

Michigan Department of Human Services:

An Evaluation of the Capacity to Assure the Safety of Foster Children

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Executive Summary

At the request of attorneys for the plaintiffs in the federal litigation *Dwayne B. vs. Granholm, et al.*, a two-part review was conducted to evaluate whether the Michigan Department of Human Services' management structures, systems, and processes create a context in which it is likely – or possible – that children will be protected from child abuse or neglect while they are in foster care custody.

The first part of the evaluation included an examination of the laws, rules, and regulations governing MDHS foster care and child protective services, and the depositions of 14 MDHS administrators holding positions important to the safety of children in MDHS foster care. The second part of the evaluation consisted of a review of the case files and other documents concerning MDHS's care of five children who died while in MDHS custody during the last four years.

The overall conclusion of the review is that children who are placed in the custody of MDHS because they were not safe with their families are highly likely to be in danger in the very foster care system intended to protect them.

Problems with the management of MDHS that lead to this conclusion include:

- MDHS is structured as if to minimize expert focus on child welfare and to all but preclude the effective protection of its foster children. The agency is responsible for many human service programs in addition to child welfare and is decentralized, so that there is minimal management focus on child welfare.
- Many top MDHS managers holding positions critical to the protection of MDHS's foster children lack any education or experience to prepare them to fulfill their challenging responsibilities.
- Many MDHS management staff members holding key positions have little or no understanding of even the rudiments of child welfare and are inclined to abdicate their responsibility for the safety of the children who depend on the agency.
- Portions of its child welfare program that have overlapping missions important to the safety of MDHS's foster children are scattered throughout the organization, diluting responsibility and accountability and impeding communication of critical information.
- Overall, the procedures directing MDHS's CPS investigations lack definition, prescription, and rigor, and are often confusing. As a result, children who are wards of MDHS are certain to be placed in, or left in, dangerous foster care settings because MDHS has failed to accurately identify abusive and neglectful substitute care providers.

- MDHS’s operational definitions of child abuse and neglect are vague and subjective. They make misclassification of child maltreatment certain and allow foster children to be placed or left in dangerous foster homes.
- MDHS’s requirements for investigative activities are unreasonably lax, permit superficial and ineffective investigations, and are sure to allow foster children to be left in or placed in dangerous settings.
- For the most part, the direction provided by the MDHS procedures for foster care is reasonable.
- MDHS’s requirement for initial health screening is not adequate to keep foster children safe from medical problems.
- MDHS rules allow foster homes to be overcrowded with children. This deprives foster children of the supervision and attention that they need and is dangerous.
- Thousands of foster children placed in the care of their relatives by MDHS are treated as “second classes citizens” as compared to those placed in licensed foster homes. Children placed with unlicensed relatives receive even less protection than children placed in foster homes.
 - MDHS rules permit the placement of foster children with relatives who MDHS knows to be dangerous.
 - MDHS places children in its care with relatives about whom little or nothing is known.
 - MDHS fails to provide even marginally adequate financial support for its wards placed in unlicensed relative foster care.
 - Children who are in MDHS’s custody and are placed with unlicensed relatives lack even the inadequate safeguards the agency provides children in licensed foster homes.
- The MDHS managers resemble blindfolded school bus drivers. They have no way to know about impending danger confronting their vulnerable passengers.
 - MDHS has no systematic program of case-based quality assurance by which it can assess its child welfare processes or outcomes.
 - MDHS’s inability to produce useful and reliable statistical information about its child safety processes and outcomes is shocking. As a result, MDHS submits information that it knows, or should know, is inaccurate to the federal government. Worse, much of MDHS’s administrative data is misleading and

has the effect of hiding the danger to which it subjects its foster children, reducing its ability to protect them.

- The fact that MDHS does not have *nearly* enough foster care caseworkers to do its job is a problem that, *by itself*, renders MDHS incapable of protecting the children in its care.

Based on the child fatality review, it is clear that children placed in the care of MDHS for their protection die because MDHS's deeply flawed systems and processes allow them to be put in harm's way. It is safe to assume that many other children in foster care are abused and neglected.

Problems with the functioning of MDHS exemplified in the child fatality review leading to this conclusion include:

- MDHS's CPS investigations are unstructured, superficial, and rarely gather sufficient information to permit an accurate determination about whether or not maltreatment has occurred.
- MDHS investigators often make determinations that are not consistent with the facts.
- Even when licensing violations or child maltreatment *are* identified in foster homes, MDHS continues to place children in them.
- MDHS has no system for meaningful oversight over the children placed in private agency foster homes.
- MDHS abdicates responsibility for the safety and well-being of the children it places in unlicensed relative care.
- MDHS direct service caseloads preclude caseworkers from protecting the children in its foster care custody.

Combining the disturbing deficiencies in MDHS' performance in the five cases reviewed with the many serious shortcomings found in the agency's structure, regulation, practices, overall management, and – especially – its staff resources, it is clear that children are far too likely to be no safer in foster care than they were with their abusive and neglectful parents.

PART 1

A MANAGEMENT REVIEW:

The Capacity of the Michigan Department of Human Services to Protect the Children Placed In Its Care

Attorneys for the plaintiffs in the federal litigation *Dwayne B. vs. Granholm* have retained me to conduct an assessment of the Michigan Department of Human Services's (MDHS) ability to keep the children in its care safe. More specifically, I have been asked to assess whether MDHS's management structures, systems, and processes create a context in which it is likely – or possible – that children will be protected from child abuse or neglect while they are in the custody of MDHS. The management review is supplemented by my review of the cases of five children who died in recent years while they were in the foster care¹ of MDHS.

As a social worker with more than 30 years of experience working in public child protective services, including direct or administrative responsibility for the safety of more than a million allegedly abused and neglected children, I believe that I am well qualified to conduct this assessment. See my resume (attached) for a more detailed description of my qualifications.

The overall conclusion of my review is that children who are placed in the custody of MDHS because they were not safe with their families are highly likely to be in danger in the very foster care system intended to protect them.

Review Process

The assessment is based entirely on a review of documents. No interviews or on-site activities were conducted. Michigan child welfare regulations, federal review results, and the transcripts of depositions of key members of MDHS management were reviewed. The deposition transcripts, attendant exhibits, and case record documents pertaining to the five child deaths reviewed were provided by attorneys for the plaintiffs. Other documents were obtained from the MDHS website (www.mfia.state.mi.us) or the Michigan Legislature's website (www.legislature.mi.gov). The documents reviewed include:

- Michigan Child Protection Law (Act 238)
- Michigan Foster Care and Adoption Services Act (Act 203)
- Michigan Child Care Organizations Law (Act 116)

¹ Throughout this paper “foster care” is used to designate children in the MDHS custody and includes all categories of placement including foster homes, relative homes, group homes, and Child Caring Institutions. When referring specifically to family foster homes, the designation “licensed foster homes” is used.

- Children’s Protective Services Manual
- CPS Field Manual
- Children’s Foster Care Manual
- Licensing Policy Manual
- Michigan 2002 CFSR results
- Michigan Performance Improvement Plan
- Mary Mehren deposition with exhibits
- Debora Buchanan depositions with exhibits
- James Gale depositions with exhibits
- James Nye depositions with exhibits
- Jerry Frank deposition with exhibits
- Marianne Udow deposition with exhibits
- James Hennessey deposition with exhibits
- Laura Champagne deposition with exhibits
- Angelo Nicholas deposition with exhibits
- Steve Yager deposition with exhibits
- Ted Forrest deposition with exhibits
- Tom Schwarz deposition with exhibits
- Margaret Warner deposition with exhibits
- Jerome Rutland deposition with exhibits

In addition, voluminous documentation was reviewed regarding the cases of five children who died while they were wards of MDHS in the past four years. These were:

James B.	Bates Range:	MIDHS00133983 - MIDHS00135840
Isaac L.	Bates Range:	MIDHS00073490 - MIDHS00074637 MIDHS00250362 - MIDHS00251457 MIDHS00290935 - MIDHS00292795
Heather L.	Bates Range:	MIDHS00071180 - MIDHS00071666 MIDHS00290642 - MIDHS00290933
Elizabeth G.	Bates Range:	MIDHS00071667 - MIDHS00072435 MIDHS00293705 - MIDHS00294995
Brandon L.	Bates Range	MIDHS00093747 - MIDHS00094635

The review of the child fatalities illuminated the information gleaned from the review of the administrative documents and depositions.

Child Welfare Services

Every state operates a child welfare program. The principal goals of all public child welfare programs are to assure the safety, permanency, and well-being of children. In 1997, with the passage of the Adoption and Safe Families Act (Public Law 105-89), Congress established that “the child's health and safety shall be the paramount concern” of state child welfare agencies. (Section 101. (a) (15) (A))

Each state child welfare program has established a mechanism by which it receives reports from professionals and from the community at large when there is suspicion that children have been abused or neglected. In Michigan, MDHS operates hotlines at the county level for this purpose. MDHS employs child welfare investigators to investigate child maltreatment reports. The purposes of these investigations are 1) to determine whether a preponderance of the evidence indicates that child maltreatment has occurred, (MCL 722.628 d), 2) to assess the risk to involved children to determine, among other things, whether a substantiated abuse/neglect report should be placed on the Michigan Central Registry (MDHS Children’s Protective Services Manual CFP 711-4), and 3) to determine whether children are in situations so dangerous that they can only be protected by placement in MDHS custody or replacement in a different foster home.

Decisions that children can only be kept safe from serious harm by removing them from their families’ care are extremely difficult. Child welfare professionals involved in making them must weigh the physical and emotional risk of leaving children with abusive or neglectful parents against the emotional trauma children inevitably suffer when they are separated from their parents. Two alternative scenarios have to be predicted: What are the likely consequences to the child if he or she remains at home, compared with the consequences if he or she is torn away from his or her family. The problem inherent in making this decision is that, in those instances where children must be removed from the care of their parents, we preserve their safety at the expense of their emotional security. When children are placed in substitute care, it is at a heavy cost to their psychological well-being. The state, having made the decision that it is the better parent, has the responsibility to live up to at least the same standard to which we hold biological parents. It must, first and foremost, keep children safe.

Unfortunately, even in the best child welfare system some children are harmed while they are in foster care. Sometimes this harm is accidental and unforeseeable. In other instances it is the result of child abuse or neglect. Recognizing this, the Administration for Children and Families (ACF) of the U. S. Department of Health and Human Services has set a national standard for the proportion of children in substitute care who are abused or neglected.

When allegations are made that children have been abused or neglected in foster homes or other substitute care settings, the child welfare agency investigates. It is important that these investigations be conducted with special rigor. Victims of child maltreatment committed by foster parents and other substitute care providers suffer multiple traumas: they are hurt by their parents, they suffer the trauma inevitably associated with being

separated from their families, and then they are abused or neglected by those who were to supposed to protect them. When abuse, neglect, or other problems affecting the safety of children in state care are discovered in these investigations, the state – MDHS in Michigan – must act quickly, decisively, and assertively to assure that children are protected.

State child welfare agencies must use care in selecting the homes and other facilities into which they place their child wards. Potential substitute care resources must be studied to ensure that they have the capacity to care for and protect the *particular* children being placed. Once children are placed, foster care caseworkers must continually evaluate the adequacy – and most especially the safety – of the homes they have selected. They must provide support for foster parents, relatives, and other caregivers to assure that good-quality care is provided and to minimize the stress experienced by caregivers as they carry out their often trying responsibilities. When problems with caregivers’ ability to meet the needs of individual children are identified, foster care caseworkers must act to resolve them. Failure to do so will inevitably threaten the safety of foster children.

The responsibilities we assign to public child welfare agencies are truly daunting. It important, therefore, that child welfare agencies be well run. They must be organized to accomplish their difficult task. They must be staffed at all levels by people who have the capacity, knowledge, and motivation to do the hard work. They must direct their front-line staff in such a way that children’s needs are met and that, above all, children are kept safe. They must have the resources necessary to discharge their important responsibilities. They must constantly monitor their performance to assure that their processes are effective and that they succeed in keeping the children they serve safe.

Child Welfare Standards

Child welfare is a comparatively new profession. The first real child protection laws were not written until the beginning of the twentieth century. For this reason, there is no well-defined standard of care for child welfare. There are, however, two sets of standards that are widely used to evaluate the performance of child welfare programs.

The Child Welfare League of America (CWLA) has published its Standards of Excellence. The CWLA standards are a series of publications intended to describe good child welfare policies for each of the various child welfare processes (e.g., agency administration, child protective services, foster care, and kinship care.) The Counsel on Accreditation (COA) accredits public and private agencies that provide mental health and child welfare services. They publish a set of standards specifically for public child welfare agencies. For a child welfare agency to become accredited, it must comply with these standards.

Although it is true that the CWLA describes its standards as being standards of “excellence” and that very few public child welfare agencies seek accreditation, with few exceptions, the standards describe reasonable practice. Who would suggest that it is reasonable for CPS investigations to be anything but thorough, that it is acceptable for

foster parents to have violent criminal backgrounds, or that foster children should be seen any less than once per month? Child welfare caseloads that exceed the standards' requirements are not reasonable because they prevent caseworkers from effectively doing the work necessary to achieve safety, permanency and well-being for the children who depend on them.

Considering the importance of child welfare services to the children who receive them, it is not possible to reasonably conclude that child welfare agencies should be held to any lesser standard than those that have been established by the CWLA and the COA. If airline pilots were held to standards of mediocrity, no one would fly. The difference is that children have no choice about their involvement with the child welfare system.

MDHS Organizational Structure and Culture

It is a truism that no child was ever harmed or protected by an organizational chart. State child welfare programs can be effectively administered in any of a number of administrative structures. Many states have freestanding child welfare departments, usually at the gubernatorial cabinet level. This structure has the advantage of maximizing specialized administrative focus on child welfare. Other state child welfare programs are parts of larger "umbrella" agencies that combine state human service programs. The child welfare portions of these agencies may benefit from the administrative proximity to other social services relevant to child welfare.

Either type of structure can work. It is necessary, however, that the structure account for the unique and complex nature of child welfare. No structure is likely to succeed in assuring the safety of a state's abused and neglected children unless professionals with specialized knowledge and understanding of child welfare are in a position to administer and manage it. Foster children need the continuous, focused, and informed attention of child welfare managers and practitioners at all levels.

MDHS is structured as if to minimize expert focus on child welfare and to all but preclude the effective protection of its foster children.

MDHS has no discrete child welfare division. The agency's structure is highly decentralized and diffuse. According to its website, MDHS is an agency that has responsibility for a very wide range of services. In addition to child welfare, MDHS administers or operates Michigan's:

- Financial assistance programs, including: Family Independence Program (welfare), Food Assistance Program, State Disability Assistance, Low Income Home Energy Program, Child Development and Care (day care), Child Support, Medicaid, SSI, and more.
- Service programs, including: Juvenile Justice, Migrant Services, Refugee Assistance, Domestic Violence, HIV Advocacy, Adult Community Placement, Family Resource Centers, and more.

- Regulatory Services, including: regulation of juvenile court facilities, homes for the aged, camps for children and adults, and more.

Since this array of programs includes many services having little relevance to child welfare, and since some of the most relevant services (e.g., mental health and substance abuse services) are not administered by MDHS, the potential benefit of ready access to important collateral services generally attributed to “umbrella agencies” is not realized by MDHS.

From the Director down, the MDHS management staff has a remarkable lack of specialization and carries responsibility for the enormous and disparate set of programs for which the agency is responsible. Field Operations is the MDHS division responsible for the actual delivery of services. Field Operations is organized according to Michigan’s 83 counties, with each county being administered by a MDHS County Director. In all but the five largest counties, the County Directors are five organizational levels removed from the MDHS Director. In four of the five remaining counties, the County Directors are four levels beneath the MDHS Director organizationally. Every one of the approximately 100 administrators from the MDHS Director through the County Directors is responsible for the MDHS Family Independence, Medicaid, day care, and many other programs run by the agency. *Not one has specialized responsibility for child welfare.*²

For example, in his deposition, the veteran Berrien County Director, Jerry Frank, described his job responsibilities as being,

“the major provider of human services, both cash assistance, social services ... Medicaid, food assistance, food stamps ... Child Protective Services, foster care, delinquency, adoption services. County directors are by nature or position, as we’re a decentralized agency, are required to exercise broad discretion and level of work.”

(Frank Deposition, pp. 48 – 49) Furthermore, in many counties there are managers who carry responsibility for child welfare in addition to many other MDHS programs and who are subordinate to the County Directors. In Macomb County, for example, Yvonne Brock, a District Manager, reports to Angelo Nicholas, the County Director. Ms. Brock is responsible for a variety of programs in addition to several child welfare units. Subordinate to Ms. Brock is Diane Noack, a Program Manager. Ms. Noack is responsible for two child welfare and four other human service teams. (MIDHS00340062 and Nicholas Deposition, pp. 142 - 150) In some counties this generalist approach goes all the way down to the front-line supervisor and, incredibly, even to the caseworker. (MIDHS00238873 – 956)

This diffuse structure is built to fail. It dilutes the management attention paid to any one area, depriving the child welfare program – and the safety of Michigan’s 19,000 foster children – of the focus it requires. It is *highly* unlikely that these managers could gain

² MDHS Website, http://www.michigan.gov/documents/DHS-Org-Chart_145051_7.pdf.

and maintain substantial understanding of the number of diverse programs for which they are responsible. It can be argued that it is extremely difficult for one person to have the thorough grasp of all areas within child welfare (e.g., CPS investigations, foster care, residential treatment, and licensing) necessary to manage all areas competently, even if their entire focus was on child welfare. In their depositions, County Directors and Regional Managers acknowledged having to split their time and attention not only between child welfare programs, but between wholly different social welfare functions. For example, Tom Schwarz, a veteran County Director, Regional Manager, and Outstate Director, testified that about 60% of his time was spent on child welfare. (Schwarz Deposition, pp. 32-33) Jerome Rutland, Director of Wayne County – by far the largest county foster care system in Michigan, with more than 30% of all Michigan foster children³ – testified that about 35 - 40% of his time was spent on child welfare in the last two years, and *half that time* in the years before that. (Rutland Deposition, pp. 86 – 87, 124) Keeping children safe in foster care is a full-time job. It requires the constant vigilance of child welfare professionals. When everyone is in charge of everything, no one is in charge of – or is responsible for – anything.

Many top MDHS managers holding positions critical to the protection of MDHS’s foster children lack any education or experience to prepare them to fulfill their challenging responsibilities.

It is doubtful that effective child welfare services – including assuring that foster children are kept safe – could be delivered by an agency structured as MDHS is. The best hope for counteracting the nearly total absence of functional specialization in child welfare would be the presence of an MDHS management staff having a substantial educational and experiential background in child welfare. According to standards established by the CWLA, directors of child welfare agencies should, at minimum, hold graduate degrees in human services and have, and be able to demonstrate competence in child welfare service delivery.⁴ Relevant advanced degrees are the exception among top MDHS staff. Few have any child welfare experience.

Marianne Udow was the MDHS Director from January 2004 through August 2007. She testified in her deposition that she had no previous background in child welfare. Ms. Udow holds a masters degree in health service administration. Before her appointment as Director she worked in the health insurance industry, most recently at Blue Cross Blue Shield. When she was appointed MDHS Director, rather than resigning from Blue Cross Blue Shield, she took a leave of absence, suggesting that she lacked a long-term commitment to MDHS.⁵ When Ms. Udow was appointed Director, Michigan Governor

³ MDHS Management Information Report, <http://www.mfia.state.mi.us/MIRData/>, accessed 02/07/08.

⁴ Child Welfare League of America (1996) *Standards of Excellence for the Management and Governance of Child Welfare Organizations*, Washington D.C., §2.50.

⁵ Press Release (December 10, 2003) *Office of Governor Jennifer M. Granholm*, http://www.michigan.gov/gov/0,1607,7-168-23442_21974-82725--,00.html.

Jennifer Granholm's priorities for MDHS were early childhood education and adult literacy. The governor did not mention child welfare. (Udow Deposition, p. 7)

Ms. Udow's successor as MDHS Director is Ismael Ahmed who, like Ms. Udow, does not have a background in child welfare. Mr. Ahmed is described on the MDHS website as being an "expert in immigration and social reform." He holds a bachelor's degree in secondary education. Before his appointment, he was the director of the Arab Community Center for Economic and Social Services (ACCESS), where he worked for 36 years.⁶ ACCESS is a community-based organization providing economic and social services to the Arab community. ACCESS provides valuable services to its clientele, but these services do not appear to include child welfare.⁷

Laura Champagne served as the Chief Deputy Director under Marianne Udow. The Chief Deputy Director's position is extremely important to child welfare because it carries responsibility for all of MDHS's field operations and because about 8,500 of MDHS's 10,000 staff report to the Chief Deputy. For the 23 years preceding her appointment as MDHS's Chief Deputy Director, Ms. Champagne worked at the United Auto Workers, where she was involved in negotiations and union policy. Approximately 10 UAW staff reported to her. (Champagne Deposition, pp. 13 and 18 - 19) She holds a bachelor's degree in English and a law degree. (Champagne Deposition, p. 9) She has no background in child welfare.

Ted Forrest is the Manager of the Children's Protective Services Program. His is the only statewide position in MDHS – and the only one above the level of second-tier supervisor – that specializes in child protective services. As Manager of Children's Protective Services, he is responsible for the development of all MDHS protective services policy. Mr. Forrest holds a bachelor's degree in business administration and has had no formal human service training. During the approximately 30 years he has worked at MDHS he has held jobs as a forms analyst, as a contract specialist assigned to special projects related to financial assistance, and as the manager of a program to help prepare older children economically for their exit from the foster care system. He has been in his current position for about 10 years. (Forrest Deposition, pp. 4 - 6) To prepare him to develop MDHS's child protection policies, Mr. Forrest was assigned to a county CPS unit for four months. During this time he "shadowed other workers for a while and eventually was able to handle a case or two." (Forrest Deposition, p. 8)

These are just a few of many examples of MDHS administrators whose education and experience is not nearly sufficient to prepare them for their complex jobs.

While it is necessary that child welfare administrators be adequately prepared for their complex jobs, it is not sufficient. In order to have any hope of running an agency that provides effective child welfare services, child welfare administrators must be well

⁶ Michigan Department of Human Services Website, http://www.michigan.gov/dhs/0,1607,7-124-5459_7097-174062--,00.html.

