STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR
OFFICE OF THE CHILD ADVOCATE
LANSING
RYAN SPEIDEL
CHILD ADVOCATE

The Child Advocate's Report of Findings and Recommendations

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Date: December 26, 2023

Case No.: 2022-0356

Child: [redacted]

DOB: March 19, 2010

DOD: April 12, 2022 (12 years)

Introduction:

The Office of the Child Advocate (OCA) is tasked with making recommendations to positively effect change in policy, procedure, and legislation by investigating and reviewing actions of the Michigan Department of Health and Human Services (MDHHS), child placing agencies, or child caring institutions. The Child Advocate's Act, Public Act 204 of 1994, also requires the OCA to ensure laws, rules, and policies pertaining to Children's Protective Services, Foster Care, and Adoption are being followed. The OCA is an autonomous entity, separate from the MDHHS.

This OCA review included reading confidential records and information in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), service reports, medical records, social work contacts, and law enforcement reports. The OCA also interviewed MDHHS staff. Due to the confidentiality of OCA investigations, the OCA cannot disclose the identity of witnesses or complainants or sources of statements and evidence.

The objective of this review is to identify areas for improvement in the child welfare system by looking at how CPS investigations involving [redacted] were handled by Kalamazoo County MDHHS, and the involvement of MDHHS staff, medical professionals, and law enforcement. This review reinforces the idea that the safety and well-being of a child is a shared responsibility of the family, community, law enforcement, and medical professionals aiding children and families. This report is not intended to place blame, but to highlight areas of concern regarding the handling of the investigations; inform policy, procedure, and practice of MDHHS and partners within the child welfare system; and advocate for changes within it on behalf of similarly situated children.

Given the nature of our responsibilities, the OCA review is inherently prompted by a worst-case scenario. The investigation and review aim to give a voice to the child or children involved. It is important for readers to understand the majority of cases investigated and managed by child

protective services, foster care, and adoption, do not lead to the 'worst-case scenario.' The OCA has also reviewed hundreds of instances where MDHHS' child welfare programs have been successful for children and families, where dedicated child welfare professionals help families remain strong and together in the face of adversity. While the OCA reviews specific cases, the items identified in the findings of this document highlight missed opportunities often observed by the OCA. If addressed by MDHHS the OCA believes it can help prevent future instances of harm.

[redacted] was twelve years old when he died on April 12, 2022. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatality. On June 6, 2022, the OCA opened an investigation into the administrative actions of CPS regarding [redacted]'s death. The following report summarizes the information and evidence found during the OCA investigation.

Family History and Background:

[redacted] and [redacted] Sr. are the birth parents of [redacted] was diagnosed with Type 1 diabetes in October 2020.

This OCA investigation concentrated on interactions with CPS and [redacted]'s family from October and November 2021 relating to medical neglect concerns surrounding [redacted]'s diabetic needs. This investigation also reviewed [redacted]'s death, which occurred in April 2022.

Prior to 2021, [redacted] was the subject of several CPS investigations in Michigan. Three of these investigations resulted in substantiations for child abuse or neglect and were opened to provide ongoing services to the family. These cases were opened in 2001, 2017, and 2018. [redacted]'s parental rights were terminated to three other children in Colorado between 2003 and 2004 due to substance abuse and a lack of benefit from services provided to her.

Review of October 2021 CPS investigation:

On October 19, 2021, [redacted] was taken to Bronson Hospital for an altered mental state. [redacted] has Type 1 diabetes and [redacted] appeared to struggle caring for [redacted] and his diabetes. While at the hospital, [redacted] made statements to medical staff that she let [redacted] crash to teach [redacted] a lesson, that he is eleven years old and should be able to take care of his own "sugar" levels. A CPS complaint was made to MDHHS Centralized Intake for concerns of child abuse and neglect based on the statements and observed behavior of [redacted] and the hospitalization of [redacted] due to potential neglect. The reporting source also expressed concern [redacted] did not have the supplies needed to monitor his blood glucose[1] levels, including his blood glucose machine, needles, syringes, and insulin. The complaint was assigned to Kalamazoo County CPS for investigation.

