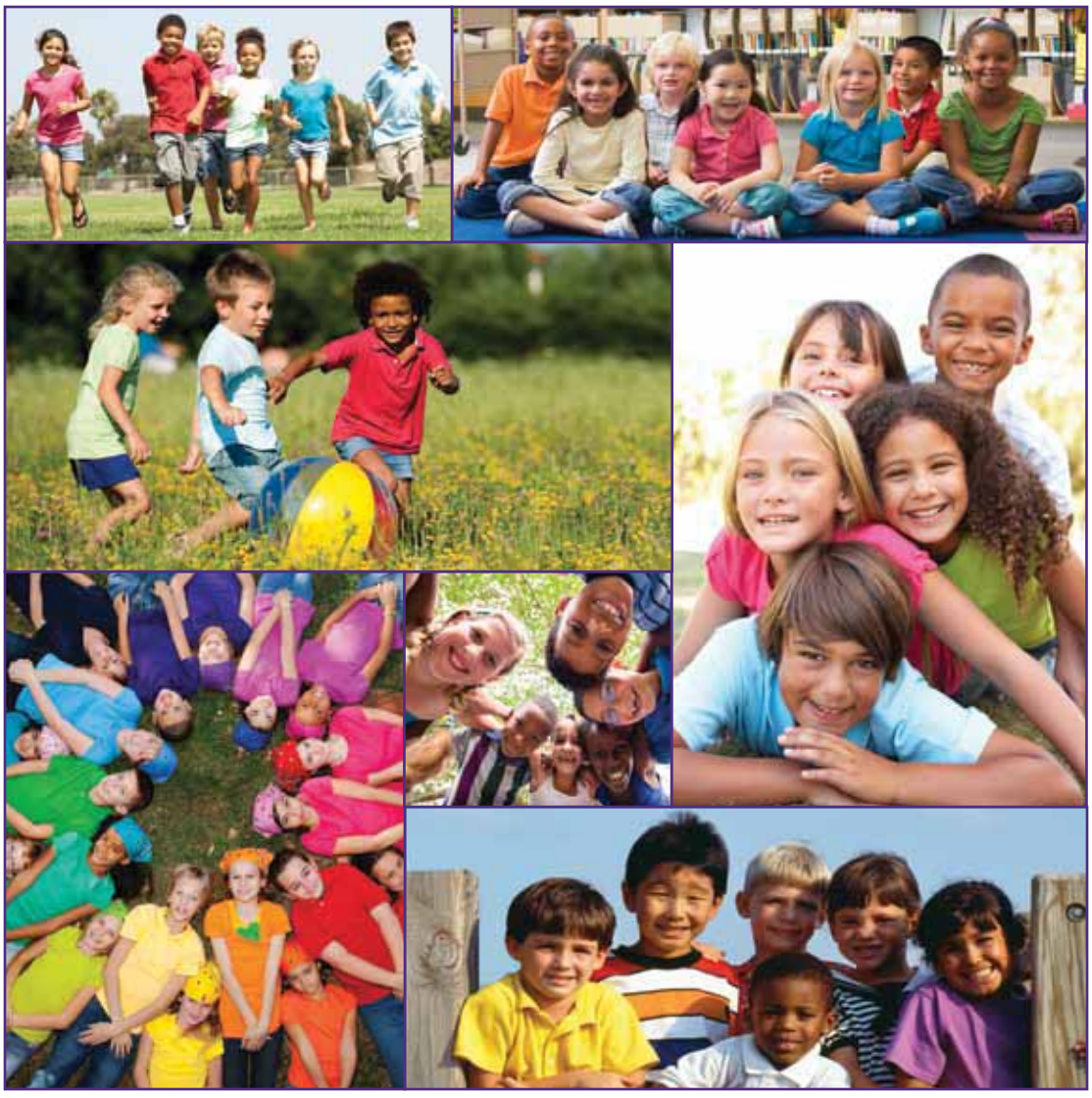
State of Michigan

Office of Children's Ombudsman



Annual Report • 2012-2013

Mission Statement

The mission of the OCO is to assure the safety and well-being of Michigan's children in need of protective services, foster care, adoption services, and juvenile justice and to promote public confidence in the child welfare system. This will be accomplished through independently investigating complaints, advocating for children, and recommending changes to improve law, policy and practice for the benefit of current and future generations.

Vision Statement

The OCO strives to be a part of the solution that fosters greater accountability and transparency for Michigan's child welfare system.

STATE OF MICHIGAN
OFFICE OF CHILDREN'S OMBUDSMAN
LANSING

RICK SNYDER
GOVERNOR

VERLIE M. RUFFIN
DIRECTOR

May 2014

The Honorable Rick Snyder, Governor
Honorable Members of the Michigan Legislature
Ms. Maura Corrigan, Director, Michigan Department of Human Services

In accordance with my statutory responsibility as the Acting Director of the Office of Children's Ombudsman, I respectfully submit the Office of Children's Ombudsman Fiscal Year 2013 Annual Report.

This report provides an overview of the activities of the Office of Children's Ombudsman from October 1, 2012 to September 30, 2013 and our role in Michigan's child welfare system. This report includes information about the complaints received, our protecting interventions and an analysis of our investigations. In addition there are six recommendations derived from case investigations.

We remain committed to our mission and vision that focus on changes in the child welfare system to improve outcomes for children and their families. This report was prepared in part during the tenure of the director and children's ombudsman in office at the time of the reporting period, Verlie M. Ruffin.