⁷ Arab Community Center for Economic and Social Services Website, <http://www.accesscommunity.org>.

motivated, must understand the daily realities of child welfare, and must take a “hands-on” approach to the work.

Many MDHS’s management staff members holding key positions have little or no understanding of even the rudiments of child welfare and are inclined to abdicate their responsibility for the safety of the children who depend on the agency.

It’s not hard to understand the impulse to look away from the sad – sometimes horrific – things that happen to children who become involved with child welfare programs. The problem is that unless the people who run child welfare agencies are paying careful attention, these children are likely to be harmed by the agencies intended to protect them. Although there is little to suggest that MDHS administrators are anything but well-meaning, there is much to suggest that they tend to take a distinctly “hands-off” approach to managing the agency.

Laura Champagne, again, the recently departed Chief Deputy Director in charge of the over-all field operation of MDHS, is an especially stunning example of this tendency. In her deposition, Ms. Champagne testified that one of the major initiatives undertaken during her tenure at MDHS was the placement of children with relative foster parents. As a result of this initiative, approximately 7,000 of the 19,000 children in the care of MDHS are placed in unlicensed relative care. (Hennessey Deposition, p. 199) When asked about the differences in the support received by children placed with unlicensed relative caregivers as opposed to those placed with licensed foster parents, incredibly, Ms. Champagne responded “I don’t know.” When asked what she did as Chief Deputy Director to see that the foster children MDHS placed with relatives received the support that they needed, she answered, “I don’t work at that level. So there is nothing I personally would have done . . . At my level it was more dealing with larger issues.” (Champagne Deposition, p. 73) It’s hard to imagine a much larger issue.

Ms. Champagne testified that she had no idea how many of the children *that were her responsibility* were placed with relatives. (Champagne Deposition, p. 73 - 74) She did not know whether there are differences for children placed with relatives compared with children placed in licensed foster homes in case planning or in the requirement that MDHS caseworkers visit them. (Champagne Deposition, p. 77 - 78) She did not review reports to determine whether MDHS caseworkers visited the foster children in their caseloads. (Champagne Deposition, p. 111) She did not receive any reports indicating the number of cases being carried by her caseworkers. In that regard she testified that “the County Directors would know what was going on in their counties.” (Champagne Deposition, p. 57) She played no part – *did not even review* – the annual priorities established for MDHS Field Operations. (Champagne Deposition, p. 136) She did not know what proportion – or even the proportional trend – of Michigan foster children qualified to receive federal Title IV-E funds. (Champagne Deposition, p. 142) She never looked at a Local Office Management Report (LOMR), a report intended to track the performance of county MDHS offices. (Champagne Deposition, p. 151) She was unfamiliar with the MDHS process for licensing its offices *despite the fact that a number*

of the offices within her responsibility were in danger of losing their licenses. These are not small details. They are basic to the management of any child welfare program.

Tom Schwarz has been the Director of several county offices, the Manager of a collection of 22 counties in Northern Michigan, and until recently has acted as the Outstate Director (Outstate refers to the entire state excluding Wayne County). Mr. Schwarz testified that Field Operations played no part in overseeing the development of corrective action plans responding to problems identified by licensing reviews saying, “it’s the county’s responsibility to establish their corrective action plan.” (Schwarz Deposition, p. 75) Macomb County is a large county near Detroit and, because of serious problems found in its licensing review, it currently operates on a provisional license. When asked when the county’s provisional license was to expire, Mr. Schwarz testified that he didn’t know. In fact, it was set expire the following day. (Schwarz Deposition, p. 75) He had not discussed caseload size with any of the County Directors or Regional Managers who report to him. (Schwarz Deposition, p. 83) He does not know whether MDHS is eligible to receive federal Title IV-E funds for foster children placed in the unlicensed homes of their relatives. (It is not eligible.) (Schwarz Deposition, p. 148) He believes (erroneously) that unlicensed relative foster parents receive foster care payments from MDHS. (Schwarz Deposition, p. 147) Medical passports are a mechanism used by many child welfare agencies to document that foster children receive medical care. In Michigan, the use of medical passports is a statutory requirement. (MCL 722.954 c) Mr. Schwarz’s testimony indicates that he did not know what a medical passport is. (Schwarz Deposition, p. 156) He testified (incorrectly) that staff from the MDHS licensing division can substantiate child abuse/neglect investigations and is not familiar with MDHS’s process for investigation of abuse/neglect in Child Caring Institutions. (Schwarz Deposition, p. 207 - 208) Again, these are not minor matters. They are basic elements of the portion of the child welfare program *that Mr. Schwarz was in charge of.*

Angelo Nicholas is the County Director of Macomb County. He has a bachelor’s degree in English and, although he has worked for MDHS for over 40 years, he has never been a child welfare caseworker and has very little child welfare experience. (Nicholas Deposition, pp. 5 – 10) Mr. Nicholas could not say how many children had been abused or neglected in MDHS substitute care in his county in the past year (Nicholas Deposition, p. 25) He did not know what the objectives in his own business plan were. (Nicholas Deposition, p. 36) He did not know what progress the county he directed had made with respect to the federal Child and Family Services Review standards. (Nicholas Deposition, p. 100) Unbelievably, he did not know what deficiencies were identified in the licensing review of Macomb County MDHS, the review that has caused his office to be placed on its second provisional license. (Nicholas Deposition, p. 120) He testified that he did not know what the repercussions of receiving a third provisional license are but did not see it as an emergency. (Nicholas Deposition, p. 121) (If an MDHS office cannot come into compliance after four provisional licenses, it cannot operate using state funds.) (MCL 722.116) He does not review the size of the caseloads in his county. (Nicholas Deposition, p. 153 - 154) He simply doesn’t know very much about the child welfare program he directs.

Again, these are only a few of many examples of key MDHS managers demonstrating almost no grasp of the subject matter for which they are responsible and of their adopting an approach that everything is the responsibility of their subordinates. Given this lack of focused, informed, and active attention on the work of the agency, it is not surprising that children get hurt.

Components of its child welfare program that are essential to the safety of MDHS foster children are scattered throughout the organization, diluting responsibility and accountability, and impeding communication of critical information.

A quality shared by effective organizations is a structure that integrates the agency's activities and fosters internal communication. CWLA standards require that the organizational structures of child welfare agencies "facilitate efficient movement toward fulfillment of the organization's mission."⁸ The same standards call for a structure that assures the internal communication throughout the organization that is essential for coordination of the child welfare agency's functions.⁹ Neither of these qualities is present within MDHS.

Private Agency Foster Care

Many of MDHS's foster children receive foster care services from private agencies. The Michigan Child Care Organizations Act (MCL 722.115) authorizes private Child Placing Agencies to provide foster care. Private Child Placing Agencies operate under purchase of service contracts with MDHS to provide full foster care services to MDHS wards. These services include recruiting, licensing, and maintaining foster homes, investigating complaints that licensing rules have been violated by foster care providers, placing children into foster homes, and providing or arranging all direct services to the MDHS foster children placed in the agencies' homes. MDHS responsibility for monitoring private agencies that provide foster care services is irrationally divided among multiple workers and units within the agency, without clear lines of responsibility.

Purchase of Service (POS) Workers: At the case level, private agency foster care cases are assigned to front-line MDHS caseworkers from the county offices. According to MDHS policy and procedure, POS workers review and approve quarterly reports and reports to the court submitted to the POS worker by the private agency. They are not required to visit foster homes, to see the MDHS foster children placed in them, or to attend court hearings. Their role is largely administrative. In addition to receiving reports, POS workers complete such tasks as applying for social security cards, securing birth certificates, monitoring the submission of required court petitions, and a lot of data entry.

⁸ Child Welfare League of America (1996) *Standards of Excellence for the Management and Governance of Child Welfare Organizations*, Washington D.C., §2.68.

⁹ *Ibid.*, §2.70.

POS workers are assigned the cases of individual children as opposed to being assigned to an agency. In fact, many MDHS caseworkers are assigned both as the foster care caseworker for some children whose cases are assigned to MDHS and as the POS worker for others assigned to private Child Placing Agencies. There is, therefore, no aggregation of information about the private agencies. If a POS worker identifies a problem with a Child Placing Agency's handling of a case, she is to tell her supervisor. If the problem cannot be resolved by the county office, it is to be brought to the attention, "through administrative channels," of Foster Care and Adoption Monitoring in the Central Office. (MDHS Children's Foster Care Manual - CFF 914)

Foster Care and Adoptions Monitoring (FCAM): Private agency foster care is also monitored by FCAM. This unit is currently a part of Field Operations. It has, however, been moved around the organization many times in the past five years (Buchanan 9-17-07 Deposition, p. 10) and may be moved out of Field Operations as part of a pending reorganization. The FCAM conducts reviews of private Child Placing Agencies to determine their policy and contractual compliance. These reviews are completed every 18 to 36 months (Buchanan 9-17-07 Deposition, p. 18) The FCAM may also conduct special reviews in response to identified issues, but there are no criteria directing decisions to conduct such reviews. (Buchanan 9-17-07 Deposition, pp. 86 and 89)

The Bureau of Children and Adult Licensing (BCAL): Finally, private agency foster care is monitored by BCAL, a separate unit reporting to the MDHS Director. BCAL, among other things, conducts annual inspections of Child Placing Agencies to determine whether they are in compliance with MDHS licensing rules. (Gale 6-26-07 Deposition, p. 67)

This dispersion of responsibility makes it likely that MDHS will fail to identify and respond to problems that threaten the safety of its children in private agency foster care. It is difficult to distinguish the roles of FCAM and BCAL, and MDHS has no system for clearly delineating them. (Gale 9-6-07 Deposition, p. 41) The head of FCAM testified that there were issues of FCAM and BCAL "tripping over each other of whose going to do what." (Buchanan 10-15-07 Deposition, p. 264) This is particularly true in response to special problems (e.g., the deaths of children in private agency foster care). (Buchanan 9-17-07 Deposition, pp. 86 - 88) Such duplicative responsibility makes it possible for each unit to view an issue as being the responsibility of the other.

It is clear that there are serious problems of poor – or nonexistent – communication between the three units primarily responsible for monitoring private agency foster care. Reports of the reviews and the resultant quality improvement plans completed by FCAM are not sent to the caseworkers responsible for monitoring private agencies in the field. (Buchanan 10-15-07 Deposition, p. 55) Neither are the results of BCAL inspections. (Gale 6-26-07 Deposition, p. 69) After MDHS attributed the homicides of several children placed in its private agency foster care, at least in part, to these communications problems, MDHS began a pilot project in Wayne County whereby a special form was created for POS workers to document and report their concerns about private agency foster homes. (Buchanan 10-15-07 Deposition, pp. 31 - 32) Creating forms is not a good way to improve communication.

MDHS's system – or, more correctly, lack of system – for monitoring its private Child Placing Agencies and Child Caring Institutions is duplicative and inefficient. So much so that the Michigan state legislature has intervened to make the system more efficient. (Gale 6-26-07 Deposition, pp. 66 - 67) This inefficiency is related to safety because it saps MDHS's dangerously meager resources – resources that could be devoted to direct services. More importantly, this arbitrary division of responsibility and accountability creates not cracks in MDHS management but crevices, into which MDHS children placed in private agency foster homes are almost certain to fall.

Investigations of Child Abuse and Neglect in Child Caring Institutions

Like all child welfare agencies, MDHS places some of its most troubled wards in Child Caring Institutions. For the very reasons they require placement in institutional settings, these children are often especially vulnerable to maltreatment. According to MDHS procedures, allegations that MDHS wards have been abused or neglected in Child Caring Institutions are investigated by licensing consultants from BCAL rather than by specialized child protection investigators. Following these BCAL investigations, the Licensing Consultants make recommendations as to whether the complaints should be substantiated. These recommendations are sent through the CPS Program Office in the policy division in Lansing to the CPS Units in the counties where the Child Caring Institutions are located. Staff from the county CPS units are then to determine whether the allegations should be substantiated and, if so, enter them on the Central Registry. Only CPS can enter perpetrators on the Central Registry. (MDHS Children's Protective Services Manual CFP- 716-6)

This is problematic for several reasons. First, the Licensing Consultants receive no specialized training in conducting child protective investigations. (Gale 6-26-07 Deposition, p. 25 and Gale 9-6-07 Deposition, p. 42) James Gale, the BCAL Director, is not aware of any of the Licensing Consultants having any previous experience conducting CPS investigations. (Gale 9-6-07 Deposition, p. 47) Given the complexity of CPS investigations – especially those involving Child Caring Institutions – this lack of preparation strongly suggests that the BCAL Licensing Consultants are woefully ill-prepared for this important and sensitive function.

Second, the BCAL recommendation concerning substantiation follows along a circuitous course. From the BCAL Licensing Consultant in the area where the investigation took place, the recommendation is sent to Mary Mehren, the head of the Child Protection/Family Preservation Unit in the policy division. She sends it to Ted Forrest, the Manager of Children's Protective Services, also in the policy division. Mr. Forrest reviews the recommendation – for no apparent reason – and files a copy. He then sends it to the Field Operations in central office, from which it is sent to the CPS unit back in the county office where the investigation took place. The county CPS unit is supposed to review the BCAL investigation and, if it approves a recommendation to substantiate, enters the perpetrator's name into the Central Registry. (Forrest Deposition, pp. 58 – 64)

Documents provided by the defendants show that, in some cases, it took BCAL many months from the time an investigation into abuse or neglect in a Child Caring Institution was completed to the time it was entered on the Central Registry. (Forrest Deposition, pp. 58 – 64) As examples, delays of *more than eight months* (Exhibit 294) and *more than five months* (Exhibit 295) are documented. Mr. Forrest acknowledged that delays entering substantiated child maltreatment cases onto the Central Registry are dangerous because they permit child abuse/neglect perpetrators to have access to children. (Forrest Deposition, pp. 69 - 72) Delays are also dangerous because – assuming the county CPS units actually conduct meaningful reviews – any added investigative activities CPS requires of BCAL will be delayed. Finally, the process subjects children to risk simply because such a winding path creates many opportunities for error (e.g., recommendations getting lost). Mr. Forrest, who is responsible for developing MDHS’s child protection policies, knows of no reason for MDHS to use such an unreasonable process. (Forrest Deposition, p. 73)

County-Based Hotlines

As has been mentioned above, MDHS receives allegations that children – including its foster children – have been abused or neglected through its county-based hotlines. Although other states operate county-based hotlines, it is unusual for state-based systems to do so. Statewide hotlines have the advantage of improving the consistency of case screening decisions. This is especially important since, as will be discussed below, MDHS has vague and subjective definitions of abuse and neglect. Statewide hotlines are much less prone to allowing local CPS workload influence screening decisions. Finally, statewide hotlines are staffed by specialized hotline workers. Whether to accept or not accept a referral for investigation is one of the most important and difficult decisions made by child welfare staff. CWLA standards require that “staff members receiving reports should possess the highest possible professional skills by virtue of training, education, and experience.”¹⁰ Although MDHS hotline staff are specialized in Wayne County, the hotline function is handled in an ad hoc manner in the rest of Michigan. (Nye Deposition, p. 454) This guarantees that some referrals about MDHS foster children involving actual maltreatment will be screened out, leaving the children in danger.

Taken as a whole, the MDHS management structure and culture resembles that of a hospital staffed by bankers instead of doctors. Some of the bankers who have been hired to perform surgery are kept in the dermatology department and some of the bankers who are supposed to act as dermatologists are housed in the emergency department. No one talks to each other, and when things go wrong it’s the fault of the teller hired to be a nurse.

¹⁰ Child Welfare League of America (1999) *Standards of Excellence for Abused and Neglected Children and Their Families*, Washington D.C., §1.12.

MDHS Regulation of Child Welfare Services

At the state level, child welfare is regulated by state law. Every state has statutes that broadly define what is required of the agency as it provides child welfare services. The Michigan laws most relevant to this review are the Child Protection Law (MCL 722.238), the Foster Care and Adoption Services Act (MCL 722.203), and the Child Care Organization Licensing Act (MCL 722.116). As in most states, the Michigan statutes set forth general policies, but also contain some fairly specific provisions. As is the case with most state child welfare agencies, MDHS has created operational procedures or manuals to more specifically regulate the day-to-day provision of child welfare services.

It is important, especially given MDHS's management deficiencies, that these procedures provide staff with very specific guidance. It is well documented that the child welfare work force is neither well experienced nor well trained. It is estimated that, nationally, the annual turnover rate for child welfare workers is between 30% and 40% and that the average tenure is less than two years.¹¹ In their depositions, MDHS managers often complained about losing direct service staff. For example, Oakland County MDHS had a turnover rate of 90% for its CPS workers in 2006. (Warner Deposition, p. 117) Most states have difficulty finding a sufficient number of caseworkers who have social work degrees or front-line supervisors who have advanced degrees.¹² Social work education is invaluable to child welfare staff at all levels because it supplies the basic building blocks necessary to do good work. However, social work schools rarely offer specialization – or even many classes – in providing child welfare services. A reasonable response to these workforce problems is the use of highly prescriptive operational procedures – procedures that tell the case worker what to do. The MDHS procedures that are most pertinent to this review are the Children's Protective Services Manual and the Children's Foster Care Manual.

Child Protective Services Regulation

The procedures directing MDHS's CPS investigations lack definition, prescription, and rigor, and are often confusing. As a result, children who are wards of MDHS are certain to be placed in – or left in – dangerous foster care settings because MDHS has failed to accurately identify abusive and neglectful substitute care providers.

The operation of its Child Protective Services (CPS) system has important relevance to MDHS's ability to protect children in foster care. As is mentioned above, every child welfare agency receives reports alleging that children in substitute care are maltreated. Some of these allegations are true and others are not. It is important that child welfare agencies have the capacity to conduct thorough investigations. Only by having this ability

¹¹ United States General Accounting Office (2003). *GAO-03-357 Child Welfare: HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*. Washington, D. C.

¹² Child Welfare League of America (1999) *Minimum Education Required by State Child Welfare Agencies*, Arlington Virginia.

can agencies hope to 1) protect foster children who have been abused or neglected (almost always by removing them from the abusive or neglectful foster home), 2) spare foster children who have *not* been maltreated the unnecessary trauma associated with their unnecessary replacement, and 3) identify abusive and neglectful foster parents so that other children will not be placed into dangerous homes. CWLA standards require that allegations of child maltreatment in foster care be investigated immediately and thoroughly.¹³

The Child Protection Law (MCL 722.238, 722.627, 722.628(d)) is unusually nondirective. In addition to broadly defining the various forms of child abuse and neglect, it establishes the evidentiary standard for substantiating child protection investigations at “a preponderance of the evidence.” Although the preponderance standard is used in many states, it is the highest level of evidence normally required for child welfare abuse/neglect investigations. This is important because comparatively high standards of evidence can weaken the safety net that child protection systems are intended to afford children. The law requires that MDHS commence an investigation within 24 hours of its receipt of a report but does not define “commence.” It is almost entirely silent about the investigative process. The law spells out a set of quite detailed – and somewhat unusual – potential investigative determinations. The results of CPS investigations fall into five categories:

- Category I and II include investigations that meet the preponderance standard and either involve a court petition or are determined to be intensive or high risk according to a risk assessment made using a structured decision making instrument. The names of perpetrators in Category I and II investigation are placed on the Central Registry.
- Category III includes cases in which a preponderance of the evidence is found and that are determined to be moderate to low risk according to the structured decision making assessment. The names of perpetrators in Category III cases are *not* placed on the Central Registry unless they are licensed child care providers or employees of licensed child care providers.
- Categories IV and V include cases in which a preponderance of the evidence is not found and the names of perpetrators are not placed on the Central Registry.

(MCL 722.628(d)) Michigan’s Child Protection Law provides only very general definition and direction to Michigan’s CPS process.

The capacity of child welfare agencies to conduct thorough and competent investigations depends on definitive, prescriptive, clear operational procedures. MDHS’s attempt at more detailed procedures for CPS investigations is the Children’s Protective Service Manual.

¹³ Child Welfare League of America (1999) *Standards of Excellence for Abused and Neglected Children and Their Families*, Washington D.C., §6.13.

MDHS’s operational definitions of child abuse and neglect are vague and subjective. They make misclassification of child maltreatment certain and allow foster children to be placed or left in dangerous foster homes.

One of the keys to an effective child protection system is the use of clear and specific operational definitions of child abuse and neglect. COA standards require that child welfare agencies use standardized and specific decision- making criteria to define what is screened in for CPS investigation.¹⁴

The definitions of child abuse and neglect provided by the Children’s Protective Services Manual are taken *verbatim* from Michigan’s Child Protection Law. While they may serve as legal definitions, they are wholly inadequate for use in the field. Without very specific operational definitions, the individual beliefs and biases of caseworkers will inevitably determine how individual cases are classified. For example, the definition of child abuse is:

... harm or threatened harm to a child's health or welfare that occurs through non-accidental physical or mental injury, sexual abuse, sexual exploitation, or maltreatment ... (CFP 711-4 p. 1)

And, according to the CPS Manual:

”Child neglect” means harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person responsible for the child's health or welfare that occurs through either of the following:

- (i) Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care.
- (ii) Placing a child at an unreasonable risk to the child's health or welfare by failure of the parent, legal guardian, or other person responsible for the child's health or welfare to intervene to eliminate that risk when that person is able to do so and has, or should have, knowledge of the risk.

(CFP 711-4 p. 2) These definitions are vague and, in the case of the definition of neglect, confusing. Words like “harm,” “welfare,” “unreasonable risk,” and “adequate” are imprecise and open to interpretation. The results of such imprecision will inevitably be that some children who have not been maltreated will be found to be abused or neglected and that MDHS will fail to identify and protect some children who have been abused and neglected.

¹⁴ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standards*, New York, §PA-CPS 4.04.

Three-year-old James was brutally murdered in his MDHS foster home. The medical examiner found the cause of his death to be blunt force trauma to the head and that the manner of his death was homicide. The only people who had access to James at the time he was fatally abused were members of his foster family. The facts notwithstanding, MDHS investigation found that there was *not* a preponderance of the evidence to show that he was abused.

CWLA standards¹⁵ (and common sense) require that investigations be thorough and comprehensive.

MDHS’s Requirements for investigative activities are unreasonably lax, permit superficial and ineffective investigations, and are sure to allow foster children to be left in or placed in dangerous settings.

