening and improving the joint investigation process. Law enforcement officers need to consider CPS workers not as Social Workers but as Investigators.** The FIA agreed with this recommendation, citing existing protocols for investigation and plans to split CPS investigation from service provision.
8. **Ensure adequate training for mandatory reporters in the identification and reporting of child abuse and neglect and in the use of death investigation protocols and need for autopsy.** The FIA agreed with this recommendation, citing CPS's plans to split CPS investigation from service provision. L-letters have been issued for counties with 6 or more CPS workers.
9. **Time lapses between complaint and case assignment, communication breakdowns and inadequate risk assessment suggest the lack of experience of workers and poor morale. Programs should be designed to retain, encourage, reward and advance good workers and to move those not up to the task to other less challenging positions within FIA.** The FIA agreed with this recommendation, citing CPS's plans to examine the issue of worker turnover and develop solutions to counter these trends.
10. **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 and thereby decreasing caseload per caseworker, allowing more attention and investigation research per given case.** The FIA agreed with this recommendation, citing current efforts to re-examine staff allocations and using the foster-care assessment tool in ongoing CPS cases.

- 11. Train workers to obtain, review and understand medical diagnoses and records, especially for infants.** The FIA agreed with this recommendation, citing that Child Welfare Institute training is under revision, with new curricula regarding pertaining to the review and assessment of medical records. The Michigan State Police has also been involved in new training at CWI.
- 12. Consider putting in place a standard of timeliness for the supervisor to review and approve all cases with a risk assessment within 24 hours. This will enhance compliance with FIA Policy “CFP 71309 Time Frame for Completion of Field Investigation” requiring completion within 30 days.** The FIA agreed in part with this recommendation, citing current policy and steps being taken to better define the roles and responsibilities of supervisors.
- 13. 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.** The FIA agreed in part with this recommendation, citing current policy and their desire to keep cases open longer than 30 days with continued attempts to locate parents.
- 14. Enhance training opportunities for law enforcement, court and FIA personnel around the implementation of joint investigation protocols.** The FIA agreed in part with this recommendation, noting the role of the Prosecuting Attorneys Association and proposed efforts to encourage local offices to review protocols regularly.
- 15. Review FIA standards of investigation to ensure that the investigators have met their obligation of ‘due diligence’ in conducting a full investigation.** The FIA agreed in part with this recommendation, citing development of a ‘field guide’ to assist them in outlining the steps they need to take. .
- 16. 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.** The FIA agreed with this recommendation, citing the planned redesign of the Child Welfare Institute, working with the Office of Human Resources to assure workers stay in the program best for them and the agency and perhaps improving screening by OHR before hire.
- 17. In each county, the FIA should designate individual court workers and/or establish practices to assure conveyance of all information to the court, investigators and the child’s attorney.** The FIA agreed in concept with this recommendation, citing the difficulty in implementing such policy because of differences in individual counties, caseloads and Family Courts and recommending local protocols to address these issues. .

- 18.* Workers should be encouraged to complete forms to the greatest possible degree --- especially completing “the narrative” section in a prominently locate section, to enhance future worker’s understanding of the case.
- 19.* CPS needs to set standards to require Multi-disciplinary Teams meeting in certain types of cases to see the entirety of the case and enlist the best services for the family.
- 20.* Build redundancy into the reporting system --- a checks and balances approach. CPS needs to foster a frame of mind among reporters that everyone is obligated to report suspected abuse or neglect --- and not to assume that someone else already has.
- 21.* Children entering foster care must have proper medical attention despite ‘looking good’. This will capture cases of serious injury to children before they enter Foster Care where the caretakers may have little or no knowledge of the imminent medical needs of the child.
- 22.* Implement peer oversight of lawyer Guardians-ad-Litem as a tool of accountability.

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