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BILL ANALYSIS



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Senate Bills 226 and 228 (as enacted)
Senate Bill 229 (as enacted)
House Bills 4385 and 4387 (as enacted)
Sponsor: Senator Mark C. Jansen (S.B. 226)
Senator Judy K. Emmons (S.B. 228)
Senator Mike Nofs (S.B. 229)
Representative Margaret O'Brien (H.B. 4385)
Representative Thomas Hooker (H.B. 4387)
Senate Committee: Families, Seniors, and Human Services
House Committee: Families, Children, and Seniors

PUBLIC ACTS 69 & 70 of 2011
PUBLIC ACT 89 of 2011
PUBLIC ACTS 67 & 68 of 2011

Date Completed: 8-15-11

RATIONALE

In recent years, partly as a result of several high-profile cases, there have been heightened concerns about the death of children in State care, including children in foster care, children under court jurisdiction, and children who died following contact with the Office of Child Protective Services (CPS) in the Department of Human Services (DHS). The exact extent of the problem is not known, however. One source of information is the Office of Children's Ombudsman, which has the authority to investigate the death of children who are under the supervision of the DHS or its private contracted agencies. According to its 2008-2009 Annual Report, the Office of Children's Ombudsman completed investigations of 58 cases in which a child died in fiscal year 2008-09. The report indicated that 15 children died in parental care during an active investigation or an open CPS case, three children died in foster care, and 96% of the investigations involved a child or siblings whose family had prior contact with CPS. In addition to the Children's Ombudsman, various other agencies report child fatalities in Michigan, using different counting standards and formats. As a result, there have been no uniform statistics regarding children who died in State care in a given year.

The lack of consistent information has been seen as a key obstacle to preventing additional deaths of children under State care. The absence of the judiciary from the child death review process also has been considered problematic. Evidently, investigations have rarely included representatives of the judicial branch, and the courts have been unable to obtain confidential information about a child from the DHS after the child died. Some suggested the enactment of various measures to enhance information-sharing among the responsible entities, increase State review of child deaths, and increase the involvement of the judiciary.

CONTENT

Senate Bill 226 amended the Child Protection Law (CPL) to require the Department of Human Services to establish and maintain a publicly accessible registry of statistical information regarding children's deaths.

Senate Bill 228 amended the CPL to make certain information available to a court that had jurisdiction over a child in a suspected abuse or neglect case, in the event of the child's death.

House Bill 4385 amended the CPL to require the DHS, if a child dies while under the court's jurisdiction in a suspected abuse or neglect case, to notify the court, the State legislators representing the district in which the court is located, and the Children's Ombudsman. The bill also requires the DHS to notify the Ombudsman within one business day when a child dies during an active Child Protective Services investigation or an open CPS case, if there were previous complaints about the child's caretaker, or if the death might have resulted from abuse or neglect.

House Bill 4387 amended the CPL to do the following:

- Require a child fatality review team and the advisory committee created under the Law to include a representative of a State or local court.
- Require the citizen review panel to review each child fatality involving allegations of abuse or neglect for each child who, at the time of death or within the prior year, was under the family court's jurisdiction in an abuse or neglect case.
- Require the advisory committee to transmit its annual report of child fatalities to the DHS, and require the Department to ensure the publication of the report between 30 and 60 days after the advisory committee transmits it.

Senate Bill 229 amended the CPL to re-enact the amendments made by House Bill 4387.

All of the bills except Senate Bill 229 took effect on June 28, 2011. Senate Bill 229 took effect on July 15, 2011.

Senate Bill 226

The bill requires the DHS to establish and maintain a registry of statistical information regarding children's deaths that is accessible to the public.

The registry may not disclose any identifying information and may only include statistical information covering all of the following:

- The number of children who died while under court jurisdiction for child abuse or neglect regardless of placement setting.
- The number of children who died as a result of child abuse or neglect after a parent had one or more CPS complaints within the two years before the child's death and the category dispositions of those complaints.
- The total number of children who died under the above conditions in the preceding year.
- The CPS disposition of the child fatality.

Senate Bill 228

A written report, document, or photograph filed with the DHS under the CPL is a confidential record available only to certain government agencies, law enforcement officials, and other specified entities, including a court that determines the information is necessary to decide an issue before the court.

The bill also makes the information available to a court that had jurisdiction over a child under Section 2(b) of the juvenile code, in the event of the child's death.

(Section 2(b) of the juvenile code grants the family court jurisdiction in proceedings involving a juvenile under the age of 18 whose parent or legal guardian neglects to provide proper or necessary support, education, medical, surgical or other necessary care; who is subject to a substantial risk of harm to his or her mental well-being; who is abandoned by his or her parents or guardian; or who is without proper custody or guardianship. The court also has jurisdiction over a juvenile whose home or environment is an unfit place to live in because of a parent's or guardian's neglect, cruelty, drunkenness, criminality, or depravity; or whose parent has substantially failed, without good cause, to comply with a limited guardianship plan or a court-structured plan.)

House Bill 4385

Under the bill, if a child who is under the family court's jurisdiction under Section 2(b) of the juvenile code dies, the DHS must give written or electronic notice within one business day to the court that had jurisdiction over the child at the time of his or her death, the State Senator and State

Representative representing the district in which the court is located, and the Children's Ombudsman.