The investigative activities required by the Children’s Protective Services Manual (713 – 1) are incredibly sparse. In addition to in-person contact with the alleged victim, the required activities are: contact with the reporting person, the family (no definition of “family” is given), the alleged perpetrator, “and other informational sources, as needed” (CFP 713-1 p.1) If the allegation is abuse and if a physician examined or treated the child, the physician must be contacted. The place where the maltreatment occurred and any objects that were used must be observed. (CFP 713-1 p. 7 (Item 18)) This describes an extremely superficial investigation. Even so, the MDHS supervisor is authorized to waive many of the contacts that are required. If the investigator decides that there is no basis in fact to support the allegations he or she may “abbreviate” the investigation. In an abbreviated investigation,

“A field contact is required. This *may* (reviewer’s emphasis) include interviews with the alleged victim and/or caretaker. Any abuse allegations require a face-to-face contact with the alleged victim.”

(CFP 713-1 p.3) One wonders how the investigator would determine that an allegation had no basis in fact without conducting an investigation.

Furthermore, the Children’s Protective Services Manual includes no direction about what information should be sought from interviews, no guidance about how to assess credibility and no information about weighing evidence. The Children’s Protective Services Manual does not tell the MDHS investigator how to conduct a CPS investigation.

MDHS supplements the information contained in the Children’s Protective Services Manual in its CPS Field Guide. Suggestions for practice – some useful

¹⁵ Child Welfare League of America (1999) *Standards of Excellence for Abused and Neglected Children and Their Families* Washington D.C., §1.14.

and some very questionable – are contained in the CPS Field Guide. It does not, however, provide the direction and regulation that should be found in the Children’s Protective Services Manual.

Two-year-old Isaac was placed in a foster home that had been the subject of *nine* CPS complaints before his placement there. Five of the complaints were investigated so poorly that it is impossible to know whether the abuse or neglect occurred or not. Two of them were unsubstantiated but, given the information available, should have been substantiated. One of them *was* substantiated. Isaac was placed in the home anyway. Less than two months after this placement, Isaac was found beaten to death. He was covered with burns and bruises, and had multiple bone fractures.

Foster Care Regulation

That competent provision of foster care services (including kinship care, congregate care, and other types of placement resources selected for children in state substitute care) is central to child welfare agencies’ ability to keep their wards safe is obvious. Foster care workers are (or should be) the foster child’s first line of defense against danger in the foster home. Because foster care workers have (or should have) frequent contact with the children for whom they are responsible, they are in the position to identify that a child has, or may have, been abused or neglected. Just as important, foster care workers play a major role in the selection of the homes for particular children. When unlicensed relative care – the placement MDHS selects for thousands of its wards – is the choice, foster care workers make the selection unilaterally. Finally, foster care workers are the main source of support for substitute care providers as they carry out their difficult task of caring for children who have been abused or neglected. For the same reason that explicit procedural guidance is important for CPS workers, foster care workers need clear, prescriptive procedural guidance.

Although the statutory regulation of foster care is contained in several laws, the Foster Care and Adoption Services Act (MCL 722.951 – 722.960) is the source of the most relevant regulation. As with the Michigan Child Protection Law, the Foster Care and Adoption Services Act sets forth very broad requirements. (MCL 722.621 – 722.638) Among its more specific provisions is the requirement the foster care workers have in-person contact with all foster children at least once a month and that they make monthly visits to foster homes. It is also specific in its requirement that MDHS or the private Child Placing Agency develop a “medical passport” to document each child’s medical information consistently through the life of the child’s case.

The MDHS Children’s Foster Care Manual contains the operational rules intended to direct foster care services at the case level. The job of a foster care worker is, by its nature, a less structured activity than that of a CPS investigator. For this reason, it is more difficult to develop highly prescriptive procedures.

For the most part, the direction provided by the MDHS procedures for foster care is reasonable. However, several of the agency’s foster care regulations are dangerous.

It is not surprising that when children enter foster care, they are often in poor health. Frequently, they have not received regular pediatric care. It is important for their health and safety, and for the health and safety of other children and adults living in the foster home, that they receive at least medical screening as they come into care.

MDHS’s requirement for initial health screening is not adequate to keep foster children safe from medical problems.

The Children’s Foster Care Manual requires that children receive a medical examination within 30 days of placement. This means that a contagious or dangerous medical condition may not be detected for a month after a child enters foster care. This is dangerous, poor practice, and contrary to the COA standard for public child welfare agencies, which requires that the child, “receives an initial health screening from a qualified medical practitioner within 72 hours of entry into care to identify the need for immediate medical or mental health care, and assess for infectious and communicable diseases.”¹⁶ Best practice is to obtain a medical screening *before* the child is placed in foster care.

Three-year-old Emma, whose brother was murdered in foster care, received no medical attention until two months after she entered MDHS foster care. This examination was a cursory check up. Some months later she was diagnosed as having the Hepatitis B virus. Hepatitis B is a dangerous condition which is most often sexually transmitted. In part because Emma had been in two foster homes before being diagnosed, it was never determined where or how she contracted the disease.

The care of foster children is demanding. For obvious reasons, they often have behavioral, emotional, physical, or other problems requiring exceptional attention from their caregivers. It is important, therefore, that reasonable limits be placed on the number of children (including foster children and the foster parents’ own children) in foster homes.

MDHS rules allow foster homes to be overcrowded with children. This deprives foster children of the supervision and attention that they need, and is dangerous.

MDHS Licensing Rules for Foster Family Homes allow *eight* children, including the children of the foster parents, to be placed in a foster home at one time. (R400.9401) This is far too many. CWLA standards¹⁷ require that the total number of children in a foster

¹⁶ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standards*, New York, §PA-FC 2.04.

¹⁷ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §2.33.

home, including the children of the foster parents, be limited to four. COA standards¹⁸ limit the number to five children, with no more than two under two years of age. COA standards further require that there be no more two children in a home if the children have therapeutic needs.

The foster home in which MDHS placed seven-week-old Brandon included five children in addition to Brandon, three of whom had serious behavioral and mental health problems requiring psychotropic medication. Shortly after his placement, Brandon died in the home, apparently suffocating while his foster mother left him unattended.

Placement of Foster Children with Unlicensed Relatives

Thousands of foster children placed in the care of their relatives by MDHS are treated as “second classes citizens” as compared to those placed in licensed foster homes. Children placed with unlicensed relatives receive even less protection than children placed in licensed foster homes.

Of the approximately 19,000 children who MDHS has taken into its custody, more than 7,000 are placed in the homes of relatives. Almost none of these relative homes are licensed. (Mehren Deposition, p. 90) According to point in time statistics, on 9-28-06, 6,747 children were placed in relative care statewide. More than 90% of these relative homes were unlicensed. (Frank Deposition Exhibit 238 – MIDHS00187385). From deposition testimony it is clear that the number of children placed in relative care has increased while the proportion of the relative homes that are licensed has not.

Michigan has made a conscious decision to increase the proportion of its foster children that it places with relatives. Michigan law (MCL 722.954a) and the MDHS Children’s Foster Care Manual (CFF 722-3) both require that, within 30 days of a child’s removal, MDHS (or the private Child Placing Agency assigned by MDHS) identify, locate, and consult with relatives to explore the possibility of placement in their homes. MDHS Director Marianne Udow testified in her deposition that the increased number of relative placements is an improvement in the child welfare system. (Udow Deposition, p. 48) Many other MDHS administrators spoke of relative placement as being a positive change in the agency’s direction.

In general, placing children who are unsafe with their parents in the care of extended family members *is* a good thing. According to the CWLA,

“Based on the needs of the child, kinship care should be the first option assessed when child must be separated from his or her parents. Kinship

¹⁸ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §PA-FC 6.05.

care brings the benefits of safety, nurturance, and stability within the child's extended kin network."¹⁹

However CWLA standards further require that there be no difference between the service design and delivery for children placed with relatives and those placed in licensed foster homes.²⁰ Although placement with relatives tends to reduce the trauma children suffer when they are separated from their parents and from their familiar surrounding, it does not eliminate separation trauma. There is no difference between the emotional, psychological, and physical scars carried by children placed with relatives and those placed in foster homes. Furthermore, not every relative home is a safe nurturing place for foster children. It is important, therefore, that foster children be placed with relatives in whose homes they will be protected and where their emotional needs will be met. COA requires that the agency, "identifies stable, nurturing kinship homes and places children with kin who can meet their need for a safe, healthy home."²¹ Overall, children placed with relatives should receive the same levels of protection, attention, services and support from the child welfare agency that children in licensed foster care receive.

CWLA standards require that potential relative caregivers be assessed with a focus on the child's safety and protection.²²

MDHS rules permit the placement of foster children with relatives who MDHS knows to be dangerous.

MDHS rules allow children to be placed in the homes of unlicensed relatives whose names have been entered on the Central Registry because MDHS has found that they have abused or neglected children *and has assessed the risk to the children as being high*. Having one's name on the Central Registry would disqualify the relative from being granted a foster care license. (Children's Foster Care Manual CFF 722-3 pp. 5, 14) MDHS rules allow children to be placed in the homes of unlicensed relatives convicted of criminal offenses (e.g., drug-related offenses and physical assault and battery) that would preclude the relatives from becoming licensed as foster parents. (Children's Foster Care Manual CFF 722-3 and MCL 722.115 (16))

MDHS places children in its care with relatives about whom little or nothing is known.

¹⁹ Child Welfare League of America (2000) *Standards of Excellence for Kinship Care Services*, Washington D.C., §1.4.

²⁰ *Ibid.*, §1.5.

²¹ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standards*, New York, §PA-KC6.

²² Child Welfare League of America (2000) *Standards of Excellence for Kinship Care Services*, Washington D.C., §2.11.

MDHS requires that, when children are placed in relative care, a “Relative/Unrelated Caregiver/Guardianship Home Study Outline” be completed. The content of this home study is very similar to the content of the home study completed as part of the process for foster care licensing. However, the foster care licensing process must be completed before any children are placed in the foster home. This is not true in the case of relative placements. When children have a need for emergency placement, as is most often the case in CPS situations, it is impractical and unreasonable to complete a full home study prior to placement. However, it is important to the safety of the children being placed that obvious risks be identified very quickly.

MDHS rules allow for criminal and Central Registry checks completed within 24 hours of placement or the next business day. (Children’s Protective Services Manual CFP 715-2) This makes it possible that a child could be placed in the home of a violent criminal or a sexual predator for as long as five days before the danger is detected. MDHS allows 30 days for the completion of its relative home study. (Children’s Protective Services Manual CFP 715-2) There is no good reason why the criminal background and Central Registry checks should not be completed before placement. There is nothing in the “Relative/Unrelated Caregiver/Guardianship Home Study Outline” that could not be completed in one day. COA standards require that criminal background and child abuse registry checks be conducted for all adults in the home *prior* to placement, and that home studies be conducted prior to placement, or as soon as possible, when the child is living with the caregiver.²³ CWLA standards call for the initial assessment of relative caregivers to be completed before or immediately upon placement.²⁴

Michigan’s system for classification of substantiated child abuse and neglect complaints permits placement with relatives that MDHS has identified as being abusive or neglectful. The names of perpetrators of Category III child abuse and neglect (complaints for which a preponderance of the evidence is found, but for which the MDHS risk assessment is moderate or low) are not placed on the Central Registry. This means that the required Central Registry check will not identify them. This permits placement of children with dangerous caretakers.

MDHS fails to provide even marginally adequate financial support for its wards placed in unlicensed relative foster care.

When MDHS places children in licensed foster homes, the foster parents receive foster care payments to be used to feed, clothe, and otherwise care for the foster children. Depending on the age of the child, foster care payments are between approximately \$400 and \$500 per month for each child. MDHS provides *no* foster care payment for its children placed in unlicensed relative care. (Children’s Foster Care Manual CFF 903-3,

²³ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standards*, New York, §§PA-KC 6.04, 6.02.

²⁴ Child Welfare League of America (2000) *Standards of Excellence for Kinship Care Services*, Washington D.C., §2.11.

p.1) The only assistance available to unlicensed relatives is \$157 per month if they are poor enough to be eligible for TANF. (Hennessey Deposition, p.139) Children placed in unlicensed relative homes are not even eligible for the clothing allowance received by children in licensed foster care. (Hennessey Deposition, p. 177 - 178) This lack of financial support is related to safety because caring for children is both expensive and stressful. The financial strain caused by the added expense only increases the emotional strain placed on relative caregivers and adds to the possibility of child maltreatment in relative homes. In a report Director Udow submitted to Michigan's governor and legislature in the summer of 2005, MDHS's own Child Fatality Review Team reported that the rate of child abuse/neglect fatalities in Michigan was higher for children living below 185% percent of the poverty line.²⁵

CWLA standards require that child welfare agencies "implement policies and procedures that establish a uniform level of financial support for all children in the legal custody of the public agency."²⁶

Children who are in MDHS's custody and are placed with unlicensed relatives lack even the inadequate safeguards the agency provides children in licensed foster homes.

Foster homes licensed by MDHS are subject to a set of 35 licensing rules regulating such things as the number of children who may be placed in the home, the physical condition of the home, the mental health of members of the relative family, the nutritional quality of food provided to the foster child, and the manner of discipline used in the home. When one of these rules is allegedly violated, MDHS conducts an investigation and, if it is determined that there has been a rule violation, either the foster care license is revoked or a corrective action plan is developed for the foster home. As will be discussed in the section on oversight below, there are some serious problems with this process. Flawed though it may be, however, it is better than no process. The licensing rules are not applicable to unlicensed relative caregivers. Even where there is an allegation that an unlicensed relative caregiver has acted in a way that would violate licensing rules (if they were to apply), there is no formal investigation and no corrective action plan. (Nye Deposition, pp. 563 - 564)

Licensed foster homes are subject to annual licensing renewal studies – essentially a repeat of the original licensing study. Re-licensing studies are important because they can detect maladaptive developments in foster homes. MDHS does not appear to require any repeat of the "Relative/Unrelated Caregiver/Guardianship Home Study Outline" required initially. This almost complete lack of oversight deprives MDHS wards placed with their unlicensed relatives of even the flimsy safety net provided to children in licensed foster care.

²⁵ Michigan Child Death State Advisory Team 5th Annual Report, Executive Summary (Summer, 2005) *Child Deaths in Michigan*, Lansing, p.14.

²⁶ Child Welfare League of America (2000) *Standards of Excellence for Kinship Care Services*, Washington D.C., §3.2.

MDHS could license the homes of the relatives into which it places its children. Doing so would have three important benefits. First, by licensing the relative homes the standards – including standards related to safety – would be raised. Second, by licensing its relative caregivers, MDHS would be in a better position to give financial support to its wards. If relative homes were licensed, MDHS would qualify for federal Title IV-E funding, which would pay for a portion of its foster care costs. Third, by licensing its relative homes, MDHS would provide an additional layer of protection, albeit a thin layer, to the children in its care.

In depositions, MDHS administrators gave lip service to their desire to license relative homes. In her deposition, recently departed MDHS Director Marianne Udow testified that increasing the proportion of Michigan relative foster parents who are licensed was one of her goals. She acknowledged that this proportion has not increased. She cited several reasons for this failure including MDHS’s lack of staff and,

“I think to some degree DHS workers on the front line, some of them did not feel that relatives should be licensed, and I think they didn’t carry through on a policy to encourage licensure...” (Udow Deposition, p. 125)

At a level much closer to the ground, Berrien County Director Jerry Frank testified that licensing relative foster parents was not a priority in the field because MDHS had insufficient staff. (Frank Deposition, p. 214) Macomb County Director Angelo Nicholas explained that he lacks the staff to license even non-relative foster homes, and certainly does not have the resources to license relative providers. (Nicholas Deposition, p. 193) In her deposition Margaret Warner, the Director of Oakland County, flatly stated that, in the large county she administers, relative foster parents can only be licensed to the exclusion of non-related foster parents because she lacks the staff to do both. (Warner Deposition, p. 207 -208)

Whatever the reasons, MDHS’s failure to license its thousands of relative foster parents is dangerous to its foster children and in violation of CWLA standards that require licensure.²⁷

14-year-old Heather was placed in the unlicensed home of her aunt and uncle. MDHS was well aware of her serious psychiatric problems, including suicidal ideation, before her placement. MSHD obtained *no* mental health services for Heather. Instead, she was placed in a filthy, chaotic home where for months, 17 people crowded into a three-bedroom, one-bathroom house. Eventually Heather ran away to South Carolina and hung herself.

²⁷ *Ibid.*, §2.35.

Oversight of Case Practice and Agency Performance

A necessary component of any effective child welfare agency is the ability of its management to know what's going on. This ability involves two interrelated components: 1) continuous quality assurance – essentially case review, and 2) the availability and use of reliable and relevant administrative data about child welfare processes and outcomes. It also depends on a management culture that encourages self-assessment and managers that value and understand how to use data. CWLA standards require that child welfare agencies “incorporate an accountability system and a quality improvement process into the organization’s management system to monitor outcomes and to measure progress.”²⁸ In the absence of accountable quality improvement, child welfare administrators are unable to evaluate the efforts of their agency to keep foster children safe. They have no way to know if the policies important to child safety are effective or if they are being followed by front-line staff. They lack needed information about the adequacy and distribution of their resources. Systematic quality assurance is especially important in large, geographically dispersed agencies such as MDHS. MDHS’s systems for oversight are entirely inadequate.

The MDHS managers resemble blindfolded school bus drivers. They have no way to know about impending danger confronting their vulnerable passengers.

Quality Assurance through Case Review

Continuous quality assurance involves the regular review of the work of the agency: its cases. The principal purposes of case review are to evaluate whether caseworkers are adhering to the agency’s regulations and to assess the quality of casework practice. COA standards call for quarterly case reviews of very substantial samples of cases.²⁹ When reviews identify shortcomings, corrective action plans must be developed, implemented, and monitored. COA standards require that the agency’s leadership regularly communicates with staff about on-going quality improvement efforts.³⁰ Follow-up reviews should be conducted to determine whether improvement has been realized. Case review must be continuous rather than episodic. None of this happens in MDHS.

MDHS has no systematic program of case-based quality assurance by which it can assess its child welfare processes or outcomes.

MDHS has no quality assurance unit for child welfare. (Udow Deposition p. 69, Mehren Deposition, p. 199, and Yager Deposition, p. 18) For a short time in 2005, there was a quality assurance team consisting of only four staff members. This team conducted case

²⁸ Child Welfare League of America (1996) *Standards of Excellence for The Management and Governance of Child Welfare Organization*, Washington D.C., §2.65.

²⁹ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standards*, New York, §PA-PQI 4.03.)

³⁰ *Ibid.*, §PA-PQI 5.01.

reviews that were narrowly focused on the federal Child and Family Services Review standards. This was ended and has not been replaced. (Nye Deposition, p. 451, Mehren Deposition, p. 199) Even if it had not been dismantled, it is impossible for four people to carry out a meaningful program of quality assurance case review for an agency the size of MDHS. There are three units within MDHS that review cases to assess aspects of the agency's child welfare effort but, taken as whole, they do not constitute anything like meaningful quality assurance.

Since becoming the director of Oakland County in May 2003, Margaret Warner testified that the *only* quality assurance review of her large and troubled county (Oakland County is currently operating on its second provisional license) has been an ad hoc review conducted to assess the county's status with regard to the national standards measured by the federal Child and Family Review. (Warner Deposition, p. 109) Even more disturbing than the lack of review is MDHS management's response to the review that was conducted. Although Oakland County failed to meet any of the seven national standards – including the standards for keeping children safe – Oakland County management did nothing other than write a corrective action plan *which is not being followed*. (Warner Deposition, pp. 112 – 113)

Foster Care and Adoption Monitoring

Foster Care and Adoption Monitoring (FCAM) is responsible for monitoring the policy and contractual compliance of private Child Placement Agencies and Child Caring Institutions. It conducts quality assurance reviews (QARs) of the approximately 85 private Child Placing Agencies every 18 to 36 months. (Buchanan 9-7-07 Deposition, p. 18) QARs include reviews of a random sample of cases, interviews with foster parents and agency staff, and observations of the Child Placing Agencies' offices. The samples reviewed are not scientifically determined, nor are they statistically significant. (Buchanan 10-15-07 Deposition, p. 172) Policy and contract noncompliance is found in 99.9% of the reviews of foster care agencies and Child Caring Institutions. In response to noncompliance, FCAM institutes quality improvement plans for the private agencies to implement.

The point of quality assurance is to identify problems so that they can be corrected – so that children can be kept safe. The quality improvement plans are not monitored by FCAM in any systematic way. Generally, FCAM learns whether a plan was followed at its next review as much as three years later. (Buchanan 9-7-07 Deposition, pp. 18, 70) FCAM relies on the POS workers in the counties to oversee the private agencies, but *it never sends them the quality improvement plans*. (Buchanan 9-7-07 Deposition, p. 71) The information gathered in the QARs is never aggregated so that pervasive systemic problems can be identified. (Buchanan 10-15-07 Deposition, p. 61 - 63) One of the most obvious potential uses of quality assurance information concerning private agencies is in making contract decisions. As recently as October 2007, the contracts for all of Michigan's private Child Placing Agencies came up for renewal. Every one of the pre-existing contracts was renewed for three years without any consideration of the results of their QARs or their performance in implementing their quality improvement plans.

(Buchanan 10-15-07 Deposition, pp. 105 and 106) MDHS does not make much use of what little quality assurance information is gathered in its review of private Child Placing Agencies.