The dedicated staff of the Office of Children's Ombudsman appreciates the opportunity and privilege to serve the children of Michigan.

Respectfully,

Charlotte J. Smith, Acting Director
and Acting Children's Ombudsman

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MESSAGE FROM THE CHILDREN'S OMBUDSMAN

The 2013 Fiscal Year marks the nineteenth annual report produced by the Office of Children's Ombudsman (OCO). Our hope is that this report offers a clear and informative description of the work we do for vulnerable children and their families who are the focus of our investigations and interventions.

During FY 2013, the OCO experienced a 14 percent increase in contacts over FY 2012 (for the second year in a row) including both citizen complaints and child death notifications. Although the resources available to handle the continued influx of complaints presented new challenges to overcome, our dedication to do the best job possible for children and the people concerned about their safety and well-being remains the same. As the number of contacts has increased, so has awareness of the OCO as a resource for citizens who seek information about the child welfare system and those who desire an independent, confidential review of their concerns.

The results of investigations during the fiscal year focused primarily on the actions and decisions of children's protective services (CPS) staff. As has been the case for more than a dozen years, compliance with current Department of Human Services (DHS) policies continues to be the basis for the vast majority of the violations we identify. Each of the six recommendations included in this annual report focus on policies and laws governing CPS case handling. The six recommendations that we believe will help make the child welfare system better for children are on the topics of unsafe sleep, medical marijuana, substance abuse, improving compliance with medical policies, forensic interviews, and petitions.

The number of child death cases opened for investigation increased slightly, commensurate with the slight increase in the number of alerts received from DHS. Our completed child death case investigations for the fiscal year also identified the need for CPS workers to adhere to already-existing policies.

We are aware that the duties and responsibilities of DHS and private child-placing agency staff to ensure the safety and well-being of children is challenging and at times overwhelming, and we appreciate the hard work and patience of those on the front lines. As a partner in the child welfare system, the OCO is proud to do its part by recommending solutions that hopefully increase the effectiveness of agency staff, and also foster accountability and increase transparency for the public we all serve. Our goal is to continue to make a positive, lasting impact on the system that will benefit children and families for years to come.

Charlotte J. Smith
Acting Director and Acting Children's Ombudsman

EXECUTIVE SUMMARY

The Office of Children's Ombudsman (OCO) was established as an autonomous agency by the Michigan Legislature in 1994 to provide greater accountability and transparency to Michigan's child welfare system. Legislators were concerned that confidentiality laws governing child welfare also served to protect the system from outside scrutiny and accountability. The OCO provides citizens with the means to obtain an impartial and independent investigation of a child's case under the supervision of the Department of Human Services (DHS) involving protective services, foster care, adoption services, or juvenile justice.

The Children's Ombudsman Act authorizes the ombudsman to obtain confidential records regarding a child's case from DHS and other entities, including documents in the possession of private child-placing agencies. OCO records are confidential and are not subject to court subpoena or discoverable in a legal proceeding, and are exempt from disclosure under the Freedom of Information Act.

This report consists of six sections: Complaints and Contacts, Protecting Interventions, Investigations, Investigation Results-Complainant Cases, Investigation Results-Child Death Cases, and Recommendations and DHS Responses.

AUTHORITY

The OCO has the authority and responsibility to: receive complaints about children involved with children's protective services, foster care, adoption services, or juvenile justice; review DHS policies and procedures via investigations; immediately intervene by protecting the rights and welfare of abused and neglected children; and make recommendations for improving Michigan's child welfare system.

Consistent with the Children's Ombudsman Act and mission and vision of the office, the OCO:

- **Responded to citizen complaints.** The OCO responded to **1,548** complaints, questions and concerns regarding **1,668** children from **80** of Michigan's **83** counties. Every attempt is made to answer questions and provide referral information that may help resolve citizen concerns.

- **Conducted independent investigations.** The OCO completed **153** investigations of **57** agencies involving **407** children from **46** of Michigan's **83** counties.

- **Immediately intervened.** In situations where the OCO became aware that an immediate review of a child's situation by DHS was warranted, a Request for Action or Request for Administrative Response was submitted to DHS. This fiscal year the OCO issued **4** Requests for Action and **13** Requests for Administrative Response.

- **Made recommendations to improve the child welfare system**. The OCO issued **238** recommendations from individual case investigations addressing compliance with state laws and policies, and that addressed problematic decisions affecting individual children. The OCO summarized six of these recommendations for this annual report.

2013 Amendments to the Children's Ombudsman Act

Public Act 38 of 2013, effective June 4, 2013, amended the Children's Ombudsman Act by expanding OCO authority, clarifying language, and codifying existing procedures. The amended sections are summarized below.

- The reference to the OCO reviewing a "departmental death review team study" regarding a child's death was removed and replaced with clearer language. The new language clarifies the OCO's authority to investigate cases involving "a child who may have died as a result of suspected child abuse or child neglect." The OCO has been investigating agency actions in child death cases since 2008.

- Remaining references to investigating adoption attorneys was removed. Investigations of adoption attorneys by the OCO were deemed unconstitutional many years ago. Only the State Court Administrative Office, the administrative arm of the Michigan Supreme Court and/or the Attorney Grievance Commission has the legal authority to investigate attorneys.

