

Michigan Citizen Review Panels 2004 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 2004.

Michigan Citizen's Review Panel for Prevention (The Children's Trust Fund) 2004 Annual Report



Purpose:

The United States Congress mandated that states receiving federal Child Abuse Prevention and Treatment Act (CAPTA) funding establish a minimum of three Citizen Review Panels to assess and develop recommendations for the improvement of a state's child protection system. Panels were to be established to look at the issues related to prevention, children coming into care in the system, and fatalities and near fatalities. The Children's Trust Fund is a statewide, public non-profit organization dedicated solely to the prevention of child abuse and neglect in Michigan. In the spring of 1999, the Children's Trust Fund Board accepted the responsibility of overseeing the Michigan 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 an ecological, holistic approach noting that the *prevention of child abuse and neglect is a community responsibility*. Engaging the community, gathering input, educating and informing and acting as a catalyst for the development or improvement of systems of services to families are all tools this panel will use to help ensure the strengthen and support families. Membership of this prevention panel includes state/local and public/private agencies, stakeholders and advocates. The work of the panel also includes obtaining information and feedback through a variety of modalities including workgroups, reports, research, focus groups, satisfaction surveys, case reviews and etc.

Members:

Yasmin Abdul Karim, Chair

Candace Cowling

Mike Foley

Sgt. Greg Jones

Douglas Patterson

Pat Sorenson

Susan Toman

Deanna DeVries

Susan Fulton

Richard Lively

Kim Sanford

Mara Stein

Betty Wright

Larry Burke

Elizabeth O'Dell

Paul Shaheen

Michele Strasz

Staff to CRPP: Deborah Strong, Ismail Noor

2004 Activities:

- Conducted case reviews on child death cases viewed from a prevention perspective. Identified missed opportunities and trends, areas that need strengthening, implementation of best practices and/or policies that need to be reviewed or developed.
- Provided resources, input and leadership to the DHS (formerly FIA) Public/Private Partnership Initiative: Prevention Workgroup. This was renamed and a continuation of round two of the 2003 Michigan Family Independence Agency Lines of Service (LOS) Initiative. The goal was still to tear down silos, help streamline or integrate services, build inter/intra systems, and identify measurable outcomes. The recommendations identified in this report are based largely upon the work completed in round one, under the leadership and guidance of the FIA Community Supportive Services, the Children's Trust Fund and the Citizen Review Panel for Prevention. Round two reviewed the recommendations, reformatted the document as recommended by the Department Director, per the strategic plan and included detailed action plan step with a baseline and measures. (See Attached)
- Department approval of the finalized prevention definition created by the CRPP and supported by the Departments of Community Health, 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 is currently used in the FIA Program Improvement Plan and federal audit, PPP/LOS Prevention Plan and process, and all other department documentation warranting a prevention definition.
- 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 and strengthen families to achieve child safety and wellbeing:

- 1) Prevention, within the DHS, needs a "home" and "champion" within the system state and locally.
- 2) There is no system to assure services are provided to Category III & IV CPS Cases (not substantiated but came to the attention of the system). Many of these, if left unchecked, will escalate over time into the system.
- 3) There is no framework for statewide prevention service delivery and evaluation
- 4) Families should receive the services they need "not what we have" . The need to use technology to help level the playing fields and increases accessibility.
- 5) Workload restraints and policy must be in place for those providing prevention services.
- 6) Ongoing training and technical assistance is critical to the provision of prevention services and system development
- 7) Prevention services must remain a voluntary program for clients.
- 8) Maintain the nature of the relationship with a client that is common to prevention workers (non-threatening, working toward a more client based relationship).
- 9) There should be no time limits or categorical barriers for clients needing prevention services.
- 10) Assure the development and continuation of a stable funding source/base for prevention Programs not subject to changes in the economy or pitted against each other, especially since they represent such a small percentage of the services expenditure and with a greater yield in the long term.
- 11) Prevention makes cents. For every dollar Michigan spends on prevention, \$34 is saved on the consequences of abuse.... not to mention the human toll...which is incalculable.