The Bureau of Child and Adult Licensing

The Bureau of Child and Adult Licensing (BCAL) performs what is probably the closest thing to quality assurance MDHS has. BCAL conducts annual licensing inspections of all public and private Child Placing Agencies and Child Caring Institutions in the state. This includes inspection and licensing of the MDHS county offices. BCAL inspections focus entirely on licensing rules, an approach that gives structure to the inspections but focuses them narrowly on compliance rather than on the quality of practice. BCAL inspections are concerned with whether or not an activity occurred and in a timely way (important considerations, to be sure) rather than with the quality with which the activity was carried out (also an important consideration). BCAL inspections do not systematically consider caseload size – perhaps the most important factor in a child welfare agency’s ability to protect the children in its care. (Gale 6-26-07 Deposition, p. 117) As with FCAM, the BCAL sample sizes are not scientifically derived, are not statistically significant, and are *very* small. (Gale 6-26-07 Deposition, p. 80) For example, in the 2007 inspection of Macomb County MDHS, of 155 children in foster care only eight files were reviewed. (Gale 6-26-07 Deposition Exhibit 27) and in the 2007 inspection of Wayne County North Central MDHS, only 12 cases of the 244 children in foster care were reviewed. (Gale 6-26-07 Deposition Exhibit 23) COA standards require the annual review of 74 cases for a foster care program the size of MDHS’s Macomb County office and 115 for one the size of Wayne North Central.³¹

When rule violations are identified, BCAL can require corrective action plans or, when the rule violations are very serious, it can issue a provisional license. Public or private Child Placing Agencies and Child Caring Institutions can only operate on a provisional license for a period of two years. If after two years of provisional licensure, a private agency fails to come into compliance with the licensing rules, BCAL has the authority to suspend its license. If a public Child Placing Agency (a MDHS office) does not come into compliance, it loses the ability to use state funds for foster care. As of this writing, at least six of the largest MDHS offices (Wayne South Central, Wayne West, Wayne Central, Macomb, Midland, and Oakland) are operating on provisional licenses.³²

While BCAL oversight is conducted routinely, is highly structured, and has real authority, its value is diminished by the extremely small review samples and from BCAL’s narrow focus on compliance. In addition, there are examples of agencies who have been allowed to continue operating after the expiration of a provisional license. For example, the Jackson County DHS Office’s provisional license expired on 2-1-07 and the renewal inspection was not completed until more than three months later. (Gale 6-26-07 Deposition, p. 109 and Exhibit 33) More importantly, BCAL does not review the

³¹ *Ibid.*, §PA-PQI 4.03.

³² MDHS Website http://www.dleg.state.mi.us/brs_cwl/sr_cwl.asp.

handling of any case involving the thousands of children placed with unlicensed relatives. Since this population comprises nearly half of all of MDHS's foster children, BCAL oversight is hardly comprehensive.

Office of the Family Advocate: Steve Yager is the Director of the Office of the Family Advocate. He testified that his office does not perform quality assurance. As far as he is aware, no MDHS unit is responsible for child welfare quality assurance. It is his belief that MDHS needs a regular quality assurance program. (Yager Deposition, pp. 17 – 19) The Office of the Family Advocate reviews cases that are identified as “problem cases.” Since this is (hopefully) not a representative sample, it does not give an accurate picture of overall agency functioning. (Yager Deposition, p. 24) When problems are identified in the course of his reviews, the Office of the Family Advocate develops a corrective action plan for the respective county office. The corrective action plan may or may not be in writing. The Office of the Family Advocate does not, however, follow up to see that the plan is being followed. (Yager Deposition, pp. 59 - 60)

In addition to case reviews, child welfare administrators must use administrative data as a roadmap giving them information about where they are and where they need to go.

Quality Assurance Using Administrative Data

In addition to case reviewing activities, it is necessary that child welfare agencies use administrative data for quality assurance. There are two types of data necessary to the management of a child welfare agency: 1) outcome data are measurements concerning the agency's achievement of its goals (e.g., the percentage of children abused or neglected by foster parents is an obviously important outcome related to safety), and 2) process or performance data are statistics about the process of the agency relies upon to achieve its goals (e.g., the frequency of caseworker visits to children in foster care and caseload size are very important process measures of an agency's ability to protect the children in its care). For administrative data to be useful, it must be aggregated at different levels (e.g., statewide, by region, by county, by supervisor group, and by individual caseworker). Most importantly, it must be accurate.

To meet CWLA standards, child welfare agencies must maintain statistical information that enables the agency to evaluate its services and that is useful to its staff.³³ COA standards require that valid, reliable data is obtained and used on a regular basis, locally and centrally, to monitor child welfare processes and outcomes.³⁴

MDHS has a shocking inability to produce useful and reliable statistical information about its child safety processes and outcomes. A result of this inability is that MDHS

³³ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §§4.28-29.

³⁴ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standards*, New York, §PA-PQI 4.0.

submits information that it knows, or should know, is inaccurate to the federal government. Worse, much of MDHS's administrative data is misleading and has the effect of hiding the danger to which it subjects its foster children, reducing its ability to protect them.

MDHS produces almost no process data that is useful to its managers' attempt to keep children in MDHS care safe. The two most important pieces of information for this purpose are the number of visits caseworkers make to see the children in their caseloads and, because caseworkers need time to make visits, the number of cases assigned to each caseworker. For either of these reports to have much utility, information about exceptions must be available. That is, real time reports identifying the children that have not been visited within the month and reports listing the individual caseworkers who carry excessive caseloads must be available to managers at all levels. MDHS produces neither. (Hennessey Deposition, p. 39)

MDHS is not able to produce aggregate information about its (or its private agencies') caseworkers' compliance with the regulation that caseworkers visit foster children once per month. (Udow Deposition, p. 84 – 85) If a caseworker could only do one thing to protect children in care, it would be to see them regularly. This inability to know anything about overall caseworker contact with foster children deprives managers of the ability to have any control over the most basic child protection process.

MDHS cannot produce any data showing the caseloads of its workers beyond average caseloads. (Hennessey Deposition, p. 111 - 112) In order get information about the number of cases that MDHS caseworkers were carrying, on 10-4-06 Jim Nye, the Director of Field Operations, was forced to send a memo to the County Directors directing them to compile lists identifying the number of cases carried by each MDHS caseworker in the state. This had to be done manually because, as Mr. Nye wrote in the memo, "We attempted to get this information electronically, but we were unable to do so." (MIDHS00238871) Again, this is one of the most basic pieces of information necessary to running a child welfare agency. Caseworkers who cannot visit the children in their caseloads or perform their other responsibilities because they are overloaded cannot assure that the children in their caseloads are safe.

With regard to outcome data related to the safety of children in MDHS care, the agency produces statistics purporting to show the frequency of incidents of abuse and neglect in foster care. The federal government requires that states report this information as part of the Child and Family Services Review. According to MDHS reports, MDHS has consistently been in compliance with the national standard that less than 0.57% of children in the state's custody be found to have been abused or neglected in any year.

MDHS's data in this area is suspicious at best. First, it is MDHS who determines whether foster children have been abused or neglected. Given the flawed investigative procedures described above and the examples of incompetent investigations reviewed in Part 2, it is certain that many maltreated foster children are never identified. Second, there are serious statistical questions about how MDHS calculates its maltreatment in care rate. The math

should be straight-forward. Simply divide the total number of foster children into the number of children who have been abused or neglected in their foster homes. On the PS830 – a report MDHS uses to track its status with regard to the federal standards – the MDHS calculation is described as “Total victims with FC Perps in CPS / Total Open and Closed FC Cases.” (MIDHS00222756) The problem is that, while MDHS includes the children placed in unlicensed homes in the denominator, according to Jim Hennessey, the head of the unit that produces the report, MDHS does *not* include children abused or neglected in the homes of unlicensed relatives in the numerator. (Hennessey Deposition p. 146) Since children placed in unlicensed relative care represent roughly half of the children in the custody of MDHS, the abuse/neglect in care rate MDHS reports is an undercount by about half. Instead of the 0.42% reported on the PS830 dated 5-1-07, (MIDHS00222745) the rate is approximately 0.84%. This takes Michigan from meeting the national standard to holding outlier status among states where foster children are unsafe.

Suspicion about MDHS data is heightened in relation to child protection data MDHS is required to report to the Michigan legislature annually. For fiscal year 2005, MDHS reported that, of a statewide total of 21,840 specific incidents of child abuse and neglect, only *four* were committed by institutional staff and only *48* involved foster parents. (Nye Deposition Exhibit 124) While one might wish that this information were true, it is totally unrealistic. Apparently not receiving or not trusting MDHS data, Margaret Warner, the Oakland County Director, indicated that, as a manager in the field, she does not receive or trust MDHS data. Specifically, she testified that in order to know the number of children abused or neglected in foster care, “hand reporting” would be necessary. She has not, however, conducted any such manual count. (Warner Deposition, p. 52) Speaking about the MDHS system for producing child protection data (the PSMIS system), she testified that she cannot rely on data from PSMIS because “It’s flawed, it’s been flawed for a number of years.” (Warner Deposition, p. 133)

In a letter dated 8-30-04 concerning children who have died as the result of abuse or neglect in MDHS foster care, Steve Yager, the head of MDHS’s Office of the Family Advocate, complained that MDHS did not have any centralized mechanism to ensure consistent and accurate reporting of child deaths due to child maltreatment. He expressed concern that this could result in inaccurate federal reporting and would hamper MDHS’s efforts to prevent the abuse/neglect deaths of children in foster care. (Yager Deposition, pp. 111- 113) MDHS has failed to effectively correct this problem in the more than three years since.

Michigan is one of only two states that failed to report child abuse/neglect fatalities to the federal government to be included in the Administration for Children and Families’ child maltreatment report, “Child Fatalities 2005.” (Nye Deposition Exhibit 73) Mary Mehren, the head of MDHS’s unit responsible for reporting child protection data to the federal government, attributed this to an old data system that is not reliable. She testified that the process for obtaining statistics about child fatalities is not automated and that MDHS has “essentially eighty-three county systems that operated without roll-up capacity.” (Mehren Deposition, pp. 195 – 196)

MDHS Staffing

Given the disturbing deficiencies in MDHS's organizational structure and culture, the dangerous inadequacies of some of its most important rules and regulations, its abdication of responsibility for the safety of the children it places with relatives, and its almost complete lack of meaningful oversight, it is impossible to imagine that the agency has any hope of assuring the safety of its foster children.

The fact that MDHS does not have *nearly* enough foster care caseworkers to do its job is a problem that, *by itself*, renders MDHS incapable of protecting the children in its care.

COA standards require that foster care caseloads not exceed 18 children, or 8 children having special needs.³⁵ CWLA standards limit foster care caseloads to between 12 and 15 children per caseworker.³⁶ The dangers of excessive caseloads to foster children are obvious. When caseworkers carry too many cases, they simply don't have time to visit the children in their caseloads, work with their foster parents, arrange for necessary services, or perform their other protective functions.

MDHS has established two caseload standards for its foster care workers. For public agency foster care workers, the budget target is 20 children per caseload. Inexplicably, the target for private agency caseworkers is 30, which is also the licensing cap. (Nye Deposition, p. 458 and Buchanan Deposition pp. 35 and 44) Generally, the hope of MDHS management appears to be to stay within 30 cases. These caseload *targets* are more than twice the size of the CWLA standard.

Although MDHS is not capable of producing administrative data to show the number of MDHS or private agency caseworkers whose caseloads exceed 30 children, it is widely acknowledged that there are many. (Nye Deposition, p. 721) Reviewing the manual case counts produced by the county offices in response to Field Operations director Jim Nye's 10-4-06 memo requesting them as a result of the *Dwayne .B v. Granholm* lawsuit, it is clear that many MDHS workers are carrying caseloads in the 30s and even in the 40s. Not surprisingly, this is especially true in the more troubled urban counties. (MIDHS00238873 – 956)

When asked her opinion of the consequences of MDHS's inadequate staffing for the children in its care, former Director Marianne Udow stated,

“My opinion is that we were placing children at risk...we I believed did not have adequate staff to do the necessary oversight and to be responsive to the needs of the children. I was concerned that with the caseloads that

³⁵ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standards*, New York, §PA-FC-19.06.

³⁶ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §3.48.

we had, that the staff would not have enough time to do thorough investigations, to spend enough time with the children themselves, for example, to do the monthly visits ...”

(Udow Deposition, pp. 24 – 25) James Hennessey, head MDHS’s children’s policy unit, testified that MDHS foster care workers cannot comply with agency policy and procedure because of their high caseloads. (Hennessey Deposition, p. 162) Macomb County Director Angelo Nicholas testified that it was unreasonable to expect his county to meet federal standards, including those for the safety of foster children, because of caseload size. (Nicholas Deposition, p. 98) Margaret Warner, the Oakland County Director, testified that her county’s inability to meet its foster care goals – in large part due to high caseloads – threatens the safety of foster children. (Warner Deposition, p. 65 and 72)

It is simply not possible for foster care workers to undertake the activities necessary to the safety of the children in their caseloads when they are carrying 30 cases or more.

Conclusion

Given the deficiencies in its child welfare system, it is not surprising that MDHS has trouble keeping safe the children it is meant to protect. It is a huge agency in which child welfare seems an afterthought. Its leadership consists of people who are, without a doubt, well-intentioned. Nevertheless, they lack sufficient time to devote to the child welfare portion of their agency. Even if they had the time, in too many instances they lack the experiential and knowledge base required to successfully administer a large child welfare agency. Compounding these things, or maybe as a result of them, too many MDHS administrators appear to distance themselves from the real work of the agency, preferring to focus their attention on “larger issues.”

These problems alone would make it impossible for a child welfare agency to assure the safety of the children in its care. In MDHS, these fundamental problems are exacerbated by some dangerous practices. The MDHS process for investigating child abuse and neglect is seriously flawed. The way that abuse and neglect are defined and the superficial investigations permitted by MDHS’s CPS procedures assure that abused children will not receive protection. The cavalier manner in which MDHS places children with relatives is dangerous and is compounded by the agency’s failure to provide these families with necessary support.

MDHS may, to an extent, be oblivious to the extent of its problems and failures. Because of its abysmal effort at quality assurance, the agency doesn’t know much about itself. The patchwork case reviews conducted by MDHS rely on laughably small samples and focus unevenly on the children who need the agency’s protection. When reviews yield disturbing results, MDHS seems to do nothing. The administrative data necessary to guide the operation of the agency at every level either doesn’t exist or, if it exists, can’t be trusted.

Even without this litany of problems, no child welfare agency that is as severely understaffed as MDHS can hope to keep the children in its care safe. Frequent visits from caseworkers are foster children's best protection against abuse or neglect in substitute care. Caseloads the size of many of MDHS's caseworkers make frequent visits impossible and leave too many children vulnerable to abusive or neglectful caregivers.

These troubling findings are based on a review of MDHS regulations and on statements made by administrators in key positions. One way to test them is to examine the cases of some of the children who have died while in the care of MDHS in the recent past. Part 2 of the review is a study of the cases of five such children.

PART 2

A CHILD FATALITY REVIEW:

The Capacity of the Michigan Department of Human Services to Protect the Children Placed In Its Care

As part of my review of Michigan Department of Human Services' (MDHS) ability to keep the children in its care safe, attorneys for the plaintiffs in the federal litigation *Dwayne B. vs. Granholm, et al.* have retained me to evaluate the cases of five children who died while they were in MDHS foster care. This request is, in part, in response to the information that, since 2004, 78 children have died while in the agency's custody.

This number is not, in and of itself, alarming. The sad fact is that children die while in foster care in every state. Many children bring problems making them disproportionately vulnerable with them as they enter foster care. Children entering foster care are often medically vulnerable. Many children in foster care have behavioral problems, making them vulnerable to street violence. Some children in foster care die as the result of unforeseeable accidents, as do some number of children placed with their biological families. The problem in Michigan, as has been discussed in Part 1, is that MDHS data is so incomplete and unreliable that it is impossible to gain any insight as to the circumstances of the deaths of these children other than by reviewing their individual cases.

The cases selected for this review were not randomly selected, nor do they represent a statistically significant sample. They were chosen to exemplify issues identified in my management review. These issues include: MDHS's inadequate CPS investigation process, its careless use of unlicensed relative placements, its generally inadequate oversight (especially of unlicensed relatives and of cases assigned to its private Child Placing Agencies), and its high caseloads. Nevertheless, the cases reviewed suffice to confirm my troubling conclusions.

Some children, placed in the care of MDHS for their protection, die because MDHS's deeply flawed systems and processes fail to protect them from harm.

The process of the child fatality review was straight forward; the case files supplied by the defendants were reviewed and compared with MDHS regulations and with basic standards of child welfare practice. The material for each child was voluminous, totaling 9,692 pages. I have reviewed thousands of child welfare files from public agencies in many states. I have *never* seen so much paper and so little information. MDHS's practice of using structured decision making and service planning forms to document every aspect of their foster care services provision made it extremely difficult for me, and no doubt for MDHS supervisors, to figure out what happened. This difficulty was exacerbated by the fact that most of the file material was in complete disarray.

After summarizing each of the five case histories, the MDHS response – including the response of any assigned private Child Placing Agencies for which MDHS is responsible – is compared with Michigan regulation and with standards of child welfare practice. This analysis highlights only the instances of poor practice related to the safety of children in MDHS care and only the most serious breaches among those. Although many issues were noted, I do not attempt to analyze the cases from the perspective of the permanency or well-being of the children involved.

James B.

Family History

James was born in July 2003 in Detroit. James was the youngest of his mother's eight children, who among them have several different fathers. On 1-31-06, James and his siblings entered state custody because it was discovered that James's father had been sexually abusing James's then 15-year-old half-sister. DNA evidence revealed that James's father was the father of at least one of James's sister's children.

Foster Care History

James and his siblings were separated and placed in five different foster homes when they came into care. James was placed in a foster home operated by Ennis Children's Center (ECC), a private Child Placing Agency. James's first placement was the foster home of Ms. R-B in Detroit. Ms. R-B was a single parent who had three biological children.

At the time of placement, Ms. R-B had a documented history of child maltreatment with MDHS. On 1-19-05 – just one year before James's placement in the home – MDHS received a report alleging that Ms. R-B had abused her then 10-year-old daughter. The MDHS investigation revealed that Ms. R-B beat her daughter with a belt, injuring her eye (MIDHS00134383). It is difficult to assess the seriousness of this incident because the investigator failed to document any effort to view the child's injuries (such an effort may have been futile because it took the investigator more than a week to contact the child victim and her injuries would most likely have faded) and because the investigator made no effort to gather information from collateral contacts outside the family. Other than family members, the only collateral contact was with Ms. R-B's MDHS licensing worker. The licensing worker told the investigator that "they were going to talk to Ms. R-B about the seriousness of the situation." Because both the mother and the child acknowledged the incident, the investigation concluded that there was a preponderance of the evidence of child abuse. The incident was classified as Category III – Low/Moderate Risk. MDHS was to open a case on this licensed foster parent and provide her with training about parenting and disciplinary techniques. These services were to be provided by ECC. (MIDHS00134381 - 383)

According to a screen print from Michigan's SWSS data system (MIDHS00135780) MDHS appears to have received one other CPS complaint about Ms. R-B (on 2-17-05)

before James was placed in the home and one while he was in the home (on 10-04-06). There is no further documentation of either referral in the case files.

During James's placement in the R-B home, his ECC caseworker visited the foster home once each month. Documentation about these visits is sparse. The only issues noted were difficulty getting James into day care, concern that his front teeth did not appear to be coming in, and the more concerning issue that James would often cry for no apparent reason. It is impossible to get any sense of the quality of care or nurturing James received in the home. There was, however, cause for concern in addition to the foster mother's history of child maltreatment. After a three-month separation from his mother and siblings, the first family visit occurred on 5-2-06. From this point on, family visits took place each week. Ms. R-B was often late in bringing James to the visits and was a no-show for at least one visit (8-28-06). On 10-9-06, Ms. R-B dropped James off and left him unattended – apparently in the ECC office waiting area. James's family complained that his foster mother had dressed him without underwear for the visit. (MIDHS00135006)

On 8-19-06 at 6:30 PM, Ms. R-B contacted the ECC on call worker to report that James had suffered a head injury requiring 12 stitches, "9 outside and 3 inside." (MIDHS00135759-761) According to Ms. R-B, the previous day James had fallen from a chair while playing. The foster mother took James to an Urgent Care medical facility for treatment. There is no evidence that ECC staff considered the possibility that this injury was non-accidental. Other than notifying the MDHS worker and the child's attorney, the only follow-up occurred when James's mother noticed his injury at the family visit on 8-21-06, prompting the ECC worker to ask James what happened. The worker documented that James said he fell out of a chair. There was no contact with the medical provider other than to resolve billing issues. There is no evidence that anyone questioned the foster mother about the incident in any detail or asked her why she waited until Saturday evening to call about an incident that happened on Friday.

On 11-26-06, MDHS received a report from a physician alleging that a four-year-old girl placed in Ms. R-B's home had been severely abused. The victim in that incident was reported to have suffered bruising to her eye, ear, and both arms, a conjunctive eye hemorrhage, and a facial abrasion. She also had healing bruises on her lower back. The foster mother's explanation that the injuries were self-inflicted is ridiculous on its face and was found to be inconsistent by the physicians involved in making the report. (MIDHS00135769-771 and MIDHS00135783)

Because of the allegations of severe child abuse in James's foster home, ECC moved him to the foster home of LK and CW in Belleville, Michigan, a suburban community about 30 miles from Detroit. The K-Ws had two children of their own: a girl, 15, and a boy, 10. Ms. W was licensed by MDHS to provide day care from her home. The K-Ws had only been licensed by ECC as foster parents on 11-6-06 and it appears that James was their first foster child.

There is no documentation of significant incidents during the first few months of James's placement in the K-Ws' home. The ECC worker continued to document, however, that James's unprovoked crying persisted. There is no evidence that any effort was ever made to explore or address this issue. This is important because crying children are often the precipitant for serious child abuse. Foster parents – especially new foster parents – need the agency's support in handling children exhibiting such problematic behavior.

In January 2007, the ECC worker prepared a court report (MIDHS00134102 - 110) for a hearing held on 1-29-07. According to that report James's mother had visited him on a weekly basis, completed parenting classes, completed sexual abuse therapy, and continued in weekly psychotherapy. According to the court report, the only barrier to James's return was housing. The report refers to a service review prepared by James's mother's therapist. (MIDHS00134111 - 113) This report verifies that James's mother had completed all of the requirements set for her by ECC/MDHS and describes her as having made "great improvements in all area of her life." It also notes that "she has gained affordable and safe housing for herself and children." The ECC court report describes the potential harm to James if returned to his mother generically as being the "likely harm of being exposed again to the neglect and abuse ... "Since there is no evidence that James had ever been abused or neglected by his mother, and based on her documented progress, it is not clear why James was not returned home after one year in care – possibly before his placement in the Ks' home.

On 1-29-07, evidently following the court hearing, a case conference involving the ECC worker, James's mother, and the MDHS worker is documented. (MIDHS00134099) James was also present and was seen by the MDHS worker. It is notable that this cursory review is the only substantial involvement the MDHS worker had in James's case until his murder.

On Monday 3-26-07, James's foster mother called an ECC office stating that she could not reach James's ECC worker and that she did not know how to reach the agency in an emergency. She was calling because James had suffered a burn to his hand the previous Friday and, when the burn appeared more extensive the following day, she took him to Urgent Care for treatment. She said that she believed that James burned his hand getting himself water at night (MIDHS00134369). A worker from ECC reported this to DHS as an allegation of child maltreatment.

