State of Michigan

Department of Health and Human Services

Children's Service Agency

CPS Fatality Reviews 01/01/15-12/31/15

The Office of Family Advocate Report

Background

The following report contains information regarding child fatalities that occurred during a children's protective services (CPS) investigation, service case, or shortly after. The Office of Family Advocate (OFA) is a centralized unit at Michigan Department of Health and Human Services (MDHHS) that oversees the CPS Fatality Review Process.

OFA Review Process of Child Fatality Cases

The OFA uses a consistent set of criteria to determine when to review a child fatality. The OFA will review the complete case if:

- The child death occurred during an active CPS investigation or open CPS case.
- The child death occurred in a family that has three prior CPS investigations, regardless of length of time since the investigations or outcome.
- The child death occurred in a family which had a recent CPS services case close (within three to four months).

OFA staff complete all reviews and carefully examine all relevant information including all the CPS complaints, prior CPS services cases (if any), MDHHS policy, and Michigan Child Protection Laws. Each review contains a summary of case facts, identified practice strengths, and findings with corresponding recommendations to practices, when applicable. After completing a review, OFA staff send it to the county for their response which may include the steps taken to improve practice and/or corrective action when necessary.

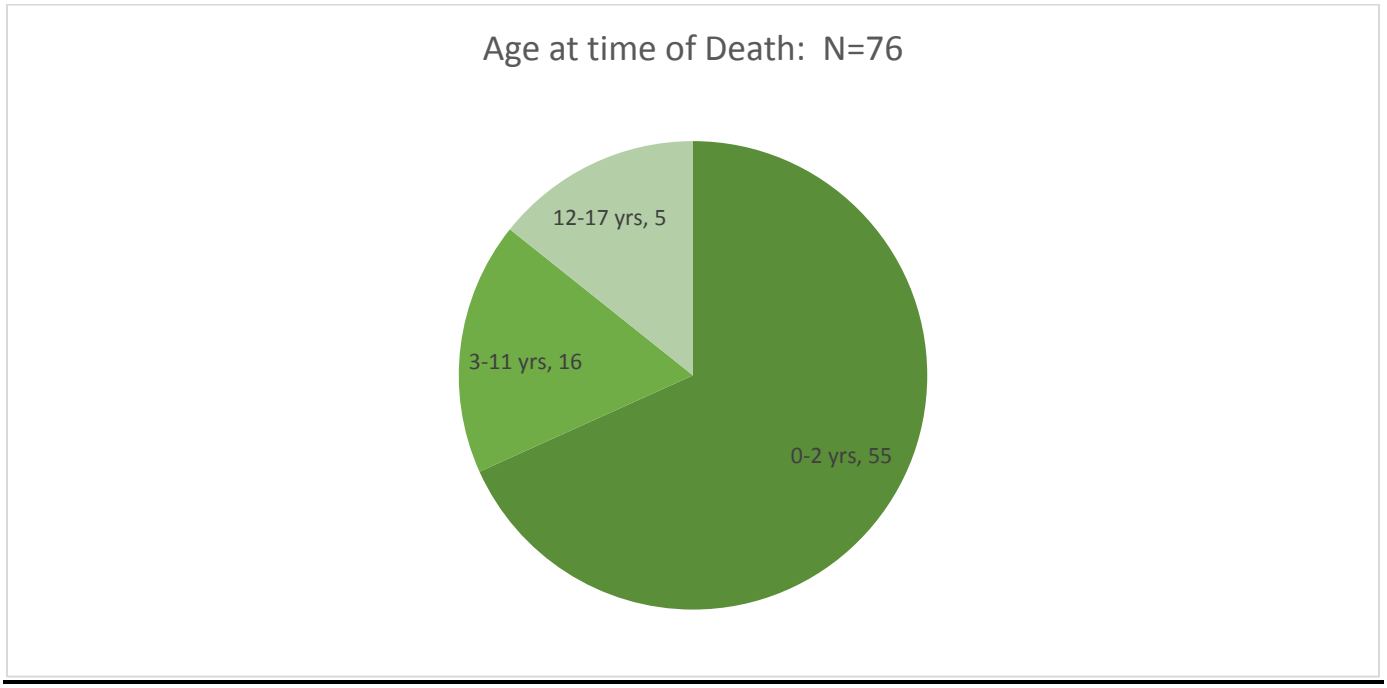
Demographics/Statistics

During the 2015 calendar year, 76 child fatalities met the previously discussed criteria in order for the OFA to complete a CPS Fatality Review.