- References to OCO access to several specific DHS child welfare computer networks and systems were removed and replaced with more general language. This change ensures continued access to child welfare computer networks as they are renamed or replaced with new technology.

- The OCO is prohibited from releasing the results of its investigation to anyone if there is an ongoing criminal investigation. Prior to the amendments, the OCO could not share information with a prosecuting attorney in order to find out if the OCO's results would interfere with the criminal case. Amended language allows the OCO to share investigation results with a prosecuting attorney so that the prosecutor can make an informed decision about whether the results would interfere with the criminal case. In addition, the amended language requires that the OCO receive notice from the prosecutor prior to releasing the investigation results to a complainant.

OFFICE OPERATIONS

2012 Performance Audit Update

As of the publication date of this annual report, the OCO has partially complied with the three 2012 performance audit findings.

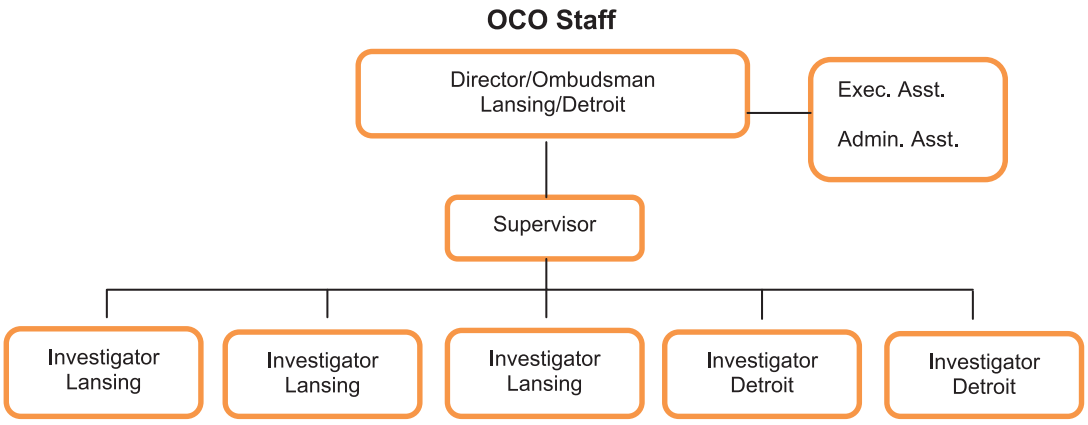
Compliance with the material finding regarding access to the DHS Michigan Statewide Child Welfare Information System (MiSACWIS) is still in process. The MiSACWIS system was scheduled to roll out late last fall; however, because of programming problems, access to all agencies, including DHS, the OCO and others outside of DHS has been delayed until the spring of 2014. OCO has been kept informed of the progress toward completing the system and OCO staff will soon be trained on its use.

The two reportable findings, timeliness of completing investigations and follow-up with DHS have been fully addressed. Regarding timeliness, the OCO now has a computer database case management system for use by the investigators to track the time it takes to complete specific investigation tasks. This tracking system will provide information for management that will be useful in identifying timeliness issues that need to be addressed and remedied. In addition, the OCO's budget was increased for FY 2014 to allow for the hiring of several staff.

Lastly, the OCO and DHS have created and are using a follow-up process whereby DHS provides documented proof that the agency took the action it agreed to take as recommended by the OCO. The Memorandum of Understanding between OCO and DHS was revised to reflect this process.

Budget and Expenditures

The OCO is an independent state agency housed administratively within the Department of Technology, Management and Budget. Appropriations for Fiscal Year 2013 were $1,194,000, allocated from the state general fund. Eighty percent of budget expenditures were for personnel and the remainder for facilities and support services. OCO staff for the fiscal year included: the director/ombudsman; five investigators; one supervisor, and two administrative staff. The OCO maintains offices in Lansing and Detroit.



Multi-Disciplinary Investigative Team and Support Staff

OCO investigators have professional experience in the areas of children's protective services, foster care, foster home licensing, and law. One investigator is assigned to each case and is responsible for conducting interviews with agency staff and collateral sources and analyzing case file documents to determine if applicable laws, DHS policies and procedures were followed. Prior to completion of all affirmation and administrative closing cases, two additional investigators analyze a background summary and review the findings and the conclusions reached by the assigned investigator. Reports of Findings and Recommendations are the result of review, input and discussion by the entire investigative team. All closing letters and reports are edited and prepared for release to agencies and complainants by the support staff.

- *Brooke Brantley-Gilbert*, Investigator, former CPS worker, 13 years at OCO
- *Paula Cunningham*, Investigator, former foster care supervisor, 3 years at OCO
- *Carolyn Hankamp*, Executive Assistant, 15 years at OCO
- *Tiffany Jackson*, Investigator, former CPS worker, 3 years at OCO
- *Brenda Konieczki*, Investigator, former foster home licensing worker and adoption specialist, 14 years at OCO
- *Tobin Miller*, Investigator, licensed attorney and legal specialist, 4 years at OCO
- *Melonie Sheneman*, Administrative Assistant, 14 years at OCO
- *Charlotte Smith*, Supervisor (during FY2013), 17 years at OCO

Collaboration and Outreach
Throughout the fiscal year, OCO staff periodically consults with the DHS Office of Family Advocate and DHS policy and administrative staff to discuss cases, agency policies, practices and programs. OCO staff also reviewed proposed changes to DHS policies related to CPS and foster care.