After unsuccessfully attempting several phone calls, the MDHS investigator went to the K-W home on 3-27-07. She observed the home and interviewed the foster mother. The foster mother said that she first noticed a blister on James's hand in the evening on 3-24-07. She said that James told her that he burned himself when he got up on a stool to get himself some water in the middle of the night. When she noticed that the burn had worsened the following day, she took him for medical care. The investigator did not interview James because he was asleep. On 3-30-07, the investigator returned to the foster home and interviewed James, who told her that he burned his hand in the kitchen sink. The other members of the K family were interviewed and all reported that James said that he burned himself getting water from the sink.

There is no evidence that anyone questioned the likelihood that a 3 ½-year-old child would suffer a second degree burn and not cry or complain, that no one would notice the burn for a day, or that James would hold his hand under the water long enough to sustain a second degree burn. The investigator never spoke with the physician who treated the burn or any physician knowledgeable about burns to verify the plausibility of the explanation. The only medical information obtained is a written statement from Urgent Care verifying that James was treated there. The disposition of the investigation was that there was not a preponderance of the evidence that James had been abused or neglected. (MIDHS00135444 - 452)

Before this investigation was completed, James was dead. On 4-9-07, MDHS received a report that James had been airlifted to the University of Michigan Hospital where he was found to have severe head injuries. On 4-13-07, James was declared dead. The medical examiner found the cause of his death to be blunt force trauma to the head and the manner of death was homicide. Incredibly, MDHS's investigation found that there was not a preponderance of the evidence that James's death was the result of child abuse.

MDHS's investigation into James's death is seriously flawed. Although 79 investigative contacts are listed on the investigation summary, several necessary investigative steps were omitted. Most notably, although there were three contacts with physicians from the University of Michigan Hospital on 4-9-07, there were no meaningful investigative contacts after the day he was admitted. A clerical worker at the hospital telefaxed the medical summary to MDHS on 9-17-07. (MIDHS00134309 – 313) According to the report James had suffered bilateral subdural hematomas accompanied by bilateral retinal hemorrhaging. They also discovered evidence of previous trauma to his leg. Any competent investigation would have included questioning the physicians in order to narrow the time frame in which the injury could have occurred and to gain the best possible understanding of probable and improbable mechanisms by which James could have been injured.

There was no contact with the Medical Examiner who conducted James's autopsy. There is not even a copy of the autopsy report, possibly because MDHS closed its investigation before the report was prepared. Again, information from the autopsy is a necessary part of any child death investigation and would have shed light on when and how James was killed.

There was little collaboration with the police, who were also investigating James's death. The MDHS investigator made no attempt to contact the investigating detective until 4-11-07, two days into the MDHS investigation. Although the MDHS investigator sent information from her investigation to the detective, there is no documentation that the detective was asked to reciprocate. Comparing statements given by subjects of investigations is an important way of detecting inconsistencies in their accounts. More generally, in serious physical abuse investigations, CPS and law enforcement typically conduct joint investigations. This assures good coordination of effort and maximizes the resources and information available for the investigative effort.

Despite these serious deficiencies, the information available was certainly sufficient to support a finding that it is more likely than not that James's death was the result of child abuse. The medical examiner found the death a homicide. The doctors who treated James at the University of Michigan Hospital concluded that his death was "most likely child abuse." Lengthy interviews conducted by the MDHS investigator with members of the K family clearly establish that James was in their care without interruption for a week prior to his injury. To suggest that James did not die as the result of maltreatment at the hands of the foster family (with whom he was placed for his protection) is ludicrous.

In addition to its CPS investigation, MDHS's BCAL conducted a Special Investigation of ECC's handling of James's case in response to his death. (MIDHS00135823 - 840) This review is focused on ECC's compliance with licensing rules. BCAL cited ECC for two rule violations related to its casework: 1) ECC violated the licensing rule related to service planning when it failed to address James unprovoked crying and 2) it violated licensing rules when it failed to notify MDHS licensing or conduct a special evaluation in response to the head injury James suffered on 8-19-06 in the R-B foster home. OCAL also cited ECC because when it licensed the Ks as foster parents, it failed to ask family members about any history of domestic violence or about its methods of disciplining its children.

On 4-13-07, BCAL issued an order of summary suspension and notice of intention to revoke the K-Ws' foster care and daycare license, ostensibly because of these violations and not because of the murder of a foster child in their home.

Analysis

Among the most serious of MDHS's failures to protect James are the facts that:

Neither James nor other children should ever have been placed in the R-B foster home because Ms. R-B had been substantiated for abusing her daughter about one year before James's placement in the home. Ms. R-B proved to be very dangerous to children in her care when she was found to have severely abused an 11-year-old foster child. This failure violates:

- MDHS licensing rules (Child Placing Agency Letter #2002-03) that require that no foster care license will be issued to a home in which an adult member of the household is listed on the Central Registry, and if a member of the household of an existing licensee is listed on the Central Registry, the license must be revoked.
- CWLA foster care standards requiring that foster care licenses be denied to substantiated perpetrators of child abuse and neglect.³⁷

³⁷ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §3.3.

- Basic standards of child welfare practice.

ECC and MDHS should have investigated the serious head injury James suffered in the R-B home. This failure violates:

- The Michigan Child Protection Law (MCL 722.623) which requires a report to MDHS when a child welfare worker has reasonable cause to suspect that a child has been abused. Given Ms. R-B's history and the seriousness of the injury, a CPS complaint should have been made.

ECC and MDHS continuously ignored James's persistent and unprovoked crying. His foster parents should have received help understanding and responding to this well known precipitant of serious child abuse. This failure violates:

- MDHS rules (R 400.12418) that require that the service plan for each child in foster care includes a behavior management plan specific to the child's needs.
- CWLA foster care standards that require continuous assessment of each foster child's needs related to any emotional or behavioral condition that may need services and which require that the foster care worker and the foster parent work as a team to identify and arrange necessary services for the child.³⁸
- COA standards that require that foster parents have access to services to prevent and reduce stress.³⁹

MDHS failed to provide meaningful oversight of the private Child Placing Agency it hired to handle James's case. This failure violates:

- MDHS rules (Children's Foster Care Manual 914) that require that MDHS POS workers receive and review service plans when they are due and meet with the private Child Placing Agency to discuss the case.
- CWLA foster care standards that require that the public agency be responsible for assuring quality foster care services.⁴⁰

MDHS should have assertively and thoroughly investigated the complaint about the burn to James's hand reported two weeks before he was killed. Burns to young

³⁸ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §§2.14, 2.54.

³⁹ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York. §PA-FC 16.09.

⁴⁰ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §4.9.

children have the potential to suggest grave danger and require an urgent response. MDHS's response was lackadaisical at best. By failing to quickly and thoroughly investigate this complaint, MDHS may well have missed its opportunity to save James's life.

And

MDHS's investigation into James's murder was woefully inadequate. Its conclusion that there was not a preponderance of the evidence that his death resulted from child abuse is entirely inconsistent with the facts and is ridiculous. In addition to common sense, these failures violate:

- CWLA standards for CPS investigations which require that CPS complaints involving foster children be investigated immediately and thoroughly.⁴¹
- COA standards that require timely and comprehensive investigations and assessment and immediate action to protect children whose safety is threatened.⁴²
- MDHS rules (CPS Manual CFP 713-9) that require that CPS investigations must be substantiated when the preponderance standard is met.

Conclusion

MDHS and its contractor, ECC, failed to protect James. They knew, or should have known, that the first foster home in which they placed him was dangerous. They failed to act when there was strong indication of danger in the second foster home. Because of the extremely poor quality of the investigation of the suspicious burn James received just before his murder, it is impossible to know whether MDHS might have concluded that the second foster home was as dangerous as it proved to be. It is not possible, therefore, to conclude that MDHS caused James's death. It did, however, miss the chance to rescue him.

Isaac L.

Family History

Isaac L. was born in Wisconsin in August 2003. At the time of his birth, his parents were also caring for Isaac's one-year-old sister. Isaac's parents had an extensive history with MDHS, as well as with human services and child protective services agencies in Ohio, Wisconsin, and Canada. This history involved the abuse and neglect of Isaac's seven

⁴¹ Child Welfare League of America (1999) *Standards of Excellence for Abused or Neglected Children and Their Families*, Washington D.C., §6.13.

⁴² Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §§PA-CPS 5.0, 5.05, 5.06.

older siblings. One of Isaac's sisters died, apparently from congenital physical problems exacerbated by parental neglect. Parental rights were terminated for Isaac's surviving six older brothers and sisters.

Before entering MDHS foster care, Isaac was a subject of at least one Michigan CPS report. On 8-14-05 the police reported that they were called to his biological home in Westland, Michigan, in response to a domestic violence situation. The police reported that the family had a long history of domestic violence, Isaac's mother had mental health problems, the home was filthy with old human feces on the floor, and there was very little food in the home. The MDHS investigator unsuccessfully attempted to visit the family on 8-15-05 and again on 8-17-05. MDHS made no other effort to investigate the situation until 9-19-05 when the police went to the home again. They found Isaac and his sister living in conditions that were filthy to the degree that they threatened the children's safety. The police took Isaac and his sister into protective custody and turned them over to Wayne County MDHS. (MIDHS00291260 – 297)

Foster Care History

Casework Services

Isaac was in MDHS foster care for 11 months. During this time MDHS contracted with Lula Belle Stewart Center (LBSC), a private Child Caring Agency licensed by MDHS, for full foster care and casework services for Isaac and his sister. (MIDHS00073807)

The LBSC caseworker initially assigned as Isaac and his sister's caseworker maintained responsibility for the case throughout LBSC's involvement. Each of the four foster care caseworkers employed by LBSC had caseloads exceeding the 30 children permitted by contract. Isaac's caseworker was assigned 37 children at the time of Isaac's murder and had been assigned as many as 46 for extended periods. (MIDS00074215) A caseload of this size precludes the most capable caseworker from assuring the safety of children in foster care.

Among the most important things child welfare agencies can do to assure the safety of the children in their foster care is to visit them frequently in the homes in which they are placed. Because of inconsistencies in Isaac's record, it is difficult to determine when the LBSC worker visited Isaac in his foster homes. Foster care visits are documented in two places in the case records: service plans include a list of contacts and LBSC "Home Visit Contact Logs" are used to document visits. The dates listed on the service plan documents are substantially different from those on the contact sheets:

Service Plans

10-14-05 (MIDHS00073621)
10-28-05 (MIDHS00073562)
11-14-05 (MIDHS00073562)
12-23-05 (MIDHS00073562)

Home Visit Contact Logs

10-14-05 (MIDHS00074117)
11-14-05 (MIDHS00074118)
1-20-06 (MIDHS00073967)
4-14-06 (MIDHS00073973)

1-20-06 (MIDHS00073535)
2-17-06 (MIDHS00073535)
4-28-06 (MIDHS00073517)
5-19-06 (MIDHS00073517)

5-30-06 (MIDHS00074106)
7-6-06 (MIDHS00074101)

It is most likely that the “Home Visit Contact Logs” are more accurate because they include some narrative description of the visits and because they are signed by the foster mothers. Even assuming that the documentation is not *completely* inaccurate, the frequency of the LBSC worker’s visits to Isaac in his foster homes did not meet Michigan’s procedural requirement that foster children be visited by their caseworker on a monthly basis. (CFF 722-6, p. 3) There is no documentation that Isaac was visited in March or in June of 2006. Documentation of visits occurring during December 2005 and February 2006 are suspicious because there are no “Home Visit Contact Logs” documenting them.

Isaac’s foster mothers began reporting that Isaac and his sister exhibited troubling behavior almost immediately after their placement. At the LBSC worker’s first visit to Isaac on 10-14-05 – nearly a month after his placement – the foster mother (Ms. B) reported that Isaac was self-abusive, and physically aggressive, and that his speech was delayed. (MIDHS00074117 - 118 and MIDHS00074122) On 11-4-05, Ms. B called the LBSC worker to complain that Isaac’s sister persistently undressed herself and Isaac and kissed Isaac on the mouth, and that the children cried and whined all the time. During the LBSC worker’s visit documented on 11-14-05 (MIDHS00074120) these concerns were reiterated and Ms. B complained that Isaac’s sister refused to use the bathroom and used the floor instead.

At the LBSC worker’s 4-14-04 visit to the foster home of Ms. K, the worker documented “a lot of bruise marks on their (Isaac and his sister’s) legs.” (MIDHS00073973) At the 5-30-06 visit, the LBSC worker noted that, “Isaac sleeps with Ms. K in the same bed. The foster parent bed is on the floor.” (MIDHS00074106) On 7-6-06, while visiting the children in the foster home of Ms. R, the LBSC worker noted that the children bite each other, neither child is toilet trained, and that Isaac is self-abusive. (MIDHS00074101) He also documented that “worker noted several abuse marks/old marks on the children lower leg.” (MIDHS00074099)

The issues noted in the Home Visit Contact Logs are also noted in the Initial and Updated Service Plans, which were reviewed and approved by the MDHS worker. (MIDHS00073518) The only service needs identified for Isaac are related to his developmental issues. The only service Isaac received aside from basic physical maintenance was enrollment in an early intervention program through the Detroit Public Schools. There is no documentation that anyone from MDHS or LBSC ever had any contact with the Detroit schools about Isaac’s progress in this area. Isaac’s aggressive behavior, purported self-abusiveness and continual crying were never assessed, much less treated. None of Isaac’s three foster mothers ever received any substantial help from LBSC or MDHS in managing these very difficult children.

DHS regulations require that an Initial Service Plan be completed within 30 days of a child's entry into state substitute care, and that Updated Service Plans be completed every 90 days thereafter until the child leaves care. (CFF 722-8) The Initial Service Plan for Isaac and his family was due, therefore, on 10-19-06. It was completed more than three months late, on 1-27-06, and was approved by the MDHS purchase of service worker on 2-3-06. (MIDHS00073625) The first Updated Service Plan was due 1-19-06 and was completed on 6-29-06, over five months late. The MDHS worker approved it on 7-3-06. The second Updated Service Plan was due on 4-19-06. It was completed on 7-19-06 and approved by the MDHS worker on 7-19-06. (MIDHS00073546 - 547) An incomplete version of the Updated Service Plan due 7-19-06 was completed on 8-18-06, two days after Isaac's death. (MIDHS00073523) This is especially problematic because service plans are MDHS's principal mechanism for documenting its foster care cases. More important, service plans are the mechanism by which MDHS monitors cases handled by private Child Placing Agencies like LBSC.

Placements

Isaac and his sister were placed in the Detroit foster home of Ms. B on the day that they were removed from their parents' custody. They remained in this foster home for less than three months. Aside from the problems Ms. B encountered in caring for the children noted above, there is very little information about their stay in her home. On 11-4-05 Ms. B requested their removal because she was moving out of state. (MIDHS00074125 - 126)

On 12-5-05, LBSC moved Isaac and his sister to the foster home of Ms. K. Before Isaac's placement in her home, Ms. K had been the subject of a number of troubling CPS complaints. These include two referrals on 8-15-96 about which no information is available. (MIDHS00290975)

On 3-5-98, MDHS received a report from a school that Ms. K's 13-year-old developmentally delayed (and obviously seriously psychologically disturbed) foster daughter had come to school with deep cuts on both wrists. According to the child, her imaginary friends cut her. According to Ms. K, the child cut herself with school scissors. During the investigation, Ms. K lied about taking the child for medical attention. Ms. K did not inform the foster care agency of the incident because she said she did not consider it to be important. MDHS found the complaint to be unsubstantiated even though Ms. K failed to get any medical attention for the cuts, which the school nurse described as infected and needing stitches, and even though the cause of the child's injuries had not been plausibly explained. (MIDHS00290995-1010) No documentation was found to indicate that the child ever received any medical or psychological attention related to the incident.

On 5-17-99, MDHS received a report from a school administrator that Ms. K threw boiling water at one of her adopted children and that she had pulled a knife on the children. (MIDHS00290989) After mistakenly conducting another superficial investigation of the older allegations reported on 3-5-98 (and not of those reported 5-17-99), the MDHS investigator found the recent referral (initiated by the 5-17-99

allegations) to be unsubstantiated. She expressed concern, however, that Ms. K received more than \$3,000 per month for the children, that the house was dirty, and that Ms. K was not cooperative with the investigation. (MIDHS00290975)

On 3-22-05, a school counselor reported to MDHS that Ms. K and her seven adopted children, ages 11 to 19, were living in a home that had no gas or electricity and that she sent the children to school in dirty clothes. The investigation revealed that the utilities were shut off because Ms. K had not been able to pay her utility bills, which exceeded \$7,000. Her house was in foreclosure and she had filed for bankruptcy. The children were staying with relatives. Ms. K suffered from diabetes, high blood pressure, and congestive heart failure. The school principal reported that Ms. K was too sick to supervise the children, that there is no structure in the home, and that Ms. K was "in over her head." One child is described as being behaviorally disordered and another is schizophrenic. Some of the children abused alcohol and marijuana and the police had been called to the home several times because of fights between the children. (MIDHS00290974 - 978)

This investigation was substantiated by MDHS and the case was opened for intensive family preservation services and counseling for some of the children. Intensive family preservation services are provided to families where child maltreatment is so serious that, without them, the children would be placed in foster care. The K family received intensive family preservation services until 5-27-05. (MIDHS00291027)

Despite the facts that MDHS had substantiated that Ms. K was neglectful of her own children, that the neglect was so serious that intensive services were deemed necessary to preserve her family, and that her severe medical, financial, and other problems prevented her from providing adequate care to the seven children already in her care, LBSC entrusted Ms. K with the care of Isaac and his sister on 12-5-05.

On 1-23-06, shortly after Isaac and his sister were placed in the home of Ms. K, MDHS received its fifth child abuse/neglect complaint involving the K home. Specific information about this referral was not found in the file but it is documented that it involved sexual abuse. The complaint was rejected at intake, (MIDHS00290957) meaning that the MDHS worker who received the report decided that the allegation did not meet the agency's standard for investigation. (CFP 712-7)

On 5-26-06, the LBSC worker reported that Isaac's three-year-old sister had been diagnosed with Hepatitis B. (MIDHS00290959) Hepatitis B is a dangerous disease that is most often sexually transmitted. MDHS investigated this as possible sexual abuse. "On or about 5-25-06," the MDHS investigator visited the K foster home, where Isaac and his sister were found sleeping on a dirty mattress on the floor. Ms. K said that Isaac's sister contracted Hepatitis B in her birth family home. Four days later, "on or about 5-30-06," the LBSC worker told the MDHS investigator that Hepatitis B tests for the K family had been returned negative. "On or about 6-8-06," the MDHS investigator documents receiving a fax from the LBSC worker confirming that Isaac's sister had tested positive for Hepatitis B, that "the whole family was ordered to complete a Hepatitis B Serology," and that one of Ms. K's adopted sons had been tested and was negative.

(MIDHS00290957) There is no documentation that the MDHS investigator ever 1) spoke with the physician to ask about potential sources of the Hepatitis B, 2) identified which, if any, of the K household members other than Isaac, his sister, and Ms. K's 12-year-old adopted son was ever actually tested for Hepatitis B, 3) interviewed Isaac, his sister or more than two of Ms. K's adoptive children, or 4) did any investigation extending beyond the K foster home. The report was unsubstantiated. (MIDHS00290958)

On 6-16-06, MDHS received the seventh abuse/neglect report. This report was made by a neighbor who credibly stated that Ms. K had called her crying saying that Ms. K's 12-year-old adoptive son had been caught molesting Isaac's sister. (MIDHS00290943) During this investigation, Ms. K lied about the identity of her adopted children and denied making the call to her neighbor. When interviewed in a group on 6-20-06 "using forensic interviewing protocol," the children denied knowing about Isaac's sister being sexually abused. The investigator then threatened the children with arrest if it was determined that the abuse had occurred. At the investigator's instruction, Ms. K took Isaac's sister to the pediatrician for a forensic medical examination on 6-22-06. The doctor who examined Isaac's sister reported that her hymen was not intact but that it did not appear that she had suffered sexual trauma in the preceding two weeks. (MIDHS00290940 and MIDHS00291069) MDHS substantiated this referral because, although it was unclear who abused Isaac's sister, it was clear that she had been molested. (MIDHS00290957)

Also during this investigation, the MDHS investigator's supervisor noticed that Ms. K had been previously substantiated for child maltreatment (3-22-05) and should not be providing foster care. For this reason, and because of the many very troubled children in Ms. K's care, her serious medical problems, and the overall poor quality of care received by the children, Isaac and his sister were removed from the K home on 6-29-06. (MIDHS002909940)

Isaac's final foster care placement was in the LBSC home of Ms. R. Prior to Isaac's and his sister's placement in the home on 6-29-06, Ms. R had been the subject of *nine* child maltreatment reports. The first of these allegations was reported on 10-2-99. MDHS received a report from doctors at a local hospital that Ms. R's 15-year-old foster daughter had been left to care for her (the foster child's) one-year-old daughter and Ms. R's five-year-old foster daughter. The 15-year-old foster child's infant daughter had a medical emergency and, because Ms. R had left no phone number where she could be contacted, the 15-year-old had no way to get her to the hospital. She contacted an adult friend who took her and her baby to the hospital, along with the five-year-old foster child. When the three children couldn't get back into Ms. R's house on their return to the home, they went to stay with the fifteen-year-old's cousins.