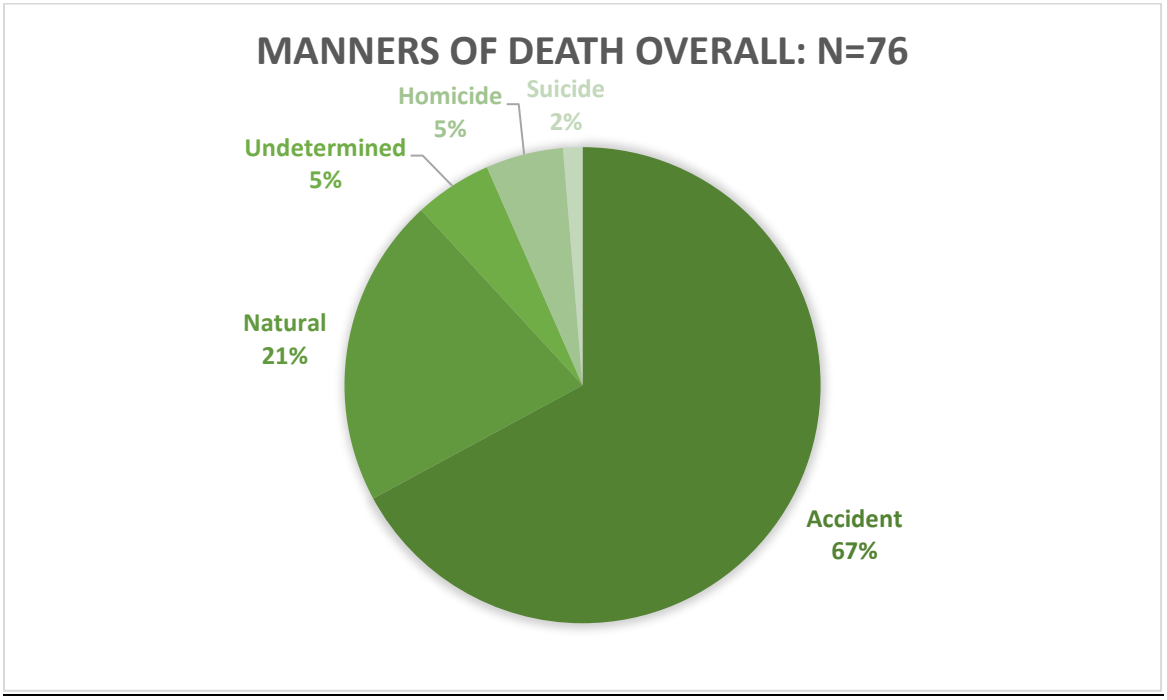
Counties Where Reviewed Fatalities Occurred

County	Number of Reviews
Wayne	23 (30%)
Genesee	6 (7%)
Kalamazoo	6 (7%)
Muskegon	5 (6%)
Oakland	4 (5%)
Macomb	4 (5%)
19 other Michigan counties	3 or less