In October 2012, the OCO supervisor and acting director of the DHS Office of Family Advocate gave a joint presentation at the University of Michigan 31st Annual Child Abuse and Neglect Conference about the agency's respective roles in the child welfare system.

The OCO director and investigators served on workgroups, and committees responsible for reviewing various aspects of child welfare such as: DHS Michigan Statewide Automated Child Welfare Information System (MiSACWIS) project, Statewide Adoption Oversight Committee, Michigan Advisory Committee on the Over Representation of Children of Color in Child Welfare, Michigan Child Death Statewide Advisory Team, Michigan Child Welfare Improvement Task Force, Court Improvement Program Advisory Committee, and the DHS Safe Sleep Advisory Committee.

Continuing Learning Opportunities
Attending conferences and workshops allows OCO staff the opportunity to stay up to date and knowledgeable about child welfare issues and connect with other entities involved in child welfare. OCO staff attended conferences sponsored by DHS, the State Court Administrative Office Child Welfare Services, Governor's Task Force on Children's Justice, and the U.S. Ombudsman Association.

COMPLAINTS AND CONTACTS

Overview

Source of Complaints and Contacts

Educating the Public

- Inquiries
- Referrals

Valid Complaints

- Valid Complaints Not Opened for Investigation
- Valid Complaints Opened for Investigation

Child Death Alerts

Most Frequently Identified Complaint Issues

- Most Common Intake Topics
  - CPS
  - Placement and Replacement of Children

"The ombudsman shall establish procedures for receiving and processing complaints…" and serve as a means of "…educating the public…"

Children's Ombudsman Act Sections 4 and 3

OVERVIEW

The primary function of the OCO is to receive and respond to complaints about children involved in Michigan's child welfare system as a result of children's protective services (CPS), foster care, adoption services, or juvenile justice.

Anyone may file a complaint with the OCO. Citizens who contact the OCO have varying degrees of understanding about Michigan's child welfare system. One of the functions of the OCO intake process is to provide complainants with detailed information about laws and policies related to their specific concerns. In addition, the OCO provides helpful referral information or responds to questions from citizens who do not have a complaint but rely on the OCO for assistance when they are unsure whom to contact to resolve their concern or obtain an answer to a question.

Number of Complaints and Contacts Per Fiscal Year

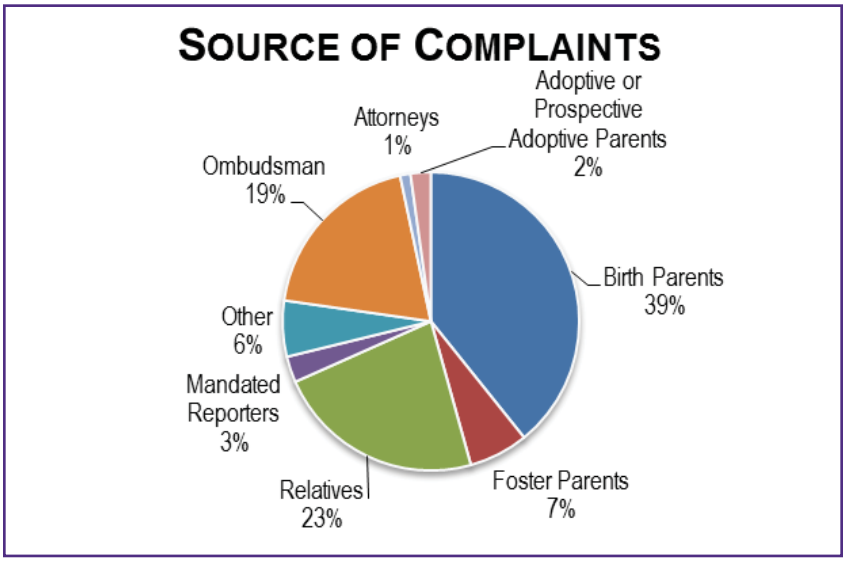
2010	2011	2012	2013
999*	1,152	1,335	1,548

*Closed new intakes were counted differently and not included in this total for FY 2010.

An attempt is made to conduct an intake (usually via phone call for only valid complaints) with everyone who contacts the office. Intakes are a means to gather detailed information in order to determine whether to intervene or conduct an investigation. When a complainant cannot be reached to complete the intake, the complaint is archived in the OCO's database as a "closed new intake." If the complainant contacts the OCO again, an intake is completed. There were **168** closed new intakes this fiscal year.

SOURCE OF COMPLAINTS AND CONTACTS

A complaint may be filed by contacting the office via telephone, mail, fax, email, or electronic complaint form accessible on the OCO website at www.michigan.gov/oco. The identity of complainants is kept confidential unless permission is given to disclose their identity in situations when doing so would be helpful in expediting a resolution to their concern.



The **1,548** complaints and contacts received this fiscal year involved **1,668** children in **80** of Michigan's **83** counties. The top three complaint sources were birth parents **(39%)**, relatives of the child **(23%)**, and the ombudsman **(19%)**. The ombudsman is listed as a complainant for all child death alerts and may also be listed for non-child death cases.

COMPLAINTS AND CONTACTS

All complaints and contacts are divided into four main categories: inquiries, referrals, valid complaints and child death alerts.