On October 19, 2021, CPS contacted [redacted] at Bronson Hospital. [redacted] was upset by CPS's involvement and would not cooperate. The CPS report documents [redacted] said she was tired of having to remind [redacted] to take his diabetes medication and shots because he is eleven years old, and she ([redacted]) should not be responsible for constantly reminding [redacted]. [redacted] advised CPS she needed to go back to work, that she was stressed, and she did not have time to be there every second to make sure [redacted] took every single shot. [redacted] admitted to CPS she did not remind [redacted] to do the

[1] Blood glucose, or blood sugar, is the main sugar found in your blood. It is the body's primary source of energy. It comes from the food you eat. Your body breaks down most of that food into glucose and releases it into your bloodstream. When your blood glucose goes up, it signals your pancreas to release insulin.

"food shot" but usually made sure he took the "long-lasting shot at night."[2] It is documented in the CPS report that [redacted] said, "I am not his slave, and I am not his servant." [redacted] also told CPS it was not her fault [redacted] left the supplies he needed to treat his diabetes at his grandmother's home. [redacted] admitted to CPS that she had some supplies at her home but did not have [redacted] "do the food one [shot] for a week to show him how shitty he would feel." [redacted] refused to provide CPS with her current address and refused to sign a safety plan.

CPS interviewed [redacted] in his hospital room. [redacted] told CPS he knew that he needed to take his shots but that he did not like to because they hurt. [redacted] said the doctor told him he could take the shot in his leg, but he was scared those would hurt as well. [redacted] told CPS they had been staying with someone in Vicksburg and that he left his glucose monitor at his grandmother's house.

The next day, October 20, 2021, contact between a hospital staff member and CPS occurred. The hospital staff member asked CPS if [redacted] was going to be removed from [redacted]'s care. CPS informed the hospital staff member that [redacted] was not going to be removed from his mother. During this conversation, CPS was advised [redacted] would be released from the hospital in a couple of days.

On October 21, 2021, contact between a second hospital staff member and CPS occurred. The hospital staff member expressed that the nurses and physician "…are concerned about discharging him [redacted] to his mother because she [redacted] will not cooperate and provide the hospital with her address." CPS advised the hospital staff member that attempts to locate [redacted] and [redacted] would continue to be made but "…that our goal is to help families remain intact…".

According to the CPS report, [redacted]'s medical records documented [redacted] was seen from October 19, 2021, to October 21, 2021, for hyperglycemia[3].

There is a requirement in MDHHS policy to answer questions regarding children identified as "vulnerable". [redacted]'s type 1 diabetes makes him a vulnerable child. CPS requested the assistance of Bronson Hospital medical staff in answering those questions, however, it is unknown whether this occurred via written or verbal communication. The OCA found that CPS wrote the vulnerable child questions on a Word document and sent it to Bronson Hospital on November 3, 2021. The vulnerable child questions were completed by CPS in MiSACWIS on November 5, 2021.

The first vulnerable child question answered was "Does [redacted] have any unmet medical, health, or safety needs?" The documented answer stated, "The physicians and social workers are concerned that [redacted] may not receive the care he needs from his mother after discharge from the hospital for his diabetes."

The second vulnerable child question answered was "Can the caretaker adequately care for and meet the needs of [redacted]?" The documented answer stated, "The physicians and social workers believe [redacted] has been neglectful of [redacted]s medical care."

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[2] To educate the reader, the difference between the "food" shot of insulin and the "long-action" shot of insulin can be explained by dividing insulin into groups depending on how it works in the body. Rapid- or short-acting insulin helps reduce blood glucose levels at mealtimes. Long-acting insulin helps with managing the body's general needs. Both help manage blood glucose levels.

[3] The American Diabetes Association (ADA) defines Hyperglycemia as the technical term for high blood glucose (blood sugar). Further describing that high blood glucose happens when the body has too little insulin or when the body can't use insulin properly.

The third and last vulnerable child question answered was "Can the caretaker adequately care for and meet the needs of [redacted]?" The documented answer stated, "The physicians are concerned that [redacted] may not be able to adequately care for and meet the medical needs of [redacted]."

CPS spoke with [redacted] Sr. on November 9, 2021. [redacted] Sr. informed CPS he had spoken with [redacted] the night prior (November 8, 2021) and [redacted] was having a difficult time getting [redacted] to take his insulin. [redacted] Sr. advised he was residing in Colorado but that he would gladly take custody of his son if needed.