Recommendations:

- ❖ Create a Prevention Division/Office reporting to the Deputy Director of Child and Family Services Administration
- ❖ Recognition that prevention is also a part of every other line of service (LOS)
- ❖ Every county DHS office should have a Prevention Services Delivery Plan.
- ❖ Every county will minimally provide adequate case management and/or contractual services to Category III and IV families.
- ❖ Develop a statewide framework for prevention service delivery that establishes minimum parameters and allows for local office flexibility in implementation.
- ❖ Move forward the concept of prevention to a community responsibility...and building in protective factors
- ❖ 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 ongoing opportunities for all workers to build and sustain knowledge in the area of prevention
 - ◆ Staff receives ongoing training, but is resistant to utilizing new knowledge and skills.
 - ◆ New staff require ongoing support from experienced workers (peers) and supervisors (reflective 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 problem solve, insure new skills and knowledge are implemented and maintained, and identify system issues and trends.
- ❖ Need to evaluate the effectiveness of prevention services.
 - ◆ Determine appropriate outcomes and measurement tools.
 - ◆ Emphasis on inclusion, collaboration and partnership(Needs to be part of culture)
 - ◆ Implement processes to document inclusion of FIA customers and stakeholder

Future Focus:

- 1) Random sample and case reviews of families receiving prevention services for appropriateness and satisfaction.
- 2) Research and make recommendations for improving services to secondary prevention customers (category III), improving needs and risk assessment processes and tools.
- 3) Assess customer input and make recommendations to meaningfully engage them throughout the prevention system and processes
- 4) All CRP team members participate in CRS local reviews.
- 5) Develop policies, procedures and/or other supports to help implement the PPP/LOS Prevention plan.

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Updated 03/2005

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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) 2004 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:

*New Appointees as of November 2004

**Served on the Panel through October of 2004

Ernestine Moore, Co-chair
Gloria Gillespie, Co-chair
Jean Carl
Susan C. Dobrich**
Kathy Kovalchik-Lacko**
Judy Labovitz **
Pamela Gilbert O'Sullivan**
Cheryl Matthews**

Christine McPherson
Ted Melinat
JoAnn Monaghan**
JoAnne Nagy**
Robert Cable*
Tracey Yockich*

Staff to the Panel: Mary Mehren, Shannon Stotenbur

This has been a year of change for this CRP. This CRP is formed from appointees to the Governor's Task Force on Children's Justice. The Governor made new appointments in October 2004 and again in January 2005. Thus the membership changed with these appointments. Members with double asterisks served until October 2004. Members with single asterisks were appointed in November 2004. We expect some of the members appointed to the GTF in January 2005 will join the Citizen's Review Panel.

2004 Activities:

The Panel met five times. The Panel focused on the Child and Family Services Review results, the Department's response to it (Program Improvement Plan), and the completion of the review of cases where children has died while in out of home care.

Members also served on several Departmental work groups addressing many issues including: screening and assessment of children in protective services, foster care and adoption, outcomes and reimbursement in foster care and adoption, relative care, and changes to the Juvenile Code and Court Rules to provide for timely adjudicatory, dispositional, and permanency planning review hearings.

Finally members served on the selection panel for the Deputy Director for Child and Family Services and the staff to the CRP. Members continued to monitor the Department's response to the Screening, Assessment, and Treatment of Children in the child welfare system.

We presented on our involvement in the Child and Family Services Review at the National Conference on Citizen Review Panels in May 2004.

This was a year of change for the CRP and the Department. Progress in implementation of previous recommendations, though positively received, has been delayed due to the change in administrations, change in staff, and the establishment of the Public-Private Partnership to address some of the issues being addressed by the CRP.

The Panel developed its 2005 Work Plan. It will:

- Complete the 2004 Annual Report.
- Conduct orientation for all three Panels.
- Investigate staffing and workload assignments in protective services and foster care.
- Conduct public education on appropriate referrals to children's protective services.
- Complete the review of deaths of children in out of home care and make recommendations to the Department.
- Provide oversight of the Child and Family Services Review Program Improvement Plan implementation.
- Review Michigan's compliance with the Indian Child Welfare Act.
- Coordinate training with the Governor's Task Force on Children's Justice's Training Committee.

Key Findings and Recommendations:

The Panel made no specific findings and recommendations this report year due to delays in getting the case file materials requested for the review of children who died in out of home care. We expect to make a report on that project within the next six weeks.