EDUCATING THE PUBLIC

Educating the public about how the child welfare system works is a statutory duty of the office and an essential component of system accountability. Citizens who are informed about the relevant laws and policies that govern practice are better able to navigate the system and advocate knowledgeably and effectively for themselves and the child. Two categories of contacts that focus solely on educating the public and providing information are:

- *Inquiries*: Issues that are about the child welfare system but not a specific child, such as how to become a licensed foster parent, adoption questions, complaints from other states about a child not in Michigan's child welfare system, or requests for information. In addition, inquiries include complaints involving child-related issues that the OCO does not have jurisdiction to investigate, such as child custody matters, cash assistance or school concerns. This fiscal year, the OCO received **222** inquiries.

- *Referrals*: Concerns about a child involved in the child welfare system (CPS, foster care, adoption services, or juvenile justice) but may involve actions of an entity or person the OCO is not authorized to investigate, such as the court, law enforcement or an attorney. Other complaints that are considered referrals include situations where parents request OCO's assistance in the restoration of their parental rights; foster parents who have not received payment; adoption subsidy denials; or complaints about alleged unprofessional conduct of a caseworker. The OCO referred **683** complainants to other agencies or provided helpful information to complainants this fiscal year.

VALID COMPLAINTS

A valid complaint is a concern about a child or children involved in Michigan's child welfare system and one or both of the following:

- DHS or a private child-placing agency may have violated state or federal laws, state rules, and/or DHS policies; or
- An alleged decision or action by DHS or a private child-placing agency was harmful to a child's safety, health or well-being.

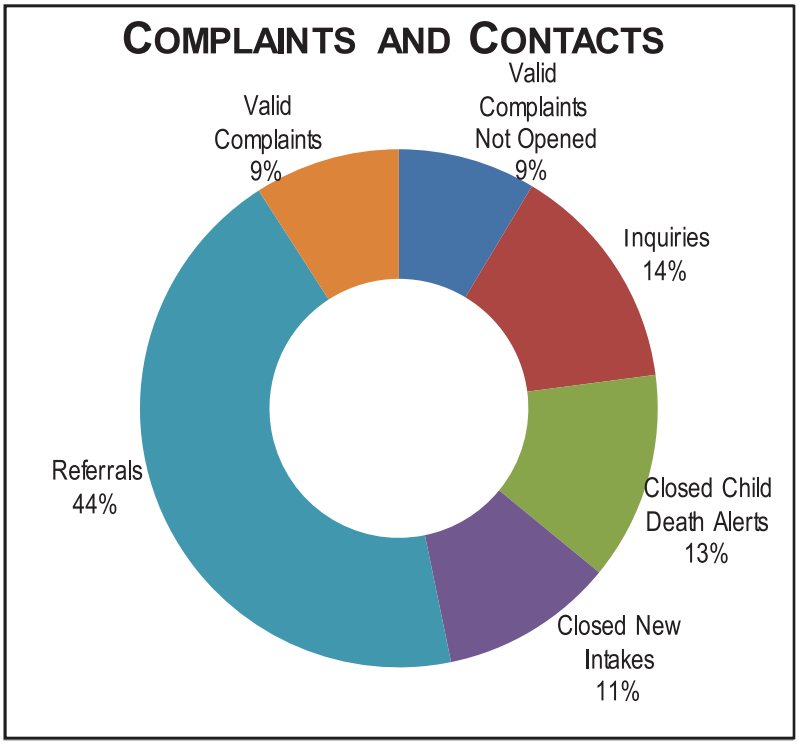
After a complaint is determined to be valid, the next step is to decide whether to open a case for investigation. The OCO considers whether:

1) The complainant has exhausted other administrative remedies to resolve the complaint without success.

2) It is possible that an investigation by the OCO will positively impact the specific child's situation or children in future cases.

- Valid Complaints Not Opened for Investigation: Complaints that are usually about a situation where an investigation will not resolve the complaint issue. For example, a parent may have a complaint about CPS' handling of their case and want their children returned; however, parental rights were terminated after a trial. Since termination of

parental rights occurs by court order, the only remedy for the parent is to file a timely appeal of the court's order. In addition, an OCO investigation of CPS will not restore parental rights or result in the return of the children. The OCO classified **133** complaints as valid complaints not opened.



- Valid Complaints Opened for Investigation: Complaints that satisfy one or more investigation criteria and other considerations result in the opening of a case for investigation. This fiscal year, the OCO opened **148** complaints for investigation. Below are some examples of valid complaints that were opened for investigation:[1]

  - CPS rejected a referral that met the legal and policy requirements for investigating.
  - The agency failed to ensure the safety and well-being of children of an alleged perpetrator who resides in a different household.
  - Threatened harm and risk to a child were not assessed during a CPS investigation.
  - No reasons were provided for placing siblings in separate out-of-home placements.

CHILD DEATH ALERTS

"Child death alerts" (discussed in detail in the Investigation Results - Child Death Cases section) are also included as a contact. A child death alert is an email notification from the DHS Office of Family Advocate that a child in Michigan has died. For all child death alerts received, the ombudsman is listed as the complainant; however, this does not preclude others with concerns to also be listed as a complainant. The OCO received **270** child death alerts this fiscal year and **201** were not opened for investigation.[2]

[1]Because each complaint has a unique set of facts, the similarity of a future complaint to the examples presented here does not guarantee that a case will be opened for investigation.

[2]Seventy-four child death cases were opened for investigation. This number also includes alerts received in the previous fiscal year but not opened for investigation until this fiscal year.