On November 12, 2021, CPS received a voice message from a staff member at WMed Pediatrics after [redacted] signed a release allowing the office staff to speak with CPS. WMed's message advised CPS and [redacted] had an appointment scheduled for November 11, 2021, and [redacted]'s doctor had concerns [redacted] was not able to meet [redacted]'s medical needs. CPS returned the phone call and spoke with this staff member on November 22, 2021. During this phone call, CPS was informed [redacted] still would not provide an address for where they are currently living as she did not want CPS to know. [redacted] told WMed staff [redacted] is being home-schooled and he was provided with a new glucose monitor. CPS was advised medical staff did not believe [redacted] was hurting [redacted] on purpose, but that [redacted] may not have the capability and medical knowledge to take care of [redacted] and make sure [redacted] takes his medication as prescribed. CPS was informed by the WMed staff that, "even though [redacted] knows how to monitor glucose levels, give shots, monitor diet, etc., she may not be able to retain the information to full capacity." WMed staff added that if "..[redacted]'s diabetes is not monitored closely, by the time [redacted] realizes [redacted] is ill and needs medical attention, it could result in possible diabetic ketoacidosis[4] with or without a coma."

The CPS report documented several efforts made by the case manager to try to locate an address for [redacted] and [redacted]. The case manager made contact approximately ten times with family members and hospital staff, attempting to find [redacted]'s address. [redacted] informed the case manager via text message on November 16, 2021, that [redacted] had a new monitor and was back on medication. [redacted] continued to refuse to provide an address.

On November 24, 2021, a case conference between the case manager, supervisor, and program manager occurred. An additional narrative was entered in MiSACWIS showing it was decided no preponderance of evidence would be found at that time, however, the mother needs to understand the expectation is the child's insulin/testing/dietary needs are her responsibility and she is expected to fulfill those needs as the adult caregiver. The additional narrative documented a letter would be mailed to the mother's address with a duty to warn and the expectations mentioned above. Because CPS still did not know [redacted] and [redacted]'s address the case manager was instructed to go to the "Drop-In Center" to try to gain more information about the family's location. It is noted in the CPS report [redacted] and [redacted] use the Drop-In Center as their address.

The CPS case manager documented receiving a text message from [redacted] on November 29, 2021. [redacted] advised finding [redacted] a new doctor who "don't blame her", and the doctor would be working toward getting [redacted] a pump. [redacted] also advised she and [redacted] would be attending diabetes education classes together. [redacted] again, would not provide an address.

[4] Centers for Disease Control and Prevention: Diabetic ketoacidosis (DKA) is a serious complication of diabetes that can be life-threatening. DKA develops when your body doesn't have enough insulin to allow blood sugar into your cells for use as energy. Instead, your liver breaks down fat for fuel, a process that produces acids called ketones. When too many ketones are produced too fast, they can build up to dangerous levels in your body.

On November 30, 2021, the CPS case manager documented a "duty to warn" letter "will be sent" to [redacted] stating that the case would not be opened but if another incident should occur where [redacted] is "medically neglected" further action could be taken by the department.

The OCA found the CPS investigation closed on December 1, 2021, as a category IV disposition. A category IV is defined in part as, "…not a preponderance of evidence of child abuse or child neglect…". The evidentiary requirement for 'preponderance of evidence' is 51% likely or greater. CPS believed they did not have enough evidence to substantiate [redacted] for abuse and/or neglect. Although the CPS disposition was a category IV finding of no child abuse or neglect, the CPS dispositional narrative currently states in part "...Category II, High-Risk Level, no overrides used".

Additional OCA Evidence Regarding October 2021 CPS investigation:

During the OCA's investigation, [redacted]'s WMed Health medical records were reviewed. The WMed Health records document concerns for [redacted]'s ability to care for [redacted]'s diabetic needs. On November 11, 2021, [redacted] obtained additional education on how to treat [redacted]'s diabetes. Statements were found in the medical records indicating [redacted] stated she "let him crash and burn to teach him how serious this is." The records document that [redacted] is responsible for the majority of his care. [redacted] was advised to take [redacted] to the hospital for further testing. [redacted] became irate and said she would take him to Helen DeVos Children's Hospital instead.

The medical records from Helen DeVos Children's Hospital showed [redacted] was treated for diabetic ketoacidosis on November 11, 2021. The medical records document [redacted] was having challenges in knowing what meals were appropriate. A home nurse was offered but [redacted] refused. The medical records also document [redacted] expressed concerns about the care provided to [redacted] by WMed endocrinology. [redacted] asked for [redacted]s care to be transferred to Helen DeVos Children's Hospital. It was noted that "…it is common for children this age to need very close supervision of their diabetes care from their parents. If expectations of diabetes self-care are not being met by the child, the parents should assume all responsibility of care."