During the investigation, the 15-year-old also reported that one of Ms. R's adult children was smoking marijuana in the home during Ms. R's absence, and that Ms. R had been drinking before she went out. The MDHS investigator did not attempt to make face to face contact with any subject of the investigation until three days after the report, saw Ms. R and one of her four foster children four days after the report, saw the fifteen-year-

old six days after the report, saw a third foster child ten days after the report, and never saw the 15-year-old's infant daughter. This report was unsubstantiated due to the 15-year-old foster child's age and maturity. (MIDHS00250473 - 481)

On 6-28-02, MDHS received an anonymous report that the foster children in Ms. R's home are dirty, poorly supervised, exposed to constant violence between Ms. R's adult children which has resulted in calls to the police, and that Ms. R never seems to be home. (MIDHS00250461) MDHS's investigation of this referral consisted entirely of an interview of Ms. R and three foster children. (MIDHS00250452 - 453) According to Ms. R and her 14-year-old foster daughter, there had been a violent altercation between Ms. R's adult son and his girlfriend while Ms. R was out of the home. The incident involved a knife and the girlfriend's threatening to kill Ms. R's son, T, by running him over with a car (which was started for that purpose). Ms. R told the MDHS investigator that she had called the police. The police were never contacted to verify this or to determine whether there had been other similar incidents. According to the Central Registry File Clearance (run date: 7-8-02), three other foster children (ages 3, 8, and 13) were placed in the home at the time. (MIDHS00250468) They were never interviewed. The MDHS investigator did not have access to the information from the 10-2-99 investigation because the file could not be located. Ms. R promised to obtain a protective order against her son's girlfriend and MDHS found the referral to be unsubstantiated. (MIDHS00290453)

On 10-17-02, MDHS received a report alleging that Ms. R fails to supervise her foster children, the children fight constantly and one was stabbed with a pencil. The resulting wound was infected and the child had not received medical attention. (MIDHS00073733) The only previous investigation noted in this investigation concerns the 6-28-02 incident. At the time of this investigation, Ms R. was caring for seven foster children ages 2, 5, 5, 8, 8, 12, and 14. (MIDHS00250439) The investigator discussed the allegations with Ms. R over the phone the day before she went to the home to interview the children. Ms. R told the investigator that the children did not really fight and that the five-year-old had injured herself. When she did interview the children, they confirmed that they fought and, in fact, actually did so in front of the investigator. It is not documented exactly which of the foster children were interviewed during the investigation. Although their accounts were somewhat different, both of the five-year-old girls involved in the incident confirmed that the pencil wound was the result of a fight. The wounded hand is described by the investigator as being blue and swollen. Ms. R said that she would take the child to the doctor in the next day or two. There is no documentation that anyone made any effort to assure that the child received any medical care. This report was unsubstantiated. (MIDHS00250441 – 442)

On 12-20-02, at 10:20 AM MDHS received a referral alleging that Ms. R's adult son T (the same son who was involved in the violent altercation described in the 6-28-02 investigation) lived in the home and that he was on parole. The previous night there was an incident involving Ms. R trying to run T over with a car. Apparently, the assigned MDHS worker identified the situation as an emergency and, at 9:30 PM, requested that a 24-hour investigator visit the family. Because the MDHS after-hours-team lacked sufficient staff to respond to all emergencies, no visit was made to the home until more

than 48 hours later, about 2:00 PM on 12-22-02. At that visit, Ms. R denied that her son lived in her home and said that she had not tried to run him over with a car but, rather, T's ex-girlfriend had done so. There is no documentation that the children were seen or that any effort was made to assess their safety.

No other significant investigation occurred until 1-8-03 when the investigator went Ms. R's home. During this visit, Ms. R denied that T lived in the home, *confirmed* that he was on probation for domestic violence, and reiterated that it was T's girlfriend who had attempted to run T down and that the incident had occurred before Christmas. The following day, the MDHS investigator interviewed the five foster children who were in Ms. R's care at the time at their respective schools. All denied that they were present at the time of the incident with the car. The investigator made no effort to verify T's legal status or confirm Ms. R's version of the incident with the police, who were involved according to Ms. R. In addition, the investigator never verified T's residence. Other than informing the LBSC licensing worker, the investigator made no collateral contacts outside the foster family. The investigator documented not being aware of any previous complaint involving the R home, even though one was noted in the initial referral and the LBSC provided information about one. This referral was unsubstantiated. (MIDHS00250431 – 434)

On 1-17-03, MDHS received a referral after Ms. R's 5-year-old foster daughter appeared at the LBSC office for a family visit with old and new scratches on her face. According to the child she was scratched in a fight with another of Ms. R's foster children when there was no adult in the home. The following afternoon, a 24-hour investigator interviewed the child, who said that an 8-year-old foster child had pinched her. Ms. R said that the children were not alone at the time of the incident and that she was present in the house. She denied that her 19-year-old son, T, lived in her home and *denied* that he was on probation. (MIDHS00250926 – 927) Several days later, the MDHS investigator went to the R home where Ms. R said that T *was* on probation. Although the initial referral notes that there had been several previous complaints about Ms. R, the MDHS investigator only documents the 12-20-02 report in the Previous Complaint Summary of this investigation. The referral was unsubstantiated. (MIDHS00250436 – 437)

On 8-12-03, MDHS received two anonymous reports concerning the R home. According to the first, Ms. R's son T lived in the home with several friends, the children were beaten, Ms. R cursed the children, she was often out of the home, and there was continual fighting. (MIDHS00250390) According to the second, there were ten or eleven people living in the three-bedroom foster home, T was living in the home, and the children were out of control, playing outside late at night. (MIDHS00250417) At the time of this report, Ms. R was caring for four foster daughters, ages 9, 11, 13, and 15. In the Previous Complaint Summary for this investigation, the MDHS investigator noted "no previous history." (MIDHS00250398) The investigation of these reports consisted entirely of an interview with Ms. R, interviews with the four foster children, and an interview with one of Ms. R's sons (not T) who happened to be at the house when the MDHS investigator was there. The home was described as being "impeccably clean." (MIDHS00250398 – 399 and MIDHS00250407 - 408) No collateral contacts are documented. There is no

documentation that either the caseworker or the licensing worker from LBSC were contacted or notified of the allegation.

On 6-9-04, MDHS received a report alleging that the home is crowded, there is fighting and violence requiring police response, and that Ms. R's 10-year-old foster daughter wanders far from the home, is unsupervised, and appears confused. (MIDHS00073715) Two days later, the MDHS investigator made an unsuccessful home visit. Four days after that, the investigator interviewed Ms. R and the four foster children in her home. They all denied the allegations. No documentation of any collateral investigative contact or notification of any staff at LBSC was found in the record. The Previous Complaint Summary indicated that "there was no previous CPS complaints reported or found." The allegation was unsubstantiated on 2-17-05, eight months after the report. (MIDHS00250530 - 532)

On 5-12-05, MDHS received a report from a school alleging that that Ms. R slapped, pinched and pulled the hair of her 14-year-old foster daughter. The school reported that the child had a bruise on her arm. (MIDHS00250374) This investigation consisted of one visit to the R foster home. Ms. R denied the allegations, as did four of the six children placed in the home. One foster child began to verify the alleged victim's account but, "stopped her statement like she realized that she has said too much." The Previous Complaint Summary documents three of the eight prior reports MDHS had received concerning Ms. R. The report was unsubstantiated. The investigator signed off on this decision on 6-16-05. The supervisor did not review and approve it for more than three months. (MIDHS00250368 - 369)

On 6-29-06, the LBSC worker moved Isaac and his sister to the foster home of Ms. R. At the time, Ms. R was caring for her three adopted children and two other foster children. At the time of placement, the LBSC worker informed Ms. R that "the children is physically aggressive toward each other," that Isaac's sister had been diagnosed with Hepatitis B, and that "the children are likely to be abusive on their self." (MIDHS00074104) The only visit the LBSC worker made to Isaac at the R home occurred on 7-6-06. At that visit he noted that the children had several marks on their legs. (MIDHS00074101) The Updated Service Plan that LBSC was due to have completed and forwarded to MDHS on 7-16-07 was signed by the LBSC supervisor on 8-18-07, two days after Isaac's death. It contains no information about activity during July, with the explanation that neither the file nor the LBSC worker were available to the supervisor. (MIDHS00073523)

Isaac was taken for a medical examination on 7-1-06. No suspicious injuries were noted at that examination. He was taken to the doctor on 8-4-06 and, again, on 8-14-06. At these examinations he had multiple bruises to his chest, torso, and legs. The doctor thought the bruises were suspicious for abuse and apparently intended to report them to MDHS, but never did so. (MIDHS00250807)

On 8-16-06, Isaac was taken to Children's Hospital, where he was found to exhibit no vital signs and to have second-degree-burns to his chest and abdomen, fresh bruises to his

forehead and ear, and old bruises to much of the remainder of his body. The following day, the hospital reported that Isaac's sister also had extensive new and old bruising. According to Ms. R, Isaac was found unresponsive under some blankets by her adopted daughter. Following an autopsy, the Wayne County Medical examiner found that in addition to the injuries reported previously, Isaac had a fractured clavicle. The cause of Isaac's death was found to be multiple blunt force injury with burn injury. The manner of death was ruled to be homicide. (MDHS00251219) MDHS substantiated its investigation into Isaac's death. (MIDHS00250808) Ms. R was charged with involuntary manslaughter and criminal child abuse as result of Isaac's murder. (Detroit Free Press January 10, 2007)

Analysis

Among the most egregious of MDHS's failures to protect Isaac are the facts that:

The private agency caseworker assigned to Isaac's case carried between 37 and 46 cases. This is far in excess of the MDHS maximum, which is itself far in excess of what is reasonable. A caseload of this size precludes even an exceptionally capable caseworker from doing what is necessary to keep children safe. This failure violates:

- MDHS rules that allow for a maximum caseload of 30 children. (R 400.12205)
- COA standards that require caseloads that do not exceed 18 children or 8 children with special therapeutic needs.⁴³
- CWLA foster care standards that require that foster care caseloads be limited to 12 to 15 children depending on the level of service required by each child.⁴⁴

The private agency caseworker assigned to Isaac's case failed to visit Isaac on a monthly basis. He did not visit him during the month of June, a time during which, had he visited, he would most likely have seen that Isaac and his sister were being abused. This failure violates:

- MDHS rules (Children's Foster Care Manual 722-6) that require monthly face-to-face contact with children in foster care.
- COA standards that require that the foster care worker meet separately with the child at least once a month to assess the child's safety and well-being.⁴⁵

⁴³ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §PA-FC 19.06.

⁴⁴ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §3.48.

⁴⁵ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §PA-FC 16.09.

- CWLA standards (that require that the foster care worker visit the foster child at least monthly and more frequently according to the needs of the child.⁴⁶

Isaac's foster mothers continuously reported troubling and difficult behaviors exhibited by Isaac and his sister. These behaviors included physical aggression, biting, self-abuse, that Isaac's sister persistently undressed herself and Isaac and kissed Isaac on the mouth, that both children cried and whined all the time, and that Isaac's sister refused to use the bathroom and used the floor instead. All of these problems were noted in the Initial and Updated Service Plans which were reviewed and approved by the MDHS POS worker. (MIDHS00073518) None of these problems were ever assessed, much less treated. None of Isaac's three foster mothers ever received any help from LBSC or MDHS in managing these very difficult children.

- MDHS rules (R 400.12418) which require that the service plan for each child in foster care include a behavior management plan specific to the child's needs.
- CWLA foster care standards that require continuous assessment of each foster child's needs related to any emotional or behavioral condition that may need services and that require that the foster care worker and the foster parent work as a team to identify and arrange necessary services for the child.⁴⁷
- COA standards that require that foster parents have access to services to prevent and reduce stress.⁴⁸

No children should have been placed in Isaac's first foster home because the foster mother had been the subject of a substantiated CPS complaint just nine months prior to his placement in the home. MDHS's investigation of this complaint found the home to be so dangerous that MDHS provided intensive services in order to avoid removing the foster mother's own children. This failure violates:

- MDHS licensing rules (Child Placing Agency Letter #2002-03) that require that no foster care license will be issued to a home in which an adult member of the household is listed on the Central Registry, and if a member of the household of an existing licensee is listed on the Central Registry, the license must be revoked.

⁴⁶ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §2.55.

⁴⁷ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §§2.14, 2.54.

⁴⁸ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §PA-FC 16.09.

- CWLA foster care standards requiring that foster care licenses be denied to substantiated perpetrators of child abuse and neglect.⁴⁹
- Basic standards of child welfare practice.

MDHS knew, or should have known, that both foster homes were dangerous places for children. Between them, the two foster homes had been the subject of 16 CPS complaints before the complaint about Isaac's murder in the second home. Only 2 of the 16 complaints were substantiated. However, at least four others (3-5-98, 10-17-02, 1-17-03, and 6-9-04) should have been substantiated. Seven investigations (5-17-99, 5-26-06, 6-28-02, 12-20-02, both complaints made on 8-12-02, and 5-12-05) were so poorly conducted that it is impossible to know what the proper determination should have been. There was no information in the files about two investigations. One (10-2-99) was correctly unsubstantiated.

Of the many very poorly conducted CPS investigations, the most important deficiencies were 1) failure to contact obvious sources likely to have information about the alleged incidents (e.g., treating physicians, police, reporting sources, children living in the home and potential witnesses), 2) wholly inaccurate records checks for previous CPS complaints (especially significant because accurate histories portray clear patterns of maltreatment in both homes), and 3) conclusions that are inconsistent with the facts. Had these investigations been handled competently, Isaac would not have been beaten, burned, and murdered in a MDHS foster home. Taken together these failures violate:

- MDHS rules (CPS Manual CFP 713-1) that set forth some required investigative contacts and require a thorough background check as well as an assessment of previous complaints about the alleged perpetrator in the current complaint.
- MDHS rules (CPS Manual CFP 713-9) that require that CPS investigations must be substantiated when the preponderance standard is met.
- CWLA standards for CPS investigations that require that CPS complaints involving foster children be investigated immediately and thoroughly.⁵⁰
- COA standards that require timely and comprehensive investigations and assessment and immediate action to protect children whose safety is threatened.⁵¹

⁴⁹ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §3.3.

⁵⁰ Child Welfare League of America (1999) *Standards of Excellence for Abused or Neglected Children and Their Families*, Washington D.C., §6.13.

⁵¹ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §§5.0, 5.05, 5.06.

MDHS failed to provide meaningful oversight of the private Child Placing Agency it hired to handle Isaac's case. This failure violates:

- MDHS rules (Children's Foster Care Manual 914) that require that MDHS POS workers receive and review service plans when they are due and meet with the private Child Placing Agency to discuss the case.
- CWLA foster care standards that require that the public agency be responsible for assuring quality foster care services.⁵²

Conclusion

The MDHS/LBSC response to Isaac's case is beyond appalling. An overloaded and, apparently, incompetent LBSC caseworker placed Isaac in dangerous foster homes, ignored his many serious difficulties, failed to visit him regularly, and overlooked evidence of Isaac's maltreatment. MDHS conducted a series of incompetent investigations into allegations that children had been abused and neglected in the chaotic and overcrowded foster homes it chose for Isaac, and came to illogical conclusions. MDHS had many opportunities to prevent Isaac's death. It missed them all. MDHS's actions and inactions, and those of its contractor, caused Isaac's death.

Heather L.

Family History

Heather L. was born in July 1987. (MIDHS00290911) She had one older sister and a brother about three years younger. Her father was murdered when she was about five. Her mother had a history of substance abuse and mental health problems. Heather's older sister lived with her paternal grandmother in South Carolina.

Before the incident leading to Heather's and her brother's placement in state care, the family had been the subject of three CPS complaints made to the Muskegon office of MDHS. On 11-16-01, Heather was beaten by her mother's live-in boyfriend. This complaint was substantiated, assessed as high risk, and opened for on-going protective services. (MIDHS00290794) On 3-20-02, MDHS received a report from a counselor who stated that Heather was cutting herself, had made references to her death, was in danger, and needed counseling which her mother had neglected to arrange. (MIDHS00290802 - 804) On 4-19-02, MDHS received a complaint, apparently from a psychiatric facility where she had been an inpatient, alleging that Heather had failed to attend her post discharge appointments and that she had "suicidal feelings." (MIDHS00290799 - 801) Both of these complaints were unsubstantiated, but were forwarded to the MDHS CPS worker assigned to Heather's case. (MIDHS00071480)

⁵² Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §4.9.

On 6-3-02, MDHS received a report that, the previous day, Heather's mother had cut Heather's leg with a pocket knife during a fight. Heather and her brother ran to the home of their aunt and uncle. Heather was taken to the hospital, where she received 15 stitches. Heather's mother was arrested. MDHS substantiated its investigation, went to court, and obtained custody of Heather and her brother. MDHS left the children in the care of the aunt and uncle, where they had essentially placed themselves. (MIDHS00071478 - 482)

Unlicensed Relative Placement in Michigan

On 6-3-02, 15-year-old Heather and her 11-year-old brother were placed in the unlicensed relative home of their aunt and uncle, who were already caring for three of their own children. Both the aunt and uncle held full-time jobs and the aunt also attended culinary school. The MDHS worker noted that the children were placed in the home without a home study and that the home was dirty. (MIDHS00071450) In fact, the home study was not completed until 1-3-03, seven months after Heather and her brother were placed in the home.

When finally completed, the home study documented that a background check was completed and that neither the aunt nor uncle had any criminal history. They reported no domestic violence or substance abuse issues. According to the home study, the family income was \$2,380 per month. This is only slightly more than the established poverty guideline which, in 2002, was \$2,022 per month for a family of six.⁵³ In keeping with its policy for unlicensed relative placements, MDHS provided no financial assistance to the family. Heather and her brother did, however, receive \$468 per month in Social Security survivor's benefits for their father. On 7-18-02 Heather's aunt complained that she was having difficulty affording food for the children. The MDHS worker referred her to a charitable organization for help with food. (MIDHS00071446) The local school provided winter jackets and other clothing for the children, who had not been provided with adequate clothing by MDHS or their relative caregivers. (MIDHS00071411)

By the time home study was completed on 1-3-03, the MDHS worker documented that,

“there are 17 people living in the family home ... There are three set of bunk beds crowded into a bedroom on the main floor. Six of the female children sleep in this room including Heather. Upstairs in the bedroom there are four beds placed side by side each other. Four of the male boys sleep there.” (MIDHS00071423)

The MDHS worker first became aware of this situation when she visited the home six weeks earlier, on 10-23-02. During this visit, Heather's uncle angrily complained about the lack of assistance his family had received from MDHS. (MIDHS00071427 - 428)

⁵³ United States Department of Health and Human Services, *Prior HHS Poverty Guideline*, <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>.

On 2-13-03, nearly four months after the MDHS worker became aware of the conditions in the home, and more than a month after she documented them in the home study, MDHS received a CPS complaint from the school. In addition to the overcrowding, the school reported that the children came to school very dirty and with a bad smell. (MIDHS00290655) The MDHS investigator went to the home and found it,

“in significant disarray with clothing and leftover food on the floor ... food and milk left open on the counters along with food debris on the floor. It was the worker’s opinion that the home was not within community standards. There was an odor in the home that of spoiled food and urine.”

Heather’s aunt acknowledged that the home was dirty, but said that the additional people in the home had moved out. (MIDHS00290656) Because when the MDHS investigator returned to the home four days later the conditions had improved, the complaint was not substantiated. (MIDHS00290658)

As part of this investigation, the MDHS investigator contacted the Muskegon Police Department to check for any criminal history involving Heather’s aunt or uncle. From this it was learned that the police had been involved in two domestic violence incidents involving the family, one in 2000 and the other in 2001. (MIDHS00290656) There is no documentation that there was ever any MDHS reaction to the information concerning domestic violence history. Domestic violence is, however, consistent with Heather’s uncle’s aggressive behavior. On 10-23-02, his behavior toward the MDHS worker was sufficiently threatening that she felt that she needed to leave the home for her safety. (MIDHS00071427) There were numerous other examples of Heather’s uncle becoming enraged and verbally abusive toward the MDHS worker. There were also many instances in which Heather’s aunt or uncle tried to prevent the MDHS worker from having access to the home or the children.

On 4-23-03, MDHS received a second CPS complaint concerning Heather’s aunt and uncle. This complaint alleged that about 10 days previously, Heather’s uncle punched her, giving her a black eye. During this investigation, the criminal background check did not detect the domestic violence issues documented in the 2-13-03 investigation but did reveal that Heather’s uncle was arrested for Operating (a motor vehicle) Under the Influence of Liquor in late 2002. (MIDHS00071396) Heather ran away and was brought to Child Haven – a county-run emergency shelter – by the police. Because Heather recanted her allegations, the MDHS investigator found the report to be unsubstantiated. (MIDHS00071396 - 403) On 4-25-03, Heather ran away from Child Haven. (MIDHS00071383)

Unlicensed Relative Placement in South Carolina

On 5-7-03, the MDHS worker received a phone call from Heather's paternal grandmother in South Carolina. Heather's grandmother reported that Heather was in her home, having replaced herself. (MIDHS00071383) The MDHS worker requested that the South Carolina child welfare agency complete a home study of Heather's grandmother's home on 5-15-03. On 5-29-03, the MDHS worker spoke with Heather's grandmother by phone. The grandmother reported that 15-year-old Heather was doing well. She was not in school but had a job washing dishes at a restaurant. (MIDHS00071384) Other than receiving a home study and one progress report from the South Carolina child welfare agency, this was the last remotely meaningful contact any MDHS worker had with anyone in South Carolina concerning Heather.

On 10-10-03, the South Carolina child welfare agency completed a home study about Heather's grandmother. (MIDHS00071349 - 353) In addition to Heather, her grandmother was caring for three other grandchildren ages 11, 14, and 16. The grandmother worked two jobs and had an income of \$1,400 per month. This is well below the 2003 poverty level of \$1,795 for a family of five.⁵⁴ On 10-28-03 – more than five months after her arrival – Heather's grandmother's home was formally approved for her placement.

On 7-19-04, the South Carolina child welfare agency completed and sent a progress report on Heather's placement to MDHS. According to the progress report, during the 14 months Heather had lived with her grandmother, she had received no medical or dental examination, she was not in any educational program, and there was no plan for Heather's future. Heather had only recently begun receiving about \$250 per month survivor's benefits for her father. There was no mention of any service provision of any kind. (MIDHS00071338 - 339)

This was the last communication MDHS received – or sought – about Heather before her death. On the Updated Service Plan dated 8-30-04, the MDHS worker's only notation concerning Heather was:

“Heather remains in her same placement and to this worker's knowledge she continues to maintain. There has been no real negative reports regarding her placement. It appears that the relative placement providers are dealing with any bumps in the road as they come along.”

(MIDHS00071304) On 11-12-04, the caseworker from the South Carolina child welfare agency noticed Heather's obituary in the newspaper. Two days before, on 11-10-04, Heather had hung herself from a tree using a dog collar. (MIDHS00071300) MDHS' last act in Heather's case was to deny the family any financial assistance with her funeral.

⁵⁴ Ibid.