COMPLAINTS AND CONTACTS

MOST FREQUENTLY IDENTIFIED COMPLAINT ISSUES

Most Common Intake Topics: CPS and Placement/Replacement of Children
CPS case handling is the topic of a majority of complaints received by the OCO. The concerns expressed by family members, mandated reporters, and other individuals are closely aligned to the results of OCO investigations this fiscal year and are the focus of this annual report:

- The majority of identified violations focus on non-compliance with CPS laws and policies.
- Each of the four Requests for Actions and six of the thirteen Requests for Administrative Response issued during FY 2013 are about CPS.
- All six of the recommendations in this annual report are related to CPS case handling.

The second most common intake topic is in the area of placement and replacement of children. The OCO has received dozens of complaints from relatives and unrelated foster parents after they are denied placement of a sibling to the children already placed in their care. There can be various reasons why this occurs and DHS placement/replacement policy states that placement with siblings is one of several criteria the agency must consider. This topic has been highlighted in several past OCO annual reports and in numerous investigations. In addition, although DHS and private child-placing agencies are doing a better job of identifying and locating relatives for possible placement, the complaints continue from relatives who are upset about the agency's decision to not place a child with them. The possible result for families and siblings if parental rights are terminated is permanent separation of the children via adoption.

The information below shows complaints and contacts divided into 10 separate categories. Each category is divided into subcategories. When individuals contact the OCO, they often have more than one concern. The bold numbers next to each category reflect the total number of complaints received in that area, and the numbers for each subcategory reflect the number of times the concern was mentioned.

Children's Protective Services – 386
- Child Safety-Failure to protect children from parental abuse/neglect – 72
- Inappropriate decision by Centralized Intake – 14
- Inappropriate disposition – 46
- Investigation not thorough – 59
- Issues about expungement from Central Registry – 23
- Other – 172

Child Safety - 43
- Current unsafe placement (home) – 35
- Current unsafe placement (out-of-home) – 7
- Developmentally delayed child in need of protection - 1

Removal Issues - 20
- Unnecessary/"illegal"/inappropriate removal from parental/guardian's care – 13
- Removal not in child's best interest – 7

Placement/Replacement – 98
- Failure to consider or place with a "fit and willing relative" – 45
- Inappropriate sibling split – 7
- Non-relative placement/replacement not in child's best interest – 4
- Relative placement/replacement not in child's best interest - 8
- Other relative placement/replacement not in the child's best interest - 8
- Other – 26

Service Provision - 60

Related to needs of parent – 17
Related to needs of child(ren) – 22
Delay in referral for/availability of services – 12
Other -9

Permanency – 36

Permanency plan not in the child's best interest – 19
Unnecessary delay in returning children to parent/guardian – 12
Other - 5

Adoption - 49

Someone not considered (relative, non-relative) – 12
Someone not recommended for or granted consent – 6
Other (including "process taking unnecessarily long") – 31

Child Death Notice (from DHS to OCO) - 549

DHS/private agency involvement within previous 24 months – 85
DHS/private agency involvement more than 24 months ago – 29
Open CPS investigation or ongoing CPS case at time of death – 26
Child a court ward at time of death (temporary or permanent court ward) – 11
Unsafe sleep environment – 86
Abuse/neglect – 15
Accidental – 39
Natural causes – 43
Other (including suicide) – 215

Other Child Welfare Related Issues/Concerns - 325

These concerns are about guardianships; the court; where termination of parental rights has occurred and parent either has or has not filed an appeal; the unprofessional conduct of case worker; foster home licensing issues (including payment related issues); and Family Independence Program (FIP) and other payments for an unlicensed relative caregiver.

Other (non-child welfare related) – 122

Friend of the Court/custody issues, public assistance, school concerns, Corrections Ombudsman, other various concerns.

PROTECTING INTERVENTIONS

Requests for Action

Requests for Administrative Response

"Pursue all necessary action…to protect the rights and welfare of a child under the jurisdiction, control, or supervision of the department…."

Children's Ombudsman Act Section 5a

REQUESTS FOR ACTION

The OCO issued **four** Requests for Action (RFA) this fiscal year. An RFA is a request to DHS for attention to a concern that if true, requires immediate attention. An RFA may be issued to DHS based solely on information obtained from a complainant at intake. Because the situation may be time-sensitive or a child may be at risk, the OCO may not verify the information prior to submitting an RFA to DHS. There are also situations during an OCO investigation where submitting an RFA may be warranted. An RFA is issued to DHS under one or more of the following circumstances:

- Immediate risk to a child(ren)
- Inappropriate placement of a child(ren) leaving the child(ren) at risk
- Employee misconduct

These requests are submitted to the DHS Office of Family Advocate who responds in writing within five business days. Requests for Action may involve one or more concerns about a child. Following is a summary of the four RFAs and the DHS responses:

OCO Requests	DHS Responses/Outcomes
File a petition in accordance with state law requesting removal of the children from a parent's custody pending the outcome of the CPS and law enforcement investigations.	DHS reviewed the case and determined that a petition was not needed as the children were not in immediate danger. A court unrelated to the abuse/neglect case had ordered that the children reside with a relative via power of attorney.
Review prior parental history of child abuse/ neglect for a complete understanding of why parental rights were previously terminated; Determine if threatened harm was properly assessed to justify a new child remaining in the parents' care and document whether the parents participated in and benefitted from services since the termination of parental rights; If warranted, reopen a CPS case and file a petition requesting immediate removal of the child and termination of parental rights.	DHS located and reviewed all documents of prior parental history of child abuse/ neglect and determined that the recent CPS investigation was improperly denied and a preponderance of evidence of neglect was evident at various stages of the investigation. DHS had not gathered or documented critical information about the parents that warranted a determination that threatened harm existed. DHS reopened the CPS investigation, found a preponderance of evidence for threatened harm and improper supervision and filed a petition requesting removal of the child and termination of parental rights. However, the court refused to authorize the petition. An amended petition was submitted, but was again rejected by the court. The CPS case remained open to provide services and monitor the family.