During the OCA's investigation, the OCA asked MDHHS staff about the statement in the CPS report alluding to a Category II disposition. The OCA investigator was informed a case could have been opened but since the mother was uncooperative and they did not know where she was living, the case was closed as a category IV instead. The OCA was informed this was the decision of management. The OCA confirmed CPS staff were and are aware policy states a petition should be filed asking for parents to participate when they are uncooperative. This did not occur as required. Through interviews, the OCA was provided with statements indicating the circumstances of [redacted]'s case and the seriousness of his diabetes was not fully disclosed to the CPS program manager. The suggestion was made that this case was closed to comply with case count statistics and federal oversight of CPS investigations. The OCA also learned that the program manager relied on incomplete information upon making a disposition decision and the program manager did not review the case file or CPS investigative report.

Review of CPS Investigation of [redacted]'s Death, April 2022:

Reports reviewed indicate that On April 10, 2022, [redacted] had an elevated blood glucose level and was non-verbal due to his condition. Reports reviewed by the OCA state [redacted] did not seek medical attention for [redacted] on April 10, 2022.

On April 11, 2022, [redacted] was found unresponsive and blue, which caused [redacted] to drive [redacted] to the hospital. [redacted] did not take [redacted] to the emergency room (ER) but to the main entrance. Hospital staff observed [redacted]'s condition and rushed him to the ER. Due to [redacted] not attending to

[redacted]'s medical needs, a CPS complaint was made to MDHHS Centralized Intake for concerns of abuse and neglect. This complaint was assigned to Kalamazoo County MDHHS for investigation.

The CPS case manager contacted the assigned detective from the Calhoun County Sheriff's Office. The detective informed CPS [redacted] took off from the hospital when they attempted to speak with her. CPS was also told that law enforcement served a search warrant at [redacted]'s hotel room. A substance suspected to be methamphetamine was seized during the search. This substance was later confirmed to be methamphetamine.

[redacted] was observed by CPS at the hospital, unresponsive and hooked up to several medical devices. [redacted] had circular red spots observed on his body. The CPS case manager was informed by hospital staff that [redacted] may not live beyond several hours and that he was suffering from diabetic ketoacidosis and a respiratory illness. On April 12, 2022, the case manager was notified by hospital staff that [redacted] had died.

CPS worked with law enforcement and had a joint interview scheduled with [redacted] for April 13, 2022. [redacted] failed to show up for the interview. [redacted] advised the detective she would not be interviewed by anyone and that she was obtaining a lawyer. The detective was able to speak briefly to [redacted] and informed the CPS case manager that [redacted] said she was having difficulty caring for [redacted]. [redacted] also told the detective [redacted] would not do what he was supposed to do, and [redacted] did not know he was so sick. The detective advised CPS that [redacted] also expressed it was her fault.

According to the CPS report, on October 6, 2022, the CPS case manager conducted a follow-up interview with Dr. [redacted], [redacted]'s treating ER physician from Bronson Hospital. Dr. [redacted] informed CPS it was his opinion the action or inaction of [redacted]'s mother, [redacted], rose "…to the level of abuse or neglect.', adding, "In his professional opinion, this was negligent homicide." Dr. [redacted] advised CPS he was very familiar with the family and [redacted] had been to the hospital on several occasions for poorly controlled diabetes. Dr. [redacted] advised CPS he could recall one occasion where [redacted] said she did not remind [redacted] to check his blood glucose and take his insulin to "…teach him a lesson." CPS documented informing the investigating detective about Dr. [redacted]'s statements. The OCA could not find evidence showing the detective subsequently spoke to Dr. [redacted] about these comments.

The death investigation was closed as a category II substantiation for child abuse and/or neglect with an intensive risk level on October 12, 2022. The preponderance was for medical neglect of [redacted] by his mother. A petition was not filed due to [redacted] having no surviving children in which she maintains parental rights.

The OCA investigator reviewed the autopsy report concerning [redacted]. [redacted]'s cause of death was documented as complications of diabetes mellitus, including diabetic ketoacidosis, and the manner of death was indeterminate.

