

**Michigan Senate
Families & Human Services Committee
Remarks of Justice Maura D. Corrigan
March 10, 2009**

Good afternoon, Senators Jansen, Hardiman and Jacobs. Thank you for this opportunity to address you regarding Senate Bills 257 through 261.

I am the Michigan Supreme Court Justice who is assigned to matters of child welfare and child support. In my remarks here today, I am not speaking for the whole Court, but as a concerned public official in the capacity of the Court's liaison on child welfare. I thank our talented child welfare staff, the Permanency Options Workgroup, and your own staff members for their work on this package. I also note that HB 4125, introduced by Representative Spade, contains similar provisions to SB 258. I hope some combination might emerge from both houses' consideration.

President Dwight D. Eisenhower once said, "There is no tragedy in life like the death of a child." During my judicial career, no issue has troubled me more than the tragedy of children who die in our state's care. When I speak of children in state care, I am referring not only to children who die in foster care, but also to children who die after being under court jurisdiction, or following any type of contact with child protective services.

These tragedies are compounded because we believe that many of these deaths could have been prevented. Not only have we failed to stop them, we can't even obtain cohesive data on what is happening and why. And the information we have isn't necessarily being shared among the various entities that are responsible for monitoring the problem.

Given these circumstances, I am delighted to tell you Senate Bills 257 through 261 would advance the sound administration of justice by improving our system of child protection. This legislation will help break down the silos that divide our child protection system, will advance the practice of information sharing, and will bring the Judiciary to the child death review table in cases for which we bear joint responsibility. Importantly, provisions of 261 would mandate state review of every death in child protection instead of the current statutory scheme of discretionary review at the state level.

What we need, first of all, is a single comprehensive source of information on child deaths. Senate Bill 257 will provide this by creating a Central Registry concerning children who have died in foster care, children who have died while under court

jurisdiction for abuse or neglect, and children who have died after contact with child protective services.

Currently, five agencies report child deaths in Michigan:

- (1) the Department of Community Health
- (2) the Child Death Review Team Program
- (3) the Department of Human Services
- (4) the Children's Ombudsman, and
- (5) a national project called Kids Count

They use different counting standards and different formats. For this reason, their statistics don't match, and a comparison of their figures doesn't provide a clear conclusion on how many children have died in state care in a given year.

A Central Registry will solve this problem. Furthermore, by making the information accessible to the public, SB 257 will permit policy makers and other interested persons to perform accurate research and contribute to the critical discussion of what we can do to prevent child deaths. This increased scrutiny will lead to much-needed improvements in our child protection system. The bill also addresses the concern of confidentiality, by excluding from the registry any identifying information about a child or an adult involved in the investigation. This will protect the privacy of children, their siblings and other family members.

Senate Bill 258 offers a huge step forward in the sharing of information on child deaths. Although the Children's Ombudsman has statutory authority to review child deaths and recommend improvements, DHS is not required to notify the Ombudsman when a child has died in state care. The Ombudsman often must rely on the media to learn about such cases, and the same thing may be said about the courts. This lack of communication is particularly troubling when you consider that the Department of Human Services, the Ombudsman, and the courts have concurrent responsibility for children who have been entrusted to the care of the state. SB 258 would require DHS to immediately notify the presiding court, the Ombudsman, and the Legislature, when a child has died while under court jurisdiction, and to provide written notification within 24 hours. Since the Department, the Ombudsman, and the court each see different angles or separate pieces of a larger system, it is essential that they begin working together. SB 258 will begin that process, and is an important step in the right direction. HB 4125, introduced by Representative Spade, requires notice but it has no immediacy provision, and only requires notice to the Ombudsman.

The requirement of notice to the Legislature leads into Senate Bill 259, which would create an office of Child Fatality Investigator within the legislative branch of our government.

Michigan currently has five avenues of investigation that may be consulted for reviewing the death of a child in state care. They are:

- (1) the Office of Child Protective Services within DHS;
- (2) the Children's Ombudsman;
- (3) the various local child death review teams;
- (4) the Legislature; and
- (5) the DHS Office of the Family Advocate.

Just as we need a single source of information, we also need something to tie all these investigations together. A legislative Child Fatality Investigator could fulfill this role and examine the entire picture of children dying while in the care of the state. It will enhance accountability to you, the people charged with making our laws. I believe that an investigator responsible to you will be akin to the legislative Auditor General – assurance of integrity and accountability. We need someone who has the freedom to say whatever needs to be said and recommend whatever needs to be done to protect our children. I wholeheartedly endorse the creation of a Child Fatality Investigator within the Legislative Council.

Senate Bills 260 and 261 deal with a disturbing gap in the child death review system, and that is the complete absence of the Judiciary from the process. As far as I know, there are few court representatives on state and local child death review teams, and these teams do not ordinarily obtain court records as part of their examination. In December 2007, as a reaction to this problem, we established a Court Child Death Review Team. Its mission was to investigate the case of any foster child who died while under court jurisdiction. Early on, the Team encountered the obstacle that DHS thinks it is unlawful for the agency to share its information with the court that was presiding over the deceased child's case. Typically, the DHS file has the bulk of the information necessary to conduct a comprehensive review.

SB 260 directs DHS to allow a court that has jurisdiction over a child who dies access to all the information the Department has pertaining to that child. This will permit the Department to share case-specific information, add profitable insight to the court child death review report, and begin building a bridge between the Judiciary and the child death review system.

While SB 260 opens the door to a thorough investigation of the court case, SB 261 will add a judicial perspective to the work of other review committees. This bill provides that county child death review teams must include "a representative of the local court" and that a state or local court representative must sit on the DHS Advisory Committee that recommends changes in child death policy and legislation. The bill also directs the Advisory Committee to review the death of any child who was or previously had been under court jurisdiction. Senate Bills 260 and 261 laudably advance the goal of involving the Judiciary in every aspect of child death review.

I want to commend the Michigan Senate and this Committee for taking on this important and very difficult issue. As a representative of the Judicial Branch, I can assure you that we are committed to reviewing every child death that has occurred during or after an exercise of court jurisdiction. As a mother, I can tell you that my heart aches with the death of any child. I applaud your efforts to tackle these serious issues. The ultimate goal of child death review is prevention. A child's death is preventable if the community, or any individual, reasonably could have done something to change the circumstances that led to the death.

I am convinced that the changes proposed in the five-bill package being considered by this Committee will strengthen the child death review system and will help save the lives of children who are in the care of the state.

Thank you for your attention!