Review CPS allegations to determine whether the complaint should be assigned for investigation and immediately commence a CPS investigation if warranted.	The complaint was reviewed by second line Centralized Intake manager and returned to CPS to complete a preliminary investigation. After review of the preliminary investigation, it was determined that the case was appropriately transferred to law enforcement.
Assess the child's safety in the parent's care due to their prior history of termination of parental rights; file a petition requesting removal if it is determined that the child is not safe; and immediately assess the appropriateness of placing the child with older siblings.	DHS assessed child safety and determined that there was not sufficient basis for removal of the child at the time. DHS found placement with the older siblings would be appropriate if out-of-home placement became necessary.

REQUESTS FOR ADMINISTRATIVE RESPONSE

In Fiscal Year 2013, the OCO issued **13** Requests for Administrative Response (RFAR). An RFAR may be issued to DHS under the following circumstances:

- A matter should be further considered by the DHS and or private child-placing agency
- An administrative act should be modified or cancelled
- Other action should be taken by the DHS and/or private child-placing agency

These requests may also be submitted to the agency following intake (based solely on information verbally reported to the OCO) or during an OCO investigation. The DHS Office of Family Advocate responds on behalf of the involved agency within 10 business days. Following is a summary of the RFARs and the DHS responses:

OCO Concerns/Requests	DHS Responses/Outcomes
DHS denied a request for a copy of case file documents to someone legally entitled to receive them.	DHS provided copies of the requested CPS files.
A CPS investigation was not thorough and did not address the allegations; a voluntary placement could not ensure child safety; services did not meet the needs of the family.	CPS documented the required measures which supported neglect and threatened harm; DHS requested removal of the children when the safety plan could not ensure safety; services provided addressed the family's needs.
DHS did not complete a full background assessment of a parent's criminal and central registry history or complete an appropriate home assessment in compliance with policy.	The court ordered placement of the children with the non-custodial parent. DHS determined agency assessments confirmed the caregivers were appropriate and the children were safe and well cared for.

Centralized Intake (CI) staff inappropriately screened out a complaint to Law Enforcement (LE) and documented the mother was not a person responsible.	CI Managers agreed the mother was a person responsible and completed a preliminary investigation which determined the complaint was appropriately screened out and referred to LE.
CPS failed to engage a parent when developing a service agreement and failed to provide a copy of the agreement to the parent.	The CPS report documented a meeting with the parent to discuss and sign the service agreement; a copy was provided to the parent and was on file with DHS.
There was an unexplained delay in parenting time after the child's removal from the parents.	CPS failed to secure a site for parenting time and with information about relatives who could assist with visits. Parenting time was scheduled after OCO contact.
DHS approved psychotropic medication for foster children without parental consent and did not have the required medical forms on file; DHS failed to identify and/or assess relatives for placement; and DHS did not complete the foster care placement decision notice form and provide copies to the required individuals.	A parent with legal custody authorized the psychotropic medication (documentation was on file); multiple relative placements were attempted but unsuccessful; DHS reported notifying all required individuals with copies of the DHS-31, "Foster Care Placement Decision Notice" form.
Whether or not CPS was required to take legal action at the conclusion of an investigation and if CPS used a voluntary placement agreement in lieu of necessary court intervention.	DHS determined the case did not require legal action and provided services to the family; the voluntary placements did not involve CPS and were determined to be safe.
DHS did not provide the Placement Decision Notice form to a relative and was non-compliant with policy and law by failing to document justification for a sibling placement split.	DHS provided the relative with a copy of the Placement Decision Notice and provided appropriate documented reasons for the sibling placement split.
DHS failed to provide a copy of the Placement Decision Notice form to a relative.	DHS provided the relative with a copy of the Placement Decision Notice form.
A CPS investigation was inaccurate and evidence did not support child abuse and/or neglect; placement with the other parent was not in the child's best interest.	DHS reviewed the investigation and the child placement decision and determined that preponderance of threatened harm was accurate and the subsequent placement was in the child's best interests.

INVESTIGATIONS

Cases Carried Over from the Previous Fiscal Year

Investigation Types

- Preliminary
- Full

Investigations by DHS Child Welfare Program

"The ombudsman shall establish procedures for…conducting investigations…."

Children's Ombudsman Act Section 4

CASES CARRIED OVER FROM THE PREVIOUS FISCAL YEAR

Cases that remain open for investigation at the end of a fiscal year are carried over into the next fiscal year. The goal is to complete a majority of investigations in less than six months; however, for various reasons this is not always possible. A case may be carried over for reasons such as:

- A case may have been opened for investigation in the last days of the previous fiscal year.
- Large caseload sizes for investigators prevent timely completion.
- A case may involve several agencies and the complexity of the issues extends the time necessary to complete the investigation.