Service Planning and Provision

At the time of placement, MDHS had ample information indicating that Heather suffered from dangerous mental health and other problems. MDHS had an open CPS case for six months preceding her placement. During this six months, Heather had been psychiatrically hospitalized. Following her discharge, mental health professionals had expressed concern about her safety and her potential for suicide. The MDHS investigator responsible for her removal documented Heather's mental health problems and noted that she had recently been psychiatrically hospitalized. At the time of her removal, Heather was receiving mental health treatment from Community Mental Health. (MIDHS00071483)

In the Initial Service Plan dated 7-4-02, Heather is described as having been diagnosed with depression, as being self-mutilating, and as having suicidal thoughts. She was prescribed an antidepressant but did not like to take it. Her therapy attendance at the Community Mental Health Center was inconsistent. On 7-12-02, Heather's aunt complained that Heather was sneaking out of the home at night. She told the MDHS worker that she wanted Heather to be back in counseling and back on her psychotropic medication. Apparently, Heather had stopped both. (MIDHS00071444 - 448) After the aunt repeated this concern a few days later, the MDHS worker spoke with Heather's therapist at the Community Mental Health Center. There is no documentation of the substance of this conversation, nor any evidence that anything happened as its result.

There is no documentation that the Updated Service Plan that was due in 10-02 was ever completed. Nothing is known about what, if any, casework activity occurred until the period documented in the Updated Service Plan dated 12-12-02. On 12-12-02, Heather's aunt informed the MDHS worker that Heather had been suspended from school for threatening to hit a teacher – one of many such suspensions. Heather had stopped taking her medication and the mental health center had closed its case because Heather was not attending her therapy appointments. In the next few days, the MDHS worker contacted the mental health center to “gather records” (none are in the file) and was informed that they had, indeed, closed their case. Heather's diagnosis at this time is identified as bipolar disorder. (MIDHS00071429 - 431) Bi-polar disorder is a dangerous but treatable disorder for which suicide is an important risk. In the Updated Service Plan dated 3-19-03, the MDHS worker complained that Heather's aunt and uncle have not complied with the agency's request that Heather receive services, as if it was their job – not the MDHS worker's – to see that Heather's mental health needs were addressed. (MIDHS00071413) MDHS did absolutely nothing to address Heather's mental health (or any other) problems for the remainder of its involvement in her case. This is despite her diagnosis and the fact that Heather's behavior consistently deteriorated, becoming increasingly defiant and aggressive as long as she was in Michigan. In every Updated Service Plan, she is identified as having problems with regard to her emotional stability. During the 16 months Heather lived with her grandmother in South Carolina, there is no shred of evidence that MDHS gave any consideration to Heather's mental health or any other aspect of her safety or well-being.

Analysis

Among the most serious of MDHS's failures to protect Heather are the facts that:

MDHS's failed to provide Heather with a professional mental health assessment despite its knowing about her dangerous psychiatric problems. This failure violates:

- The Michigan Foster Care and Adoption Services Act (Act 203) that requires that if a child under the care of a supervising agency has a mental illness, the supervising agency shall have an experienced and licensed mental health professional who is trained in children's psychological assessments perform an assessment or psychological evaluation of the child. (722.954c (4))
- CWLA standards for kinship care that require children should be assessed comprehensively at the time the agency assumes their custody. The assessment should include the child's emotional and psychological needs. The assessment should identify treatment and service strategies.⁵⁵
- CWLA foster care standards that require that within 30 days of placement, the foster care worker should arrange for a comprehensive assessment for each child in care, because children in foster care are at risk of physical, mental health, educational, and developmental problems.⁵⁶
- COA standards that require that children should receive an initial health screening from a qualified medical practitioner within 72 hours of entry into care to identify the need for immediate physical or mental health services and to assess for infection and communicable disease. The mental health screening can address suicidal ideation or history of suicide attempts and aggressive, dangerous, self-destructive, or psychotic behaviors.⁵⁷

MDHS's failed to assure that Heather receive mental health services despite its being aware of her dangerous psychiatric illness. This failure violates:

- CWLA foster care standards that require that the foster care worker arrange for and use available resources and, when necessary, advocate for additional resources so that children in foster care receive the psychological services they need.⁵⁸

⁵⁵ Child Welfare League of America (2000) *Standards of Excellence for Kinship Care Services*, Washington D.C., §2.17.

⁵⁶ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §2.63.

⁵⁷ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §PA-KC 2.04.

⁵⁸ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §2.64.

- COA standards that require that children with significant emotional or behavioral needs receive intensive clinical and supportive services.⁵⁹

After becoming her custodian, MDHS allowed Heather to remain in the home of her aunt and uncle without conducting any assessment of their ability to safely care for her for 7 of the 10 months she lived with them. No home study of Heather’s grandmother’s home was conducted until she had lived in her home for 5 months. This is a violation of basic standards of child welfare practice. These failures violate:

- MDHS rules (CPS Manual CFP 715-2) that requires that when placing children in relative homes, the home study must begin immediately and be completed within 30 days of placement.
- CWLA kinship care standards that require that when children are already placed with relatives when the agency becomes their custodian, the agency should immediately complete an assessment focused on the relative’s willingness and ability to meet the children’s need for safety, protection, immediate health, educational, developmental, and emotional needs.⁶⁰
- COA standards that require that the agency conduct home studies to identify stable, nurturing kinship homes and that home studies be conducted prior to placement, or as soon as possible when the child is already living with the caregiver.⁶¹

MDHS inexplicably allowed Heather to remain in the home of her aunt and uncle despite its knowledge that the home was *dangerously* overcrowded and chaotic for at least four of the ten months of her placement there, and that it was regularly unsanitary. In addition to defying common sense, this failure violates:

- MDHS rules (Foster Care Manual CFF 722-3) that require that in selecting a placement for a child in its custody, the MDHS worker must evaluate the family/home to determine whether it can meet the physical, emotional, safety, and special needs of the child. It further requires that the worker must realistically consider the number, ages, and special needs of the children in the home.

⁵⁹ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §PA-KC 11.

⁶⁰ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §§2.11, 2.18.

⁶¹ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §PA-KC 6.02.

- CWLA kinship care standards that require that the child welfare agency should inspect the relative home to evaluate whether the home meets basic health and safety standards. Standards for relative care should be the same as those for licensed foster homes.⁶²
- COA standards that require that the agency continually assess relative placements to verify that basic health and safety requirements are met, including adequate sleeping arrangements.⁶³

MDHS failed to find that there was a preponderance of the evidence that Heather's aunt and uncle were neglectful on the basis that their house was filthy and was overcrowded by the 17 people living in it for four months. This failure violates:

- The Michigan Child Protection Law (ACT 238 722.622 (j)) and the MDHS rules (CPS Manual (and CFP 711-4)) that define child neglect as harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person responsible for the child's health or welfare that occurs through negligent treatment, including the failure to provide adequate shelter.

MDHS failed to assure that the homes in which it allowed Heather to be placed had the financial wherewithal to adequately care for her, despite the fact that it had information to the contrary. This failure violates:

- The MDHS rules (Foster Care Manual CFF 722-3) that require that in selecting a placement for a child in its custody, the MDHS worker must evaluate the family/home to determine whether it can meet the physical, emotional, safety, and special needs of the child.
- CWLA kinship care standards that require that the child welfare agency should implement policies and procedures that establish a uniform level for financial support for all children in the legal custody of the public agency. Further, the agency should anticipate and respond to the concrete needs, including financial needs, of the kinship care provider.⁶⁴
- COA standards that require that the agency help the relative care giver receive financial assistance.⁶⁵

⁶² Child Welfare League of America (2000) *Standards of Excellence for Kinship Care Services*, Washington D.C., §§2.35-2.36.

⁶³ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standard*, New York, §PA-KC 6.05.

⁶⁴ Child Welfare League of America (2000) *Standards of Excellence for Kinship Care Services*, Washington D.C., §§3.17, 3.20.

⁶⁵ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standards*, New York, §PA-KC 12.03a.

Conclusion

MDHS acted only as a witness to Heather's stay in its "care." She placed herself in the overcrowded, chaotic, and otherwise inappropriate home of her aunt and uncle. She replaced herself into the impoverished home of her grandmother, about which MDHS knew next to nothing. It did *nothing* to address her precarious psychiatric state, either while she was in Michigan or after she ran away to South Carolina. It stood by, apparently without much interest, as she led a completely unstructured existence while she was with her grandmother.

Because of the uncertainty of mental illness, it is impossible to know whether Heather would have been safe even if she had received high quality mental health services and even if she had been placed in a setting with the structure and support she obviously needed. MDHS's blatant disregard allowed Heather to be in a situation in which her suicide was predictable.

Elizabeth G.

Family History

Elizabeth G. was born in Grand Rapids in August 2004. Elizabeth's mother was 16 and her father was 18 at the time of her birth. Both parents were high school students. Elizabeth and her parents lived in the basement of her maternal great-grandparents' home in Jenison, Michigan. Heather's great-grandparents were both in their early 60's and were retired.

MDHS CPS Investigation

On 8-20-04, MDHS received a CPS complaint that 14-day-old Elizabeth had suffered multiple injuries including a fractured skull, three fractured ribs, and a fractured clavicle. (MIDHS00293710) The MDHS investigation continued for eight days, until 8-28-04. The essential facts gathered by the MDHS investigator and the Ottawa County Sheriff's Office (which were shared with MDHS) were:

- Elizabeth's injuries were very recent and were the result of a single incident of blunt trauma. (MIDHS00293716)
- Her injuries, in combination with the absence of any history of severe accidental trauma, were indicative of child abuse. (MIDHS00294317)
- Elizabeth's injuries occurred sometime between the late afternoon of 8-18-04 – when Elizabeth's pediatrician thoroughly examined her – and late in the afternoon on 8-20-04 – when Elizabeth returned to the pediatrician, who sent her to the hospital

emergency room after discovering that Elizabeth had been seriously injured. (MIDHS00293736 – 737 and MIDHS00294314)

- It is most probable that the injuries were inflicted between the time Elizabeth left the pediatrician's office on 8-18-04 and the evening of the same day, when Elizabeth's mother called the pediatrician, because Elizabeth's father discovered a bruise on Elizabeth's leg during that period, and because Elizabeth was fussy for the next two days. (MIDHS00293737)
- Although there are inconsistencies in their statements, the only people who had any access to Elizabeth during the time she was abused were her parents and her great-grandparents. (MIDHS00293714 – 715 and MIDHS00293726 – 737)
- Although her mother's statements are inconsistent, Elizabeth was in the nearly constant care of her mother during the time that she was injured. (MIDHS00294293 and (MIDHS00294222 - 229)

After the investigation was formally concluded, the following information was sent to the MDHS investigator:

- The hospital protective services team reported on 10-13-04 that injuries to Elizabeth's head were, in fact, bilateral skull fractures. (MIDHS00294316)
- Much later, on 2-7-05, MDHS received documentation that Osteogenesis Imperfecta (brittle bone disease) had been ruled out as a potential cause for Elizabeth's injuries. (MIDHS00294951)

After the last investigative contact was completed on 8-28-04, MDHS determined its investigation to be substantiated *even though it had not determined who was responsible for the brutal abuse of 14-day-old Elizabeth.* (MIDHS00293716)

Unlicensed Relative Placement

At the end of the investigation the MDHS investigator completed a safety assessment for Elizabeth. Because her caretakers had been found to have caused Elizabeth serious non-accidental harm, she was found to be Unsafe. (MIDHS00293720 – 721) In the context of child welfare safety assessments, a child is Unsafe when, without assertive protective intervention, the child will likely be severely harmed in the near future. According to the MDHS Children's Protective Service Manual, when a child is assessed as being Unsafe, "the only possible protecting intervention is the removal of the child from the family. Without placement, the child will likely be in danger of immediate or serious harm." (CFP 713-9)

Inexplicably, MDHS did not remove Elizabeth from her family. On 8-24-04, MDHS caused a petition to be filed in Ottawa County Family Court. MDHS's position was that

1) Elizabeth should be placed in the custody of her great-grandparents, 2) her father should be required to leave the home, and 3) her mother should be allowed to remain in the home, but her contact with Elizabeth should be supervised by her great-grandparents. (MIDHS00293716) *There is no rationale for failing to consider that Elizabeth's grandparents may have abused her. There is no explanation for MDHS believing that Elizabeth's mother was less dangerous than her father.* Nevertheless, on 8-24-04 the Court made Elizabeth a ward of MDHS, and followed the agency's other recommendations. (MIDHS00293974) A few days later, the order was amended to allow Elizabeth's father two hours visitation per day under the supervision of the great-grandparents. (MIDHS00294017)

Effective the day after Elizabeth was made an MDHS ward, her case was contracted out to Bethany Christian Service (BCS), a Child Placing Agency licensed by MDHS to provide full foster care services to Elizabeth and her family. (MIDHS00071935) In addition to foster care services, BCS provided individual counseling and parenting training (Parenting Plus) to both parents. (MIDHS00294049)

On 8-26-04, a Relative Home Study was completed for Elizabeth's great-grandparents. With the exception of the criminal background check (which did not reveal any criminal history), the home study is entirely based on information provided by the great-grandparents themselves and can only be described as superficial. (MIDHS00071861 - 862)

During the first several months after Elizabeth was made a ward of MDHS, her father visited her daily, regularly eating dinner in the home. There is no documentation to suggest that BCS verified, or even discussed, with anyone in the family the supervision Elizabeth's great-grandparents were ordered to provide when she was in contact with either of her parents. There is no evidence that anyone from MDHS or BCS took any action to protect Elizabeth.

On 12-30-04, MDHS filed a petition to terminate Elizabeth's mother's and father's parental rights. (MIDHS00071685) On 1-10-05, the BCS Parenting Plus worker discussed the termination petition with Elizabeth's parents. When they understood its implications, they informed the Parenting Plus worker that Elizabeth's father would plead "no contest" to the allegation that he had injured Elizabeth. (MIDHS00293794) At the hearing held on 10-18-05, Elizabeth's father made an admission that he "acknowledges responsibility for causing the injuries inflicted on the child." (MIDHS00071682) It is clear that the admission was made in order to avoid the termination of parental rights. More specifically, Elizabeth's father told the court that he thought Elizabeth was having a seizure and he tried to hold her down in the her crib. (MIDHS00071807) No one questioned how this entirely implausible explanation could possibly account for Elizabeth's bilateral skull fracture or her other injuries. At the same hearing, Elizabeth – while remaining a ward of MDHS – was returned to the care of her mother.

After making his admission, Elizabeth's father's visitation was reduced to supervised weekend visitation. Elizabeth's mother was allowed to supervise these visits. Following

an altercation between Elizabeth's parents on 7-22-05, during which her father broke some objects, Elizabeth's visitation with her father was moved to the BCS office. On 8-29-05, Elizabeth's father was sentenced to 90 days in jail because of the admission he made in Family Court on 1-18-05. (MIDHS00071749)

By 11-05, Elizabeth's mother had decided to divorce Elizabeth's father and had become involved with a new boyfriend. Elizabeth's mother's new boyfriend moved into the home with Elizabeth, her mother, and her great-grandparents. The MDHS worker conducted a criminal background check and learned that he had no criminal history. (MIDHS00293772) On 11-15-05, the BCS foster care worker visited the home. At the visit she met Elizabeth's mother's new boyfriend and noted that Elizabeth was fussy, did not want to be held and appeared "agitated about something." (MIDHS00072067) This was the last time she saw Elizabeth.

On 11-21-05, Elizabeth's great-grandfather called the BCS worker to report that Elizabeth had burned her foot and was being taken to the doctor. (MIDHS00072061 and 72327) The following day, he informed the BCS worker that Elizabeth's pediatrician had found the burn to be sufficiently serious that Elizabeth needed specialized treatment and referred her to a burn unit. Elizabeth's burn was second degree and was reportedly from a space heater. The BCS worker asked Elizabeth's great-grandfather to photograph the burn. (MIDHS00072061 and 72328) She never, however, made any effort to see the burn, determine the plausibility of the explanation, or otherwise investigate the incident. She never called Elizabeth's pediatrician or the burn unit to verify treatment or to discuss potential causes of the burn. It does not appear that she ever received the requested photograph. *She did nothing.* In fact, the burn covered the bottom of Elizabeth's foot entirely and was highly suspicious. (MIDHS00293772)

In addition to the BCS foster care worker, two other BCS workers were also aware of the burn and did nothing. (MIDHS00293772) After Elizabeth was badly burned, the BCS Parenting Plus worker observed Elizabeth to have bruises on her bottom. Elizabeth's mother's explanation that Elizabeth had fallen from her crib seemed plausible to the worker, and the injury was never reported.

Two written Reports of Actual or Suspected Child Abuse or Neglect were completed by BCS staff. The first, dated on 12-7-05 – more than 3 weeks after the BCS workers became aware of the burn – reported that:

“Elizabeth was brought to the hospital with 2nd degree burns on her foot ... She was returned to the hospital with 2 black eyes and broken blood vessel in her eye. It doesn't appear that she is being watched properly and may be abused.” (MIDHS00293757)

The record contains no evidence that any effort was made to investigate or otherwise address the two black eyes referenced in this report. *No one did anything. This report was never sent to MDHS.*

The second Report of Actual or Suspected Child Abuse or Neglect was completed by the BCS Parenting Plus worker, apparently after Elizabeth's death. It reported that,

“12/05 observed bruises on Elizabeth's buttocks. Yellow/green, 2 circle shapes consistent with the explanation that she fell from the crib on her butt. Child had a burn on bottom of her foot 2 weeks prior.”

(MIDHS00293758) This report was forwarded to MDHS the day *after* Elizabeth was killed.

On 12-11-05, Elizabeth's mother's boyfriend checked on Elizabeth, who was taking a nap, and found her to be dead. Elizabeth's death was caused by non-accidental blunt force trauma. At the time of her death, Elizabeth had other injuries in various stages of healing suggesting on-going child abuse. Elizabeth's father was in jail when she was murdered and could not have been responsible. Clearly, Elizabeth was beaten by someone living in the home. (MIDHS000293772) Because of the criminal implications of Elizabeth's death, MDHS did not conduct an investigation and, therefore, there is almost no information about her murder in the record. Relying on information from the police investigation, MDHS substantiated the death to an unknown perpetrator. The file was kept open so that if the police identified Elizabeth's killer, her or his name could be added to the registry. (MIDHS000293772) As recently as 7-17-07, the file remained open because no arrests had been made. The MDHS investigator documented:

“I strongly suspect Rachel was responsible for the injuries that place Elizabeth under protective custody in foster care. I also believe she is responsible for the additional injuries to her child that resulted in her death.” (MIDHS000293868)

Analysis

Among the most serious of MDHS's failures to protect Elizabeth are the facts that:

MDHS, having failed to identify the perpetrator of the brutal abuse Elizabeth suffered in 8-04, failed to take reasonable protective action. It should have removed her from the care of both parents and both great-grandparents because any one of them could have been responsible for the abuse. Instead, it took a guess that Elizabeth's father was responsible, leaving Elizabeth in terrible danger. This failure violates:

- MDHS rules (CPS Manual 713-9) that require that when children are found to be unsafe the only possible protecting intervention is the removal of the child from the family. Without placement, the child will likely be in danger of immediate or serious harm.
- Basic child protection practice that requires that safety plans be adequate to control the safety threats that confront the child.

Caseworkers from the MDHS contract agency failed to make a report to MDHS, or to take any other action, in order to protect Elizabeth after they had information that she had suffered several very suspicious injuries. This is especially inexplicable given the uncertain circumstances of her first abuse. This failure violates:

- The Michigan Child Protection Law (Act 238) which requires a report to MDHS when a child welfare worker has reasonable cause to suspect that a child has been abused. Given the history of child abuse in the home and the seriousness of the injury, a CPS complaint should have been made.

MDHS failed to provide meaningful oversight of the private Child Placing Agency it hired to handle Elizabeth's case. This failure violates:

- MDHS rules (Children's Foster Care Manual 914) that require that MDHS POS workers receive and review service plans when they are due and meet with the private Child Placing Agency to discuss the case.
- COA foster care standards that require that the public agency be responsible for assuring quality foster care services.⁶⁶

Conclusion

The decision to leave Elizabeth in the care of her mother and great-grandparents is incomprehensible. At the time MDHS made this decision, the available information indicated that the mother was more likely to have abused her infant daughter than any of the four other caretakers who may have been responsible. This never changed. Had MDHS taken the action that was obviously indicated by the facts of the case and removed Elizabeth, she would not have been killed.

Near the end of her life, caseworkers from the private agency saw evidence that Elizabeth was being abused. Given the facts they had available to them, their inaction was inexcusable. MDHS and BCS allowed Elizabeth to be murdered.

Brandon L.

Family History

Brandon was born in April 2004 in East Leroy, Michigan. His only sibling was his brother, who was three at the time of Brandon's birth. Before Brandon was born, his brother and mother were the subjects of four neglect complaints made to MDHS. Based on these complaints, Brandon's brother was taken into MDHS custody and placed in foster care. Because his mother had made no progress toward regaining custody of

⁶⁶ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington D.C., §4.9.

Brandon's brother, MDHS took custody of Brandon directly from the hospital where he was born. (MIDHS00093802 – 809)

Foster Care History

On 4-27-04, MDHS placed Brandon into the foster home of the B family. The B foster home was selected for Brandon because it was the foster home in which his brother was placed. In addition to Brandon and his brother, there was one other foster child – a six-year-old boy – in the home. The Bs also had one biological son (17) and two adoptive sons (15 and 17) in the home at the time of Brandon's placement. All three of the teenaged boys had significant psychological problems and were prescribed psychotropic medications.

The B home had a decades-long history of trouble with MDHS. Before becoming a foster parent, Mr. B, who at the time was married to a previous wife, was alleged to have sexually abused his then 13-year-old daughter. This incident was reported on 2-24-72 by her school, who noticed "hickies" on the girl's neck. When the daughter told her teacher that her father, Mr. B, had put them there, the school reported to MDHS. After almost no investigation, MDHS dismissed the allegation, deciding that Mr. B had only been "horsing around." (MIDHS00094510)

In 1980, Mr. B and his first wife applied to become foster parents, and on 3-10-80, MDHS completed its first licensing study of the family. Although the Bs said they wanted to help children by giving them a secure home, it appears more likely that they were interested in receiving foster care payments. Shortly before applying to become foster parents, the elderly man to whom they had provided adult foster care for 14 years had died. He had been an important source of income for the Bs. Also, during the MDHS licensing interview Mr. B, who was a school bus driver, told the worker how he had resolved some difficulty with a troublesome youth by slapping him in the face. The Bs both had debilitating medical problems. Their annual income, including welfare payments, was less than \$6,500. Despite these things, MDHS approved the Bs' application for a foster home license. (MIDHS00093968 – 971)

On 10-16-80, not long after the Bs were licensed as foster parents, MDHS received a report alleging that Mr. B hit a 16-year-old foster son with a belt. After investigation it was determined that, several days before the report, Mr. B wrestled the 16-year-old to the ground and hit him repeatedly with a belt. The child said that the belt left welt marks and that he was sore for several days. MDHS attributed the incident to family stress caused by the Bs' financial situation, medical problems, and the behavior of the foster child. (MIDHS00094504 - 507) It was noted that Mr. B has had difficulty with his temper. The report was substantiated and opened so that MDHS could provide child protective services to the family. (MIDHS00094513 - 514)

Despite the substantiated incident of child abuse, MDHS continued to place children in the B home until at least May 1981. (MIDHS00094497) It appears that the Bs' license lapsed in the early 1980's and, in mid-1985, they reapplied. (MIDHS00093964 - 967) By

this time, Mr. B had married his second wife, S. In 1989, responsibility for the foster home was transferred from Calhoun County MDHS to Youth Guidance, a private Child Placing Agency operating under a license and contract with MDHS.