Diabetes Type 1 Mellitus:

According to the National Institutes of Health (NIH) National Center for Biotechnology Information (NCBI), "Type 1 diabetes mellitus (T1D) is an autoimmune disease that leads to the destruction of insulin-producing pancreatic beta cells. Individuals with T1D require life-long insulin replacement with multiple daily insulin injections daily (sic), insulin pump therapy, or the use of an automated insulin delivery system. Without insulin, diabetic ketoacidosis (DKA) develops and is life-threatening. In addition to insulin therapy, glucose monitoring with (preferably) a continuous glucose monitor (CGM) and a blood glucose monitor if CGM is unavailable is recommended. Self-management education and support should include training on monitoring, insulin administration, ketone testing when indicated, nutrition including carbohydrate estimates, physical activity, ways of

avoiding and treating hypoglycemia, and use of sick day rules. Psychosocial issues also need to be recognized and addressed."[5]

The NIH NCBI describes the care of T1D; "Self-management of T1D includes administering insulin multiple times daily with glucose monitoring and attention to food intake and physical activity every day, which is a considerable burden. Whereas newer technologies have helped people improve their glycemic control, they are costly, complex, and require education and training. Many people with diabetes fear hypoglycemia, hyperglycemia, and the development of complications, and depression, anxiety, and eating disorders can develop. The medical, education, training, psychological, and social challenges faced by people with T1D daily are best addressed by an interprofessional team that includes clinicians (MDs, DOs, NPs, and PAs), nurses (including diabetes nurse educators), pharmacists, dieticians, mental health professionals, social workers, podiatrists, and the use of community resources. Individualized treatment approaches, which can reduce the burden and further improve outcomes, are needed, and the interprofessional care model will yield the best possible patient outcomes."[6]

Factual Findings:

Introduction:

The Child Advocate shall prepare a report of the factual findings of an investigation and make recommendations to the department or the child placing agency if the Child Advocate finds one or more of the following:

a) A matter should be further considered by the department or the child-placing agency.
b) An administrative act or omission should be modified, canceled, or corrected.
c) Reasons should be given for an administrative act or omission.
d) Other action should be taken by the department or the child-placing agency.

The Child Advocate believes the findings should be further considered by the department, an administrative act should be corrected, and additional actions by MDHHS and other child welfare partners are necessary to help detect and prevent child abuse.

Findings:

1. The Child Advocate finds the Michigan Child Protection Law, MCL 722.628d Categories any departmental response, section 8d (1), which identifies the Category levels for CPS investigations and what should occur in each Category. In part, Michigan law states if evidence of child abuse or neglect is confirmed, the case must be classified as a category I, II, or III. The child protection law further discusses when a case should be escalated and when a petition should be filed, listing "the child's family does not voluntarily participate in services" as one reason to file a petition.

2. The Child Advocate finds Kalamazoo County MDHHS did not make a finding for medical neglect of [redacted] by [redacted] and classified the October 2021 investigation as a Category IV closure.

[5] https://www.ncbi.nlm.nih.gov/books/NBK507713/
[6] https://www.ncbi.nlm.nih.gov/books/NBK507713/

3. The Child Advocate finds, after reviewing all applicable evidence, that [redacted] placed [redacted] at an unreasonable risk of harm due to [redacted]'s failure to take reasonable steps to intervene to eliminate that risk, and that [redacted] abused and/or otherwise neglected [redacted], causing a life-threatening injury that required immediate medical attention and hospitalization. Kalamazoo County did not follow guidelines in MCL 722.638 which states in part, "(1) The department shall submit a petition for authorization by the court… if 1 or more of the following apply:" "…a parent… … has abused the child… and the abuse included 1 or more of the following: (v)Life-Threatening Injury".

   Additionally, Kalamazoo County MDHHS did not follow PSM 713-01, which states if evidence of child abuse or neglect is confirmed, the case must be classified as a category I, II, or III. Despite having a preponderance of evidence for the medical neglect of [redacted] by [redacted] the October 2021 case was closed as a category IV. The correct disposition, at the very least, should have been a Category II, an open services case. Given [redacted]'s refusal to cooperate with CPS, and her expressed intention to cause direct harm to [redacted], a petition for removal in a Category I case could have been justified.

4. The Child Advocate finds Kalamazoo County MDHHS did not intervene sufficiently to ensure [redacted]'s safety as a result of the incorrect disposition being reached in the October 2021 CPS investigation.

   a. A petition should have been filed in accordance with MCL 722.638, and PSM 714-1. PSM-714-1 states in part: "A court petition is required if the department previously classified the case as Category II and the child(ren)'s family does not voluntarily participate in services."

   b. Kalamazoo County MDHHS had evidence supporting medical neglect and concerns for [redacted]s safety, if he continued in [redacted]'s care, from medical professionals equipped to understand [redacted]'s medical needs. Kalamazoo County MDHHS also had evidence [redacted] did not believe she should have to care for [redacted]'s medical needs, it was his responsibility, and she withheld his diabetic supplies to teach him a lesson. [redacted] was also not cooperative with CPS and CPS was unaware of [redacted] and [redacted]s living arrangements, or if [redacted] was continuing to meet [redacted]'s needs at the time of case closure.