The carried over cases are not included in the number of newly opened cases. **Eighty-seven** open cases were carried over into FY 2013.

INVESTIGATION TYPES

There are two types of investigations, preliminary and full. All investigations are assigned to one primary investigator; however, for each case at least two additional investigators review a summary and recommendations from the assigned investigator prior to case completion.

A case may involve more than one DHS county office or private child-placing agency. The OCO completed a total of **153** cases this fiscal year involving **45** DHS county offices and **12** private child-placing agencies.

Preliminary Investigations
A case is opened for a preliminary investigation to determine whether a full investigation is warranted, or if it is determined at intake that the complainant's specific concern may be quickly resolved. Preliminary investigations are typically completed within 30 days. A preliminary investigation may consist of reviewing agency or court documents, submitting questions to a caseworker via email, or speaking with agency staff by phone. If after reviewing preliminary information the assigned investigator determines that a more extensive investigation is warranted, the preliminary investigation will be changed to a full investigation.

Some examples of preliminary investigation issues addressed during the fiscal year include:

- Why the agency is pursuing termination of parental rights when the parent has complied with the requirements in the Parent Agency Treatment Plan and Service Agreement
- Whether CPS was ensuring a child's safety during an active investigation
- Whether a family who adopted older siblings is being considered as a placement for a newborn sibling
- Whether CPS conducted a preliminary investigation of a complaint alleging sibling-on-sibling sexual abuse
- Whether the agency complied with relative placement policy
- Whether a parent has sufficiently completed services to warrant unsupervised parenting time with a child victim

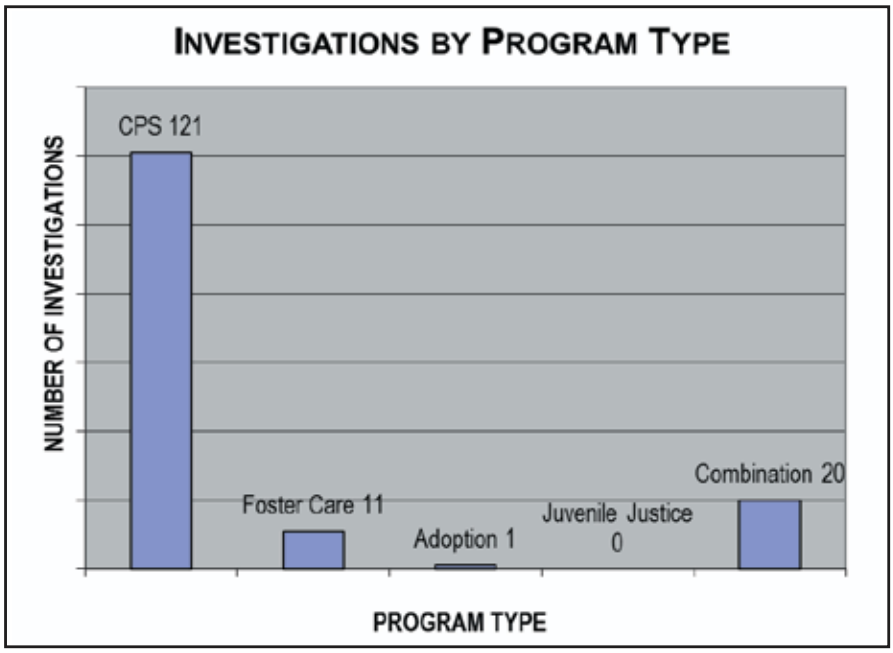
A total of **24** cases were closed as preliminary investigations this fiscal year.

INVESTIGATIONS

Full Investigations
A full investigation consists of requesting a broad range of case file records and documents from DHS and/or a private child-placing agency. Documents such as agency-generated records and reports, court documents, service provider reports, personal/confidential documents (as long as DHS has a signed release from the parent) and other information deemed relevant by the OCO. The assigned investigator reviews the documents and conducts interviews with agency staff and other sources as needed. Documentation and information obtained by the OCO is reviewed and compared with DHS policy, procedure, and applicable laws to determine agency compliance.

During this fiscal year, cases opened for full investigation focused on complaints such as:

- Whether CPS cases that are opened for services are ensuring the safety of the children who remain in the home
- Whether the agency was following law and policy regarding considering placement of children with relatives
- Whether CPS investigations and dispositions complied with law and policy
- To determine whether agency involvement with a family within 24-months of a child's death was in compliance with law and policy and whether there was any connection between the previous complaints and the child's death



The OCO completed **129** full investigations this fiscal year.[3]

INVESTIGATIONS BY CHILD WELFARE PROGRAM (CPS, FOSTER CARE, ADOPTION SERVICES OR JUVENILE JUSTICE)

Full investigations primarily focus on resolving concerns identified by the complainant. However, if other issues were identified during the OCO's investigation, those issues are also included as part of the OCO's review. These additional issues may be incorporated into the closing report to the complainant and/or addressed with the involved agency.

Of the **153** investigations completed this fiscal year, the majority (**79%**) focused exclusively on CPS concerns; **13%** involved more than one program type (combination); and **7%** addressed only foster care concerns.

[3]Preliminary investigations that upon review, were subsequently opened for full investigation, are included in this total and not in the preliminary investigation total.

INVESTIGATION