Membership Roster

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Michigan Citizen's Review Panel on Child Fatalities 2004 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
Nancy Stimson
Douglas M. Paterson
Jacqueline Wood

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

Support Staff from MPHI: Heidi Hilliard
Lynda Meade
Jane Paterson

Robin Bell
Lori Corteville

2004 Activities:

The Child Fatality Citizen Review Panel and its subgroups met five times during 2004 (June 2, July 30, August 27, October 8 and December 9) to review the 52 maltreatment deaths identified for the year 2002. These come from over 120,000 fatal and non-fatal child cases reported to MDHS that year. Three sources were used to identify the cases: 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. At our meetings, we conducted intensive case reviews of the fatalities and reviewed our findings and recommendations. Our meetings also included presentations regarding MDHS policies and procedures and medical issues associated with child fatality. 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 (26 abuse and 26 neglect, for a total of 52). As in the previous year, a sub-group of the panel reviewed all the abuse and neglect-related cases. Based upon that process, cases (11 abuse and 6 neglect) were selected for an in-depth review by the entire panel, having been selected what were determined to be “new” findings.
- 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 federal CAPTA changes, specifically the membership composition, continue to be discussed.
- Compilation of our Annual Report to the Michigan Family Independence Agency including our Findings & Recommendations and a summary of Findings from our first three reports. The Fatality CRP team identified concerns in 38 of the 52 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 MFIA; and (3) problems with court petition and adjudication. We included numbers by each finding to indicate the number of cases identified with that concern. Bolded items were noted in our previous reports and were again noted this year.

Key Findings:

Fatality Citizen Review Panel: 2005 Findings and Recommendations (based on cases of child maltreatment fatalities that occurred in 2002)

FINDINGS:

Numbers refer to the number of cases identified with that concern. Bolded items were noted in our previous reports and were again noted this year.

I. IDENTIFICATION, REPORTING AND FOLLOW-UP:

- | | |
|---|----|
| A. Failure among medical professionals to diagnose and report suspected abuse or neglect. | 5 |
| B. Poor medical follow-up by families and medical professionals after hospitalization. | 2 |
| C. Unaddressed mental health needs led to the death of a child. | 13 |
| D. Failure among law enforcement to recognize and report suspected abuse or neglect. | 3 |
| E. Failure on part of Medical Examiner to correctly classify cause or manner of child's death, based on lack of autopsy, unacceptable autopsy, lack of adequate death scene investigation, or inaccurate conclusions. | 6 |
| F. CMH or its contractors failed to recognize risk to the child, failed to report to CPS, or provide services which could have prevented death. | 1 |
| G. School personnel failed to verify that high-risk child was properly transferred to a new school, resulting in missed opportunity to intervene and prevent death. | 1 |
| H. Lack of available, affordable, quality child care. | 6 |
| I. Failure by mental health system/provider to recognize imminent danger to society | 1 |
| J. EMS personnel failed to report suspected abuse or neglect. | 1 |

II. INVESTIGATION, ASSESSMENT AND THE PROVISION OF SERVICES BY MFIA:

- | | |
|---|---|
| A. Inappropriate screening-out of complaints and delay in acceptance of complaints and case assignment. | 1 |
| B. Incomplete and insufficient complaint investigation by MFIA staff. ("Incomplete" refers to concluded investigations, but no supervisory sign-off; "insufficient" refers to the apparent omission of required tasks). | 4 |
| C. Failure of CPS supervisor to sign off on child abuse/neglect assessments and/or properly review the case materials, in accordance with established procedures. | 1 |
| D. Poor communication among law enforcement and MFIA and failure to perform joint investigation resulted in the whole picture of the child and family's condition not being properly investigated. | 1 |
| E. Inaccurate assessment and improper coding of the five-tiered system. | 6 |
| F. Failure of worker to properly assess well-being of child(ren) in the home 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). | 2 |

G.	Failure to modify level of risk when evidence of reasonable cause to believe caregiver is dishonest in responses or failed to follow care recommendations.	1
H.	Failure to recognize and respond to parents' repeated and clear indications that they do not want the pregnancy or child/children.	1
I.	Safety Assessment completed incorrectly or not at all.	3
J.	Risk Assessment completed incorrectly or not at all.	1
K.	Totality of case inaccessible to the caseworker, including timelines, substantiations and unfounded reports.	1
L.	Failure to cooperate with and/or coordinate investigations with Consumer and Industry Services.	1
M.	Failure to assess the effects of Domestic Violence on the accuracy of the investigation and the steps needed to protect the child.	4
N.	LEIN/criminal history check was not done; if done, was not complete.	1
O.	CPS workers did not utilize multidisciplinary teams to see the entirety of the case and enlist the best services for families.	3
P.	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.	1
Q.	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.	1
R.	Interstate communication is poor, resulting in workers not receiving entire client history.	2
S.	MFIA 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.	2
T.	Inaccurate investigation summary completed by MFIA.	6
U.	Poor supervision in foster care by MFIA or its contractor.	2
V.	Lack of physical or mental health services to meet needs of the adolescent in the MFIA system.	3
W.	Inappropriate triage of referral by MFIA.	1
X.	Ineffectiveness of birth match because of voluntary guardianship, substantiation or murder without termination.	3
Y.	MFIA failed to address important substance abuse and domestic violence issues in case service planning.	2
Z.	MFIA failed to identify a perpetrator, leading to failure to protect child from further injury.	1
AA.	Inappropriate response by MFIA because of 'custody dispute'.	1
BB.	Failure to completely investigate referral because parent 'feigned' cooperation but continued maltreating child.	2
CC.	MFIA failed to seek police assistance to properly identify perpetrator.	1
DD.	MFIA failed to seek police assistance when needed to complete initial contact with family to assess safety of child.	2
EE.	Failure by MFIA to recommend medical assessments and/or specialized evaluation.	1