In addition, the DHS must notify the Ombudsman within one business day when a child dies and any of the following apply:

- The child died during an active CPS investigation or an open CPS case.
- The DHS received a prior CPS complaint concerning the child's caretaker.
- The death may have resulted from child abuse or neglect.

Senate Bill 229 & House Bill 4387

The CPL requires each county to have a standing child fatality review team, although two or more counties may appoint a single review team for those counties. The Law also requires the DHS to establish a multi-agency, multidisciplinary advisory committee to identify and make recommendations on policy and statutory changes pertaining to child fatalities and to guide statewide prevention, education, and training efforts.

The bills require a review team to include a representative of the local court, and require the advisory committee to include a representative of a State or local court.

The CPL requires the advisory committee to prepare an annual report on child fatalities, using an annual compilation of child fatalities reported by the State Registrar under the Public Health Code and data received from the child fatality review teams. The report must include information specified in the Law, and the DHS must transmit it to the Governor and the legislative committees with jurisdiction over child protection matters. Under the bills, beginning December 31, 2012, the advisory committee must write an annual report on child fatalities reviewed during the previous year, using the information already specified in the CPL as well as data received from the citizen review panel.

The bills require the advisory committee to transmit the final report to the DHS by December 31 of each year. The DHS must ensure publication of the report not less than 30 or more than 60 days after the advisory committee transmits it to the DHS.

In addition, the bills require the citizen review panel to review each child fatality involving allegations of child abuse or neglect for each child who, at the time of death or within the preceding 12 months, was under the jurisdiction of the family court in an abuse or neglect case.

(The CPL defines "citizen review panel" (CRP) as a panel established as required by the Federal Child Abuse Prevention and Treatment Act. Pursuant to Federal law, Michigan has a Child Death CRP, a Prevention CRP, and a Child Protective Services, Foster Care, and Adoption CRP.)

MCL 722.627b (S.B. 226)
722.627 (S.B. 228)
722.627b (S.B. 229)
722.627k (H.B. 4385)
722.627b (H.B. 4387)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

This package of legislation will improve Michigan's child protection system by advancing the practice of information-sharing, breaking down the silos within the system, and increasing the judiciary's role in the child death review process. By enabling public officials to identify systemic problems that might be contributing factors in child deaths, the bills ultimately may prevent the death of additional children under State care.

Without a comprehensive, uniform source of information on child fatalities, the State has not had cohesive data on what was happening and why children were dying in State care. Child deaths are reported by at least five agencies: the DHS, the Department of Community Health, the child death review team program, the Children's Ombudsman, and a national project called Kids Count. The data collected by these agencies are not widely available to all and can be inconsistent, because the respective entities may use differing methodologies or have access to varying sets of information. As a result, their statistics do not match, and a comparison of their figures does not give a clear picture of how many children have died in State care in a given year.

Senate Bill 226 addresses this problem by requiring the DHS to create a registry of statistical information about children who die while under court jurisdiction for abuse or neglect or as a result of abuse or neglect after CPS complaints. The availability of one central registry should help to remove institutional barriers between the different agencies involved, reducing the isolation of information within the various entities. In addition, because the registry of nonidentifying information will be publicly available, policy-makers and others interested in child safety will be able to perform accurate research and contribute to the discussion of how to prevent child deaths.

House Bill 4385 also will advance the sharing of information on child fatalities. Although the Children's Ombudsman has statutory authority to review child deaths and recommend improvements, the DHS was not previously required to notify the Ombudsman when a child died in State care. The bill requires the Department to notify not only the Ombudsman but also the court that had jurisdiction over a child when he or she died and the legislators whose districts include the court. Since each of these parties sees the system from a different angle, it is important that they all work together.

Supporting Argument

Senate Bills 228 and 229 and House Bill 4387 address the absence of the judiciary from the child death review process. It appears that there have been few court representatives on State and local child death review teams, and the teams did not ordinarily obtain court records as part of their investigation. In reaction to this situation, the Court Child Death Review Team was formed in December 2007 to investigate the case of any foster child who died while under court jurisdiction. The DHS, however, has the bulk of information needed to conduct a comprehensive review, and the court's team was unable to obtain information that the Department considered confidential. Under the law, a court has access to information about a child if a case involving the child is before the court. If the child dies, however, the case is no longer before the court.

Under Senate Bill 228, the DHS is required to make case-specific information available

to a court that had jurisdiction over an abused or neglected child who died. This will give the court valuable insight into a child's death, and help build a bridge between the judiciary and the child death review system. At the same time, Senate Bill 229 and House Bill 4387 will add a judicial perspective to the work of other review entities, by requiring a representative of the court to be included on county child fatality review teams and the DHS advisory committee on child fatalities. The bills also mandate State review of the death of any abused or neglected child who was under the court's jurisdiction, rather than leaving review discretionary. Together, these bills will advance the goal of involving the judiciary in every aspect of child death review.

Legislative Analyst: Suzanne Lowe

FISCAL IMPACT

According to the Department of Human Services, data that will be used in the registry mandated by Senate Bill 226 are already collected by the child fatality review teams and made available to the Legislature. The bill will likely lead to a small, indeterminate increase in administrative cost to the Department associated with modifying available information for use in a registry and modifying the Department's internet home page to meet the requirements of the bill.

The remaining bills will have no fiscal impact on State or local government.

Fiscal Analyst: Frances Carley

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.