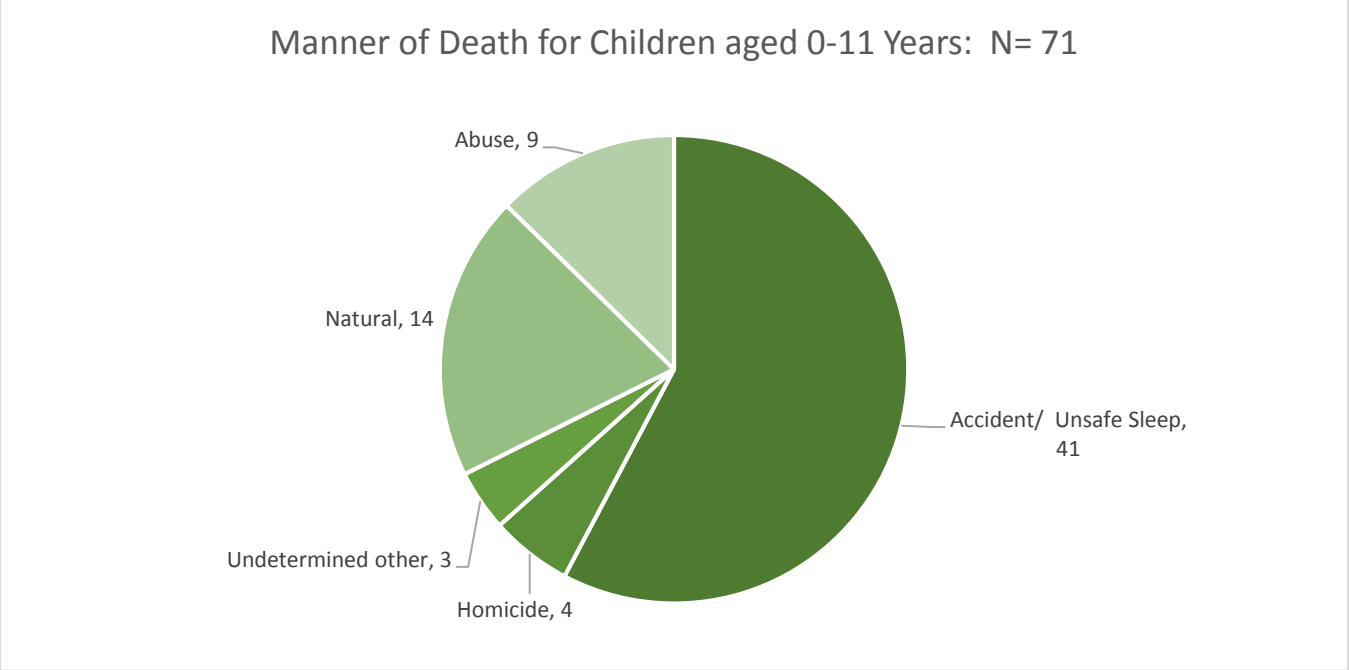
- The 19 other counties: St. Clair, Midland, Eaton, Jackson, Allegan, St. Joseph, Kent, Berrien, Shiawassee, Oscoda, Ottawa, Calhoun, Lenawee, Antrim, Ingham, Saginaw, Dickenson, Cheboygan, and Lapeer.



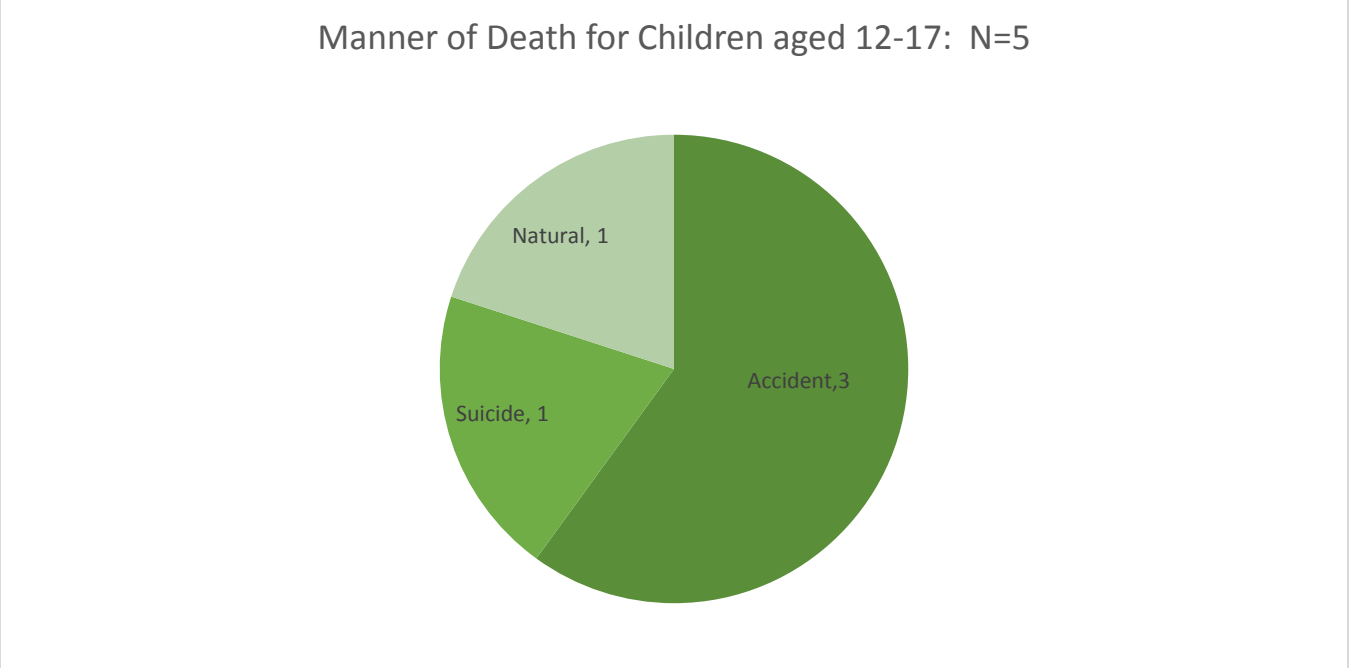
- Children 0-2 years of age represent 72% of the total number of fatalities. Their number is greater than all other age groups combined.
- Children 3-11 years of age represented 21% of the total numbers of fatalities.
- Children 12-17 years of age represent 14% of the total numbers of fatalities.



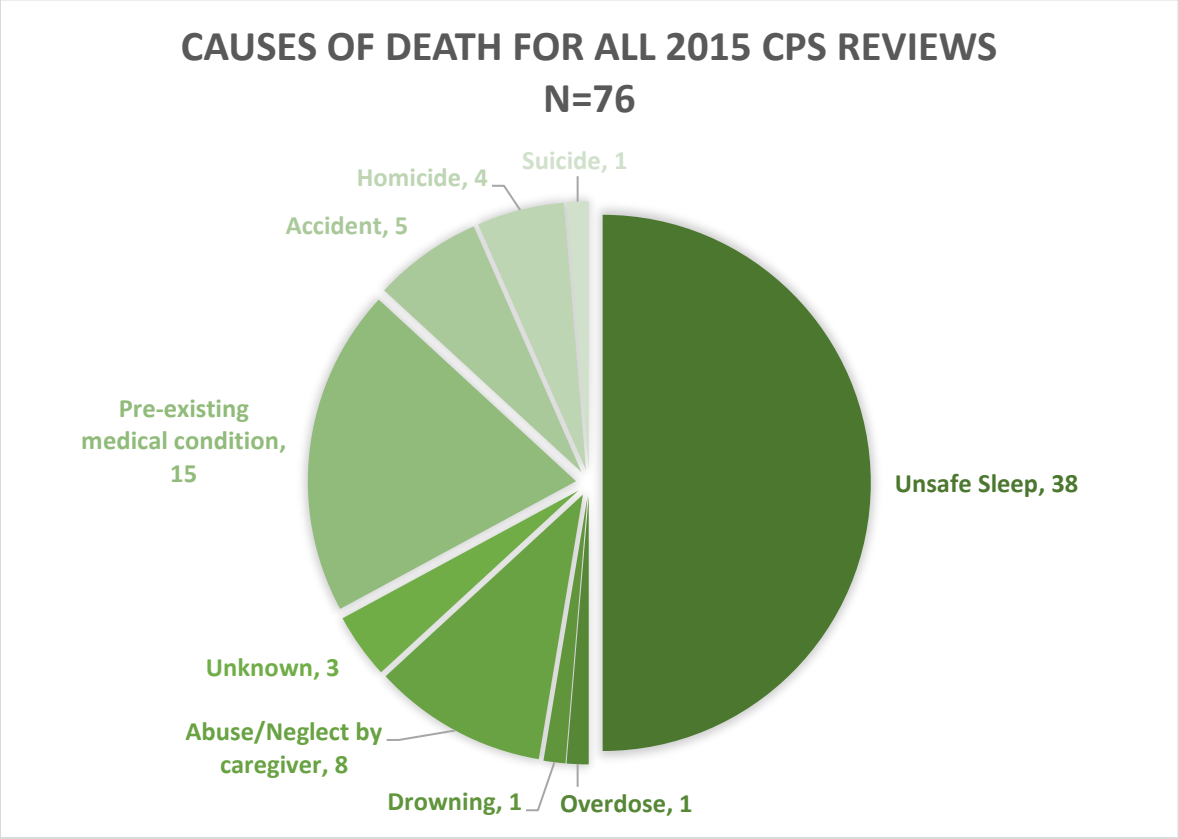
- The manner of death most often identified is “accident” (56%) which includes deaths resulting from placing an infant in a compromised sleeping position (unsafe sleep). “Natural” deaths followed (21%), which include deaths related to medical issues.



- For children under the age of 11, the most common manner of death was “accident” (54%), most notably from unsafe sleep.



- For children 12 and over, the most common manner of death was also "accident". The causes ranged from one teen dying after playing with a gun, another was hit by a falling tree branch, and the third died in a car accident.



- For two-thirds (66%) of unsafe sleep fatalities reviewed, a CPS worker had already discussed the tenets of safe sleep with the parents prior to the death and in some cases more than once.
- 15% of the children died from a pre-existing medical condition; in many cases the child's death was expected.
- Three of the 38 unsafe sleep deaths (8%) also involved a parent who was substance affected when they put the child in a compromised sleeping position.

Summary of 2015 CPS Fatality Reviews

Overall Strengths in 2015 reviews

The Office of Family Advocate identifies practice strengths in every CPS Fatality Review. These strengths highlight efforts a worker, supervisor, or local county employee made in relation to the case to ensure child safety. In 2015, the OFA cited the following practice strengths:

- 55% of the CPS Fatality Reviews cited staff engaging parents with safe sleep education.
- 34% of the CPS Fatality Reviews cited efforts made by staff to obtain medical records or an exam.

- 28% of the CPS Fatality Reviews cited efforts made by staff to contact and collaborate with law enforcement.
- 21% of the CPS Fatality Reviews cited efforts made by workers to engage the family in comprehensive safety planning.

Overall Findings in 2015 Reviews:

For each CPS Fatality Review, the OFA may identify findings or concerns that may have adversely impacted the child's safety or wellbeing during the time the family is involved with the child welfare system. Because the OFA looks at a case in its entirety, a finding might relate to a policy or action not related in any way to the child's death and should be viewed as an opportunity to focus on improving overall practice at all levels of intervention.

Of the 76 completed Fatality Reviews:

- 35 reviews (46%) had findings related to CPS not completing a required face to face interview, most notably with the non-custodial father.
- 8 reviews (11%) had findings related to CPS not completing a mandated medical exam of a child.

F*ollow-up of Past Findings and Recommendations:*

In its previous annual report, *CPS Fatality Reviews: 1/1/14 – 12/31/14 Office of Family Advocate Report*, the OFA made recommendations to MDHHS based on its overall findings from the Fatality Reviews conducted in that year. Since that issuance of that report, MDHHS has taken the following steps to improve practices.

- The OFA recommended in its previous annual report that MDHHS further research and develop a job aide which highlights best practice and information regarding educating parents/caregivers as to the tenets of safe sleep. Since then, MDHHS has spent considerable time and resources ensuring all child welfare staff receive education regarding infant safe sleep within their local office. Their training covers several different ways in which the education and conversations regarding safe sleep can be conveyed to parents. Child welfare staff are encouraged to use the crib/sleeping surface in the family home to demonstrate safe sleep with the family and utilize this as a starting point in the conversation. This and additional training will continue to be provided to child welfare staff through a contract with the Michigan Public Health Institute (MPHI).

  Additionally, the topic of Safe Sleep is addressed multiple times with all new CPS staff during their Pre-Service Institute. Additional and more in depth training regarding safe sleep education and ways to approach this topic with families was also provided at the MDHHS 2015 Safety Conference. The training opportunity was voluntary, and open to all child welfare staff.

- The OFA recommended in its previous annual report that CPS Program Office, Child Welfare Field Operations management, and the Children's Welfare Training Institute consider strategies to improve field compliance with standards of promptness and face to face contacts, especially related to investigations involving a child fatality. Those strategies may include considering additional training approaches, such as web based

trainings and podcasts, trainings for staff on how to utilize the MiSACWIS Book of Business, and regular reminders to the field through monthly contact at child welfare supervisory meeting." Since then, MDHHS began a CPS worker caseload study which, when finalized, will provide a framework for caseload expectation and assist the field achieving compliance with applicable policies and standards of promptness.

OFA Unit Recommendations

Safe Sleep

The majority of the reviewed deaths continue to be caused by a parent putting an infant into an unsafe sleeping environment. The OFA determined that in almost all cases it reviewed involving a fatality due to unsafe sleep, a child welfare worker had previously provided the family with safe sleep education which the parents, for a number of reasons, did not adhere to. As such, the OFA believes that MDHHS **must** take new approaches to engage parents around safe sleep that go beyond education.

The OFA recommends that MDHHS examine what additional methods and/or programs can be incorporated into current policy and practice that will enable workers to encourage and motivate sustained behavior change.

We challenge MDHHS to consider developing a collaborative effort within a county office or through another appropriate resource which will not only identify predictive factors that lead parents to not use a safe sleep environment, but enlists strategies which may include engaging the parent in a therapeutic interview, providing effective safety planning, developing a comprehensive safe sleep plan with the parents' input and support, providing concrete items when needed, such as cribs, and creating a support network for the parent in an effort to elicit sustained behavior change and decrease the number of reported deaths caused by unsafe sleep.