FF.	MFIA failed to assure adequate medical assessment of child.	2
GG.	Incomplete CPS history check by MFIA.	1
HH.	MFIA did not recognize need to refer to APS and/or CMH for mental incompetence of adult parent.	1

III. COURT PETITION AND ADJUDICATION:

None were identified in 2002 cases.

RECOMMENDATIONS

This section includes MFIA’s responses to the previous report and this year’s Recommendations of the Fatality CRP to address specific Findings. These are categorized as being New Findings and/or those with increasing incidence, Ongoing Concerns, and Resolving Issues that have either been adequately addressed by the MFIA or are no longer relevant. Parentheses refer to specific Findings addressed.

A. New Findings **and/or** Previous Findings with noted rise in incidence:

1. Inaccurate Investigation Summary completed by MFIA (II.T.)
MFIA should train workers to complete a comprehensive and accurate Investigation Summary and require that Supervisors ensure the accuracy of the information prior to “signing off”.
2. Unaddressed Mental Health needs lead to the death of a child: Mental Health providers failing to recognize mental health issues. (I. C.)
MFIA should coordinate with CMH to recognize the intersection of mental health needs with child maltreatment and coordinate to increase and improve services to families and caregivers.
3. Unaddressed Mental Health needs lead to the death of a child: The lack of physical or mental health services to meet the needs of the adolescent in the MFIA system (I.V.)
MFIA should work with the Children’s Cabinet to promote local community collaborations that maximize the capacity of current mental health network of services.
4. Ineffectiveness of birth match because of voluntary guardianship, substantiation or murder without termination (II. X.)
MFIA should work with MDCH to obtain more timely access to birth records.
5. Ineffectiveness of birth match because of voluntary guardianship, substantiation or murder without termination (II. X.)
MFIA should work with the Michigan Hospital Association to encourage Michigan’s hospitals to both verify the birthing mother’s identity at the time of admission and ensure the accuracy of the information given for the birth certificate and register the birth in a timely manner.
6. Ineffectiveness of birth match because of voluntary guardianship, substantiation or murder without termination (II. X.)
MFIA should conduct an internal evaluation of the Birth Match process.

7. Failure on part of Medical Examiner to correctly classify cause or manner of child's death (I.E)
MFIA should advocate with MDCH to establish a state-based regional Medical Examiner system with statewide standards of practice.
8. Lack of available, affordable, quality child care (I. H.)
MFIA should work to establish a tiered system of quality childcare (as in states in the nation), with tiered reimbursements and, similar to the state of Pennsylvania, tiered incentives.
9. Lack of available, affordable, quality child care (I. H.)
MFIA should continue to support collaborative efforts with MDCH and other stake holders aimed at the improvement of the child care system.

B. Ongoing Concerns which the Panel will monitor in future cases:

1. Develop a policy about placing and returning a child and monitoring a home that has lost its Foster Care license (II. P., II. S., II. U.). Last year, the MFIA agreed in part with this recommendation, citing the need for careful evaluation and discretion before placing or returning a child to kinship care. **The Panel renews its concerns and recommends that MFIA revisit the standards applied to kinship care to make sure the kinship care is equivalent to non-kinship foster care.**
2. 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 (II. D., II. N., II. O., II. CC., II. DD.). **Last year, the MFIA agreed with this recommendation, citing CPS's plans to split CPS investigation from service provision. Local offices are mandated to use this split, but all offices are encouraged to use the model joint investigation protocol. The Panel is concerned that these efforts are insufficient and will monitor their implementation in future cases coming to our attention.**
3. 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 (I. A., I.B., I.D., I.E., I.F., I.G., I.J.). **Last year, MFIA agreed with this recommendation, citing a guide for mandated reporters under development and ongoing specialized training. The Panel recommends continuation of current training efforts, with additional steps to ensure that EMS, school and mental health professionals are included.**
4. 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 MFIA Policy CFP 713-8 (II.DD.). **Last year, the MFIA agreed in part with this recommendation, citing current policy and the need for local directors to develop more resources in this area. The Panel again recommends that the worker enter a preliminary finding of 'Unable to Locate' but continue the investigation.**