On 5-22-90, MDHS received a CPS complaint that Ms. B pulled the hair of a 15-year-old foster son and slapped him in the face. The MDHS investigator verified the allegations and noted that the child had a mark on his lip. (MIDHS00094515) MDHS and Youth Guidance continued to place children in the home despite this incident. It is not clear whether this incident was substantiated.

On 3-1-92, the Youth Guidance worker completed a Foster Home Renewal Summary in which she noted that the Bs seemed able to handle one foster child but that when additional children were placed in their home “problems seem to erupt.” (MIDHS00093947)

On 12-29-92, MDHS received a CPS complaint concerning an incident occurring several months earlier. According to Mr. B, Ms. B hit their six-year-old in the face, leaving a mark. MDHS did not begin to investigate the complaint until 1-4-93, because it was not viewed as priority. During the investigation it was found that the Bs were having serious difficulty controlling their son’s aggressive behavior. Although the incident appears to have occurred, MDHS found it to be unsubstantiated, apparently because it had occurred months before the complaint. (MIDHS0009519 - 525)

In a 4-30-93, Foster Care Annual Summary, the Youth Guidance worker noted that Ms. B had some unreasonable expectations for foster children and that the Bs were having trouble with the behavior of their son. She concluded, however, that “in spite of the problems encountered with the B foster home over the past years, this home is still worth using.” (MIDHS00093943)

On 7-5-95, Youth Guidance investigated a licensing complaint that Ms. B grabbed a foster child (age unknown) by her arm and hurt her. Ms. B told the licensing worker that she only grabbed the child’s arm to move her out of a store. There is no documentation that anyone other than Ms. B was interviewed. (MIDHS00094099 - 103) The licensing investigation found no rule violation, describing this finding as “a judgment call.” No action was taken. (MIDHS00094103)

On 1-12-96, MDHS received a CPS complaint that Ms. B hit her then nine-year-old biological son in the stomach. She was also alleged to have pulled the hair and grabbed the face of an 11-year-old foster child. During the investigation of this complaint, Ms. B acknowledged hitting her son in the stomach, knocking the wind out of him. She claimed that it was an accident and that she meant to hit his legs. She also admitted pulling the foster child’s hair. In spite of these admissions, the CPS allegation was unsubstantiated. (MIDHS00094530 - 536) The incident was referred to licensing and the Bs were put on a provisional license between 1-17-96 and 7-16-96. The corrective action plan was that Ms. B would not hit or pull the foster children’s hair and that the Bs would receive training. (MIDHS00094095)

On 6-1-96, MDHS received a CPS complaint alleging that Mr. B got into a struggle with an 11-year-old foster son, put him in a hammer lock (held the foster child's arm behind his back – a maneuver that is very dangerous and is illegal in college wrestling), slammed him to the ground, pulled his hair, and, perhaps accidentally, poked him in the eye. This incident was investigated by the Michigan State Police. Evidentially, because of the police involvement, MDHS did not conduct a CPS investigation. (MIDHS00094539) The police investigation verified the allegations, and they requested that the county prosecutor issue an arrest warrant for Mr. B for assault and battery. (MIDHS00094541 - 546) The Youth Guidance licensing investigation found that Mr. B had violated the licensing rule prohibiting severe corporal punishment, and the Bs were placed on their second provisional license. Again, the corrective action plan consisted of the Bs' agreement to refrain from physical discipline and their agreement to receive training. (MIDHS00094079)

On 8-13-96, a Youth Guidance caseworker made a licensing complaint that Mr. B grabbed a foster child (age unknown) by the neck, drew back his fist, and told the foster child that "I sure would like to pop you." Mr. B allegedly tore a foster care license up in front of the foster children and told them that they had all lost their placement because of the child he threatened to punch. Mr. B had made generally threatening remarks to the child over the previous few weeks. (MIDHS00094072) Although the Youth Guidance licensing investigation was probably correct in finding that the allegations were somewhat exaggerated, it did conclude that a licensing rule requiring that foster parents "be of suitable temperament to care for children" had been violated. No licensing action was taken, however, and the Bs agreed to be seen by the Youth Guidance psychologist. (MIDHS00094069 – 071) The Bs did receive a psychological evaluation but not until nearly a year later. The evaluation focused on family dynamics and seemed to ignore Mr. and Ms. B's anger, seemingly the paramount issue. (MIDHS00093933)

On 12-18-96, Youth Guidance completed a Renewal Summary. Renewal summaries are required annually. No summary was found for 1994 or 1995. During this period, it appears that the Bs' only source of economic support was foster care payments. Despite this and the three substantiated complaints the Bs amassed during the year, they were given a regular license. (MIDHS00093921)

On 10-1-97, a Youth Guidance caseworker complained to Youth Guidance licensing that during a home visit Mr. B became enraged, tore his foster care license off the wall and threatened to drop the children off at Youth Guidance if he did not receive more money. The licensing investigation found, again, that Mr. B violated the licensing rule related to the foster parent's temperament. (MIDHS00094062)

On 11-19-97, Youth Guidance investigated a licensing complaint alleging that Mr. B intentionally broke a toy that a foster child wanted and that Ms. B called him a brat. The rule violation related to the Bs having no income other than foster care payments, noted almost a year earlier in the 12-18-06 renewal summary, was also investigated. During this investigation, the foster parents more or less admitted the allegations about breaking the

toy and calling the child a brat. In addition, the children consistently described Ms. B calling the children names and saying derogatory things about them. The Bs refused to supply any documentation related to their income. The rule violations were substantiated and the Bs were, once again, put on a provisional license. The Bs agreed to sign a corrective action plan on the condition that their license would be transferred from Youth Guidance to MDHS. (MIDHS00094044 - 046) The corrective action plan consists entirely of the Bs “committing” to do better.

In 2-98, responsibility for the B foster home was transferred from Youth Guidance to Branch County MDHS. In her transfer summary, the Youth Guidance licensing worker observed there were “concerns that the B home lacked the wholesome environment that foster children need.” She further noted that the Bs’

“unwillingness or inability to learn ... resulted in their exhibiting what we believe as an unsuitable temperament, an inability to understand the needs of children and an unwillingness to cooperate with our agency. At times they demonstrated a reactionary temperament such as yelling, excessive force and intimidation (alleged name calling).” (MIDHS00093903 - 906)

On 6-22-99 (MIDHS00094237), 6-26-00 (MIDHS00094221 - 223), 6-29-01 (MIDHS00094188), and 6-21-02 (MIDHS00094164), the MDHS licensing worker completed Foster Home Renewal Evaluations. The first three evaluations note that the Bs completed none of their required training. The 2002 evaluation indicates that the Bs were tired and were ready to stop fostering. All the evaluations can be described as cursory and seem to focus heavily on the physical condition of the home.

On 1-9-02, an MDHS caseworker complained to MDHS licensing that Mr. B admitted to her that he had spanked a nine-year-old foster child. Mr. B said he knew it was a rule violation but he felt it was necessary so he did it anyway. The rule violation was substantiated. No licensing action was taken. A “verbal corrective action plan” in which the Bs said they would not do it again was the only consequence. (MIDHS00094006)

On 7-7-03, MDHS conducted a licensing Foster Home Renewal Evaluation. Again, the study is cursory and is focused on the physical condition of the home. It was noted in the summary that there had been no complaints or investigations involving the home in the last year, the 1-9-02 complaint notwithstanding. The home was licensed for one child. (MIDHS00094143) On 1-23-04, MDHS increased the Bs’ licensed capacity to two children. This increase was due to a child who was in the Bs’ guardianship being placed in residential treatment. (MIDHS00094134) This additional foster care slot was filled by Brandon’s brother. On 4-26-04, MDHS again increased the Bs’ capacity so that Brandon could be placed with his brother. (MIDHS00094130)

On 6-14-04, only 48 days after Brandon was placed in the troubled B foster home, Ms. B called paramedics after she found him unresponsive. He was pronounced dead at the scene. Although the medical examiner found the manner of Brandon’s death to be undetermined (MIDHS00094604), it appears most likely that his death was from

asphyxiation. According to the Bs' reasonably consistent statements during the investigation, Ms. B had propped Brandon up in a sitting position on an adult bed while she dressed and did chores around the house. It appears from the history that Brandon rolled over, burying his face in the bedding, and suffocated. This is particularly disturbing because, according to Mr. B, Brandon had been propped up in a similar fashion and had nearly suffocated on two previous occasions. (MIDHS00094579 - 583)

At the time of Brandon's death, serious safety hazards were noted in the B home. A rifle was found lying on the floor in a room that would be accessible to all of the children. Multiple prescription bottles – at least some of which contained the teenage boys' psychotropic medications – were found open on the kitchen counter, accessible to the younger children placed in the home. (MIDHS00094579 - 583)

MDHS substantiated its CPS investigation, finding that Ms. B failed to adequately supervise Brandon. When the six-year-old foster child was interviewed following his replacement, he reported that the Bs spanked him and Brandon's brother, hit Brandon's brother hard in the face, and that Ms. B pulled their hair. (MIDHS00094583)

MDHS also substantiated its licensing investigation. (MIDHS00093979) Both of the surviving foster children were replaced. The Bs' foster care license was revoked.

Analysis

Among the most serious of MDHS's failures to protect Brandon are the facts that:

MDHS placed Brandon with foster parents who had been the subjects of at least one substantiated CPS complaint. This failure violates:

- MDHS licensing rules (Child Placing Agency Letter #2002-03) that require that no foster care license will be issued to a home in which an adult member of the household is listed on the Central Registry, and if a member of the household of an existing licensee is listed on the Central Registry, the license must be revoked.

MDHS placed Brandon with foster parents who had been the subjects of four unsubstantiated CPS complaints. Two of these (1-12-96 and 6-1-90) should have been substantiated. The investigations were flawed by failures to make important investigative contacts and by final determinations that are inconsistent with the facts. Had either of these reports been substantiated, MDHS rules would have required revocation of the foster care license. This failure violates:

- MDHS rules (CPS Manual CFP 713 -1) that set forth some required investigative contacts and require a thorough background check as well as an assessment of previous complaints about the alleged perpetrator in the current complaint.
- MDHS rules (CPS Manual CFP 713-9) that require that CPS investigations must be substantiated when the preponderance standard is met.

- CWLA standards for CPS investigations which require that CPS complaints involving foster children be investigated immediately and thoroughly.⁶⁷

There were at least six licensing complaints involving the B home between 1992 and the time of Brandon’s death. Most of these resulted in rule violations. Although the home was put on provisional license status as the result of three violations, the corrective action plans all involved the Bs agreeing not to “do it again.” Combining the licensing complaints with the five CPS complaints – for which there were also no real consequences – MDHS should have seen, and reacted to, the obvious pattern. The Bs did not believe that there was any reason for them to adhere to any rules. There were repeated documented instances of corporal punishment, hair pulling, name calling, and other inappropriate – and sometimes just mean – behavior. MDHS should have realized that the Bs could not safely care for children *years* before Brandon was placed in their home. Its failure not to come to this obvious conclusion violates:

- MDHS rules (Children’s Foster Care Manual 722-3) that require that before placing children in a foster home, all CPS and licensing complaints must be reviewed and factored into the decision to use the home.
- CWLA foster care standards that require that foster parents be reassessed “at least every two years” to assure compliance with the agencies requirements.⁶⁸
- COA standards that require that foster parents be reassessed annually to identify factors that may impact the ability of the foster parents to provide care and protection including personal characteristics, motivation for providing foster care, parenting skills, and the overall home environment.⁶⁹

MDHS virtually ignored the fact that the Bs went for extended periods without a source of income other than foster care payments. In addition to placing the foster children into an economically untenable situation, this – together with the Bs continuously inappropriate behavior toward children -- calls into question their motivation to be foster parents. This failure violates:

- MDHS licensing rules (R400.9201) that require that foster parents have a defined source of income adequate to meet the needs of the foster family.

⁶⁷ Child Welfare League of America (1999) *Standards of Excellence for Abused or Neglected Children and Their Families*, Washington D.C., §6.13.

⁶⁸ Child Welfare League of America (1995) *Standards of Excellence for Family Foster Care Services*, Washington DC

⁶⁹ Council On Accreditation (2006) *Eighth Edition Child Welfare Accreditation Standards*, New York, §§PA-FC 17.01-17.02.

Conclusion

Although the manner of Brandon's death was ruled undetermined by the medical examiner, it is almost certain that he suffocated when he rolled over onto some bedding, having been propped up and left unattended by his foster mother. This was part of a continuous pattern of substandard care that Brandon's foster parents provided to their foster children. It should have been clear to MDHS from the beginning that the Bs should not be foster parents; as early as 1980, Mr. B, already a substantiated child abuser, boasted to a MDHS worker that he controlled a child on his school bus by slapping him.

No children should have been placed in the Bs' care. Because of the medical examiner's finding, one cannot be certain that Brandon would have survived had MDHS not placed him in the dangerous foster home. It is, however, far more likely than not.

Conclusions

As is noted above, this review of child fatalities is not intended to be research. The sample is small and is far from being random or representative. Although the five cases considered are very different, some commonalities are clear. Many of the issues presented by the fatalities are predictable from the findings of the management review.

MDHS's CPS investigations reviewed are unstructured, superficial, and rarely gather sufficient information to permit an accurate determination about whether or not maltreatment has occurred. In all, the files identified 28 CPS complaints against six of the seven foster care providers. These do not include the investigations that involved the children's parents or the investigations into their deaths. Of the 28 complaints, MDHS unsubstantiated 18, substantiated 4, and in 6 cases the result was not found in the file. In 16 of the 22 complaints about which there was information in the file, there were serious omissions in the investigations. In eight of these investigations, the omissions are so serious that it is impossible to know what the reasonable finding should have been.

When there is enough investigation to make a judgment about the finding, MDHS investigators often make determinations that are not consistent with the facts. Six of the complaints that were unsubstantiated should have been substantiated. These serious deficiencies in CPS investigations have ominous implications for the safety of children in MDHS care. The inability to accurately identify abusive and neglectful foster parents guarantees that children will be placed in dangerous homes. The five children whose cases are reviewed above certainly were.

These deficiencies are consistent with the vague definitions of child abuse and neglect and the lack of specificity and prescription in MDHS's investigative procedures. They may also be related to the confusing and subjective category system MDHS uses to classify maltreatment determinations. MDHS should develop much more detailed definitions of child abuse and neglect and much more rigorous and prescriptive procedures for its CPS investigations.

Even when licensing violations or child maltreatment *are* identified in foster homes, MDHS continues to place children in them. Three of the five children were placed in homes where there had been a previously *substantiated* CPS complaint. When licensing violations were found, MDHS never took any concrete corrective action. Essentially, foster parents were told not to repeat their violation. When they did, nothing happened. Unenforced rules are no rules. MDHS's failure to enforce its licensing rules defeats the purpose of licensing. At least in part, this failure can be attributed to the way that responsibility is scattered around the organization. Although BCAL has licensing authority, the field has responsibility for actually licensing and maintaining foster homes. Staff in the field may be reluctant to enforce rules because they are dependent on the homes that they license.

Three of the children's foster care cases were managed by private Child Caring Agencies. The child welfare service provided by the agencies ranged from dangerously careless (BCS) to the outer reaches of incompetence (LBSC.) In no case did MDHS assert any oversight. Bad decisions, terrible foster homes, and abysmal practice were overlooked. Other than data entry, there does not appear to be any point to the work of the POS workers. MDHS should either use the headcount wasted on its POS monitors to create a genuine quality assurance system or redeploy the headcount to perform direct services in the field to reduce caseloads.

In only one case (Isaac's) was any caseload information available. Isaac's caseworker carried more than three times as many foster care cases as would be reasonable. His work on Isaac's case was about as bad as it could possibly be. Although there was no information available about the workloads of the other caseworkers or the CPS investigators involved in the cases reviewed, given the understaffing problems faced by MDHS, it is safe to assume that much of the poor performance is directly related to the agency's core problem of too few workers and too many cases. Even absent the many serious problems with the agency's structure, culture, regulation, and oversight, no child welfare agency can hope to keep kids safe unless it has adequate staffing to do so.

Combining the disturbing deficiencies in MDHS's performance in the five cases reviewed with the many serious shortcomings found in the agency's structure, regulation, practices, overall management and – especially – its staff resources, it is clear that children are far too likely to be no safer in foster care than they were with their abusive and neglectful parents.

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WORK EXPERIENCE

Independent Contractor: May 2003 - Date

- Develop procedures for investigation of child abuse and neglect allegations, for the provision of in-home protective services, and for foster care services for the Clark County, Nevada Division of Family Services Child Abuse Hotline. August 2007 to Date
- Develop operational child maltreatment definitions for the Nevada Division of Child and Family Services. February 2007 to Date.
- Develop intake procedures for the Clark County, Nevada Division of Family Services Child Abuse Hotline. February 2007 to Date
- Conduct an assessment of decision making at the Clark County, Nevada Division of Family Services Child Abuse Hotline. August 2006 to October 2006
- Expert witness for the plaintiff in state litigation Ray v. Washington University Children's Hospital. September 2007 to February 2008
- Expert witness for the defense in federal litigation Harris v. Lehigh County. October 2005 to Date
- Expert witness for the defense in federal litigation Tatar v. Armstrong County. August 2005 to Date
- Provide consultation to the Archdiocese of Chicago concerning the prevention of and response to clergy child abuse. March 2006 to Date
- Provide consultation and training concerning child protection to the New Jersey Division of Youth and Family Services. July to August 2005
- Provide hands on consultation to the Philadelphia Department of Human Services related to the redesign of its Child Protection System. July 2004 to March 2005

Juvenile Protective Association: May 2003 to December 2004

Provide hands on consultation to Family Services of Metro Orlando related to the design of the Child Protection System for the Orlando, Florida metropolitan area.

Act as an expert witness for the plaintiff in federal class action litigation concerning the safety of children in foster care in the Atlanta, Georgia metropolitan area. Principal investigator in two research reviews of child maltreatment in foster care.

Illinois Department of Children and Family Services: January 1975 to April 2003

- Deputy Director, Division of Child Protection. Direct and administer the Illinois child protective services system; manage a staff of approximately 1200 employees, a purchase of service budget of approximately \$25 million, and grants totaling approximately \$20 million. Responsible for public and private sector child protection investigations, in-home protective services, child welfare intake, and the emergency shelter system; work in close collaboration with major legal, medical, law enforcement, and social service agencies and institutions; participate in planning for changes in state legislation and policy related to child welfare; participate on committees, work groups and advisory boards at the local state, and national levels; frequent contact with media; frequent public speaking. December 2001 to May 2003.
- Associate Deputy Director, Cook County Child Protection. Direct and administer the Cook County, Illinois child protective services system; manage a staff of approximately 700 employees and a purchase of service budget of approximately \$12 million. Responsible for child protection investigations, in-home protective services, family preservation, family reunification, child welfare intake, and the emergency shelter system; work in close collaboration with major legal, medical, law enforcement, and social service agencies and institutions; participate in planning for changes in state legislation and policy related to child welfare; participate on committees, work groups and advisory boards at the local, state, and national levels; frequent contact with media; frequent public speaking. June 1986 to November 2001
- Assistant Child Protection Administrator. Directed staff of 90 employees engaged in the investigation and assessment of child abuse and neglect reports; responsible for the investigation of all sexual abuse reports in Cook County. September 1984 to May 1986.
- Child Welfare Supervisor. Developed and implemented plans for the establishment of specialized units that investigate reports of child sexual abuse, take legal or other action to protect victims from further abuse, and arrange or provide social services as needed. February 1982 to August 1984.

Developed and implemented plans for the establishment of a unit that reviewed completed child abuse and neglect investigations, assigned them to follow-up teams for service provision, and initiated payment to foster parents and other service providers; acted as the liaison between the investigative and Follow-up divisions in Cook County. June 1981 to January 1982.

Supervised nine caseworkers who investigated reports of child abuse and neglect, took necessary protective action, and arranged or provided social services; responsible for the northeast quarter of Chicago. September 1980 to May 1981.

- Assistant Supervisor. Monitored five contracts with private social service agencies that provided case management and in-home protective services to abused and neglected children and their families. July 1979 to August 1980.
- Caseworker. Investigated reports of child abuse and neglect; took protective action; arranged or provided social services. December 1978 to June 1979.

Provided a wide range of social and other services to abused, neglected, dependent, status offending, and delinquent children living in substitute care or with their families in inner city Chicago. January 1975 to November 1978.

Illinois Bureau of Employment Security: October 1972 to December 1974.

Interviewed and counseled applicants for employment; referred to job vacancies and training programs; ran a highly successful summer employment program for disadvantaged youth.

United States Naval Air Reserve. May 1971 to May 1977 (active duty May 1971 to August 1971).

OTHER CURRENT PROFESSIONAL ACTIVITIES

Chicago Children's Advocacy Center

Member: Board of Directors. Oversee the work of the process for the law enforcement/child welfare investigation of all sexual and serious physical child abuse cases in Chicago, Illinois. Chair Program and Strategic Planning Committees.

Cook County Child Fatality Review Team

Member. Participate in the review of circumstance surrounding the deaths of Cook County, Illinois children. Make recommendations for systemic change in the child welfare and other systems to prevent future deaths.

EDUCATION

University of Chicago School of Social Service Administration. Master of Arts degree in Service Administration (Social Work) June 2001.

Loyola University School of Social Work. Attended MSW program January 1979 to March 1981.

DePauw University. Bachelor's of Arts degree in political science. Graduated May 1971.