5. The Child Advocate finds that Kalamazoo County MDHHS-CPS mailed a duty to warn letter to [redacted] despite having no information about [redacted]'s primary residence. That same duty to warn letter states, "MDHHS is closing the investigation as a Category IV which indicates the Department found a no preponderance of the evidence to confirm the allegations. As this investigation is closing and an Ongoing Case is not being opened, you are not being placed on the Central Registry at this time. **No perpetrator is being found in this investigation; however, should another incident occur in which your child is medically neglected, and something were to happen that places your child at an unreasonable risk of harm, and the department is notified, further action could be taken by the department. It is your duty as a parent to ensure the safety and well-being of your child is met at all times."**

Recommendation(s):

1. The Child Advocate recommends that when child abuse or neglect is present Kalamazoo County MDHHS-CPS comply with Michigan law and take the necessary actions to protect the child from their abuser or neglecter.

2. To assist Kalamazoo County CPS, and any other county agreeable to this solution, the Child Advocate recommends that MDHHS adopt a process of CPS case management review when there are allegations of severe abuse and/or neglect. This review can include the following process:

    a. The first line Children's Protective Services Manager requests a Case Review Conference with the Children's Protective Services Program Manager regarding the CPS Investigation/Ongoing Case.

    b. A meeting between the parties is scheduled and held within 24 hours of the initial request.

    c. The managers review the documents that memorialized the steps taken in the active investigation, service plan, or updated service plan, as well as the case history before the scheduled meeting.

    d. A case conference will be held with the Children's Protective Services Program Manager regarding the active investigation/ongoing case via telephone, Microsoft TEAMS, or in person.

    e. The Children's Protective Services Manager provides the Children's Protective Services Program Manager with an overview of the case, as well as the protective interventions that have occurred and progress regarding the investigation/ongoing case to date. A consensus will be reached regarding necessary case actions after the following items are discussed:
        i. What are the allegations listed in the complaint?
        ii. Who were the identified victims and perpetrators?
        iii. How many children are in the home and what ages?
        iv. What are the identified needs for the family and child based on the CANS/FANS, FTM/TDM, and interactions?
        v. What services have been provided to the family to date? Have there been any barriers to providing services?
        vi. What safety plans are currently in place?
        vii. Who are the identified supports for the family?
        viii. What, if any, are the safety concerns?
        ix. What are the service recommendations?

    f. The conference between the Children Protective Services Manager and Program Manager be documented in narrative format in the MiSACWIS case file in a social work contact.

3. The Child Advocate recommends that MDHHS correct the disposition of the October 2021 CPS investigation to reflect a preponderance of evidence for the medical neglect of [redacted] by [redacted], changing the disposition into a Category II (a Category I with a mandated petition is not warranted as [redacted] has no surviving children in which she maintains parental rights).

Conclusion:

Under authority pursuant to The Child Advocate's Act, MCL 722.930, the OCA respectfully submits this report of findings and recommendations.

The matters addressed in this report must be further considered by MDHHS. These recommendations may effectuate positive change and can improve the lives of similarly situated children involved in Michigan's child welfare system.

Before publishing, MDHHS has 60 days to provide a written response to this report in defense or mitigation of the action. The published report will include any statement of reasonable length made to the OCA by MDHHS.

Ryan Speidel, Michigan's Child Advocate
Office of the Child Advocate
111 S. Capitol Avenue
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STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

February 29, 2024

Ryan Speidel, Director
Office of Child Advocate
111 S. Capitol Avenue
Lansing, MI 48933

Dear Mr. Speidel:

The following is the Michigan Department of Health and Human Services (MDHHS) response to the findings and recommendations from the Office of Child Advocate (OCA) Report of Findings and Recommendations regarding [redacted].

This report contains confidential information from a Children's Protective Services file. The Michigan Child Protection Law [MCL 722.627, section 7(3)] prohibits the release of this information to any individual/entity not authorized under Section 7(2) of the law. Pursuant to Section 13(3), release of this confidential information to an unauthorized individual/entity may subject you to criminal and/or civil penalties.

Findings:

1. The Child Advocate finds the Michigan Child Protection Law, MCL 722.628d Categories any departmental response, section 8d (1), which identifies the Category levels for CPS investigations and what should occur in each Category. In part, Michigan law states if evidence of child abuse or neglect is confirmed, the case must be classified as a category I, II, or III. The child protection law further discusses when a case should be escalated and when a petition should be filed, listing "the child's family does not voluntarily participate in services" as one reason to file a petition.

   MDHHS Response to Finding 1: Agree. On January 9, 2024, Kalamazoo County Administration reviewed policy and the Child Protection Law in reference to MCL 722.628d with all CPS specialists and supervisors. Additionally, Kalamazoo administration has implemented random case reads to ensure ongoing compliance which is monitored closely by the Business Service Center (BSC).

2. The Child Advocate finds Kalamazoo County MDHHS did not make a finding for medical neglect of [redacted] by [redacted] and classified the October 2021 investigation as a Category IV closure.

   MDHHS Response to Finding 2: Agree.

3. The Child Advocate finds, after reviewing all applicable evidence, that [redacted] placed [redacted] at an unreasonable risk of harm due to [redacted]'s failure to take reasonable steps to intervene to eliminate that risk, and that Trina abused and/or otherwise neglected [redacted], causing a life-threatening injury that required immediate medical attention and hospitalization. Kalamazoo County did not follow guidelines in MCL 722.638 which states in part, "(1) The department shall submit a petition for authorization by the court… if 1 or more of the following apply:" "…a parent… … has abused the child… and the abuse included 1 or more of the following: (v)Life-Threatening Injury".

   Additionally, Kalamazoo County MDHHS did not follow PSM 713-01, which states if evidence of child abuse or neglect is confirmed, the case must be classified as a category I, II, or III. Despite having a preponderance of evidence for the medical neglect of [redacted] by [redacted], the October 2021 case was closed as a category IV. The correct disposition, at the very least, should have been a Category II, an open services case. Given [redacted]'s refusal to cooperate with CPS, and her expressed intention to cause direct harm to [redacted], a petition for removal in a Category I case could have been justified.

   MDHHS Response to Finding 3: Agree.

4. The Child Advocate finds Kalamazoo County MDHHS did not intervene sufficiently to ensure [redacted]'s safety as a result of the incorrect disposition being reached in the October 2021 CPS investigation.

   a. A petition should have been filed in accordance with MCL 722.638, and PSM 714-1. PSM-714-1 states in part: "A court petition is required if the department previously classified the case as Category II and the child(ren)'s family does not voluntarily participate in services."

   b. Kalamazoo County MDHHS had evidence supporting medical neglect and concerns for [redacted]'s safety, if he continued in [redacted]'s care, from medical professionals equipped to understand [redacted]'s medical needs. Kalamazoo County MDHHS also had evidence [redacted] did not believe she

should have to care for [redacted]'s medical needs, it was his responsibility, and she withheld his diabetic supplies to teach him a lesson. [redacted] was also not cooperative with CPS and CPS was unaware of [redacted] and [redacted]'s living arrangements, or if [redacted] was continuing to meet [redacted]'s needs at the time of case closure.

MDHHS Response to Finding 4a-b: Agree. On January 9, 2024, Kalamazoo County administration completed a review of PSM 714-1 with all CPS specialists and supervisors. Additionally, Kalamazoo administration has implemented random case reads to ensure ongoing compliance which is monitored closely by the BSC.

5. The Child Advocate finds that Kalamazoo County MDHHS-CPS mailed a duty to warn letter to [redacted] despite having no information about Trina's primary residence. That same duty to warn letter states, "MDHHS is closing the investigation as a Category IV which indicates the Department found a no preponderance of the evidence to confirm the allegations. As this investigation is closing and an Ongoing Case is not being opened, you are not being placed on the Central Registry at this time. **No perpetrator is being found in this investigation; however, should another incident occur in which your child is medically neglected, and something were to happen that places your child at an unreasonable risk of harm, and the department is notified, further action could be taken by the department. It is your duty as a parent to ensure the safety and well-being of your child is met at all times."**

MDHHS Response to Finding 5: Agree. On January 9, 2024, Kalamazoo County administration completed a review regarding interactions with parents including the validity of a "duty to warn" letter, mailing items without an available address, the vulnerable child policy, and correctly assigning Categories with all CPS specialists and supervisors. Additionally, Kalamazoo administration has implemented random case reads to ensure ongoing compliance which is monitored closely by the BSC.

Recommendation(s):

1. The Child Advocate recommends that when child abuse or neglect is present Kalamazoo County MDHHS-CPS comply with Michigan law and take the necessary actions to protect the child from their abuser or neglecter.

MDHHS Response to Recommendation 1: Agree.

2. To assist Kalamazoo County CPS, and any other county agreeable to this solution, the Child Advocate recommends that MDHHS adopt a process of CPS case management review when there are allegations of severe abuse and/or neglect. This review can include the following process:

    a. The first line Children's Protective Services Manager requests a Case Review Conference with the Children's Protective Services Program Manager regarding the CPS Investigation/Ongoing Case.

    b. A meeting between the parties is scheduled and held within 24 hours of the initial request.

    c. The managers review the documents that memorialized the steps taken in the active investigation, service plan, or updated service plan, as well as the case history before the scheduled meeting.

    d. A case conference will be held with the Children's Protective Services Program Manager regarding the active investigation/ongoing case via telephone, Microsoft TEAMS, or in person.

    e. The Children's Protective Services Manager provides the Children's Protective Services Program Manager with an overview of the case, as well as the protective interventions that have occurred and progress regarding the investigation/ongoing case to date. A consensus will be reached regarding necessary case actions after the following items are discussed:
        i. What are the allegations listed in the complaint?
        ii. Who were the identified victims and perpetrators?
        iii. How many children are in the home and what ages?
        iv. What are the identified needs for the family and child based on the CANS/FANS, FTM/TDM, and interactions?
        v. What services have been provided to the family to date? Have there been any barriers to providing services?
        vi. What safety plans are currently in place?
        vii. Who are the identified supports for the family?

viii. What, if any, are the safety concerns?
ix. What are the service recommendations?

f. The conference between the Children Protective Services Manager and Program Manager be documented in narrative format in the MiSACWIS case file in a social work contact.

MDHHS Response to Recommendation 2: Effective August 21, 2023, MDHHS implemented the Statewide Critical Case Review (CCR) process to better assess high risk investigations and provide critical support to staff. The protocol is intended to further support local office staff and supervisors with challenging and often complex safety decisions through a team-oriented approach to help ensure the safety and well-being of children and families. The process engages all levels of leadership within the local office throughout the investigation for required cases, up to and including the district manager and/or county director and requires robust discussion at designated points during the investigation. Discussion points include, but are not limited to prior child welfare history, child and family strengths, barriers, concerns, and safety planning. A final disposition conference must occur prior to case disposition.

The current scope requires a CCR for the assigned referrals outlined below.

CPS referrals involving an alleged child victim three years of age and under with the assigned maltreatment type of physical injury that include any of the following:

- Physical injury.
- Threatened harm of physical injury involving excessive physical discipline without a visible injury or unknown injury.
- Infants exposed to substances, except for those exposed only to THC.

AND a family history that includes –

A prior confirmed case of physical abuse, physical injury, threatened harm of physical injury, or other related maltreatment type with a parent or living together partner (LTP) as the identified perpetrator.

OR

One or more denied investigations that involve allegations of physical abuse, threatened harm or failure to protect regardless of alleged perpetrator type, or

physical injury, threatened harm of physical injury, or placing a child at an unreasonable risk.

In cases where CCR criteria are not met upon initial review yet are determined to meet criteria throughout the course of the investigation, the CCR protocol must be followed. All items of the protocol should be reviewed, with the understanding that upper management should be involved at the first case conference (even if delayed) and prior to disposition.

MDHHS will review the current scope to determine if enhancements should be made based on the OCA's recommendations.

3. The Child Advocate recommends that MDHHS correct the disposition of the October 2021 CPS investigation to reflect a preponderance of evidence for the medical neglect of [redacted] by [redacted], changing the disposition into a Category II (a Category I with a mandated petition is not warranted as [redacted] has no surviving children in which she maintains parental rights).

   MDHHS Response to Recommendation 3: Kalamazoo County DHHS corrected the disposition of the October 2021 investigation on January 8, 2024.

Thank you for the opportunity to respond to this Report of Findings and Recommendations. If you have questions or concerns, please feel free to contact me.

Sincerely,

Demetrius Starling, Senior Deputy Director
Children's Services Administration