5. Enhance training opportunities for law enforcement, court and MFIA personnel around the implementation of joint investigation protocols (II.D., II.N., II.O., II.CC., II.DD.). Last year, the MFIA 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. Current funding limitations, however, are also cited as impediments for workers attending training. **The Panel recommends that steps be taken to allow workers adequate time for training and provide support for them to attend approved training when offered.**

6. 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 (II. E., II.F., II. G., II. H., II. O., II. Q., II. W., II. Z.). **Last year, the MFIA agreed with this recommendation, citing research regarding worker retention, etc. The Panel again suggests matching new hire skills sets with those needed at CPS and enhancing training in legal issues at CWI while the agency awaits the results of this research.**

7. 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 (II. V., II. EE., II. FF.). **Last year, the MFIA agreed with this recommendation, citing current policy requiring medical evaluations within 30 days. MFIA cites the undue stress and lack of services which prevent more timely medical assessment. MFIA hopes the new Child Assessment of Needs and Strengths tool will help identify those children needing more immediate service. The Panel applauds these efforts but continues to be concerned that children are entering foster care with their physical and mental health needs being unmet and that MFIA should take further steps to better screen and 'triage' cases. The MFIA Physicians Advisory Committee, for example, could assist MFIA in developing a medically-focused screening tool.**

C. Resolving Issues:

1. Information Technology improvements to assure access to the complete profile of an individual/family to further assist in the current investigation (II.K., II. Q.). Last year, the MFIA agreed with this recommendation, mentioning the new SWSS-CPS system which was implemented in part in February 2004 and is to be fully implemented in 2005.

2. Risk Assessment and Safety Assessment: The committee recommends timely and effective assessments of these critical factors. We highly recommend that MFIA 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 (II.E.,II.G., II.I., II.J., II.T.). Last year, the MFIA agreed with this recommendation, citing efforts in improving and monitoring their use. Peer review standards have been implemented at local offices. The current safety assessment tool will no longer be required in 2005.

3. 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 MFIA (II.A., II. B., II.C., II.F.). Last year, the MFIA agreed with this recommendation, citing CPS's plans to examine the issue of worker recruitment, retention and supervision. Research projects requiring three years were cited. The Panel is concerned about the long implementation times.

4. Train workers to obtain, review and understand mental health and medical diagnoses and records, especially for infants (II.A., II.V., II.EE., II.HH.). Last year, the MFIA agreed in part with this recommendation, citing their inability to promulgate policy for private agencies and law enforcement. They are implementing a Child Needs Assessment SDM tool. The Panel encourages MFIA to hold agencies under contract to high standards of performance.
5. 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 MFIA Policy "CFP 71309 Time Frame for Completion of Field Investigation" requiring completion within 30 days (II.B., II.C., II.P.). Last year, the MFIA agreed with this recommendation, citing current policy and steps being such as reading tools and standards to assist supervisors and improving supervisor/worker ratios.
6. During case review, the Fatality CRP members often sensed fragmentation among MFIA 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 (II.H., II.O., II.Q., II.S.). Last year, the MFIA agreed with this recommendation, citing current efforts to re-examine staff allocations and using the foster-care assessment tool in ongoing CPS cases.
7. Review MFIA standards of investigation to ensure that the investigators have met their obligation of 'due diligence' in conducting a full investigation (II. A., II. E., II.F., II.G., II.H., II.L., II.R., II.Z.). Last year, the MFIA agreed with this recommendation.
8. 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 (II.T.). Last Year, the MFIA agreed with this recommendation, citing the importance of supervisors in ensuring form completion. MFIA also cited new training for supervisors at CWI and the impact of SWSS-CPS database which will automate this.
9. CPS needs to set standards to require Multi-Disciplinary Teams (MDT) meeting in certain types of cases to see the entirety of the case and enlist the best services for the family (II.O.). Last year, the MFIA agreed with this recommendation, citing current standards for practice and policy, and other initiatives to address services, medical, and DV issues.
10. 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 (II. A., II. B., II. .D., II. E., II. F., II. G., II.J., II. BB.). Last year, the MFIA agreed with this recommendation, citing ongoing efforts to educate the general public and their Mandated Reporters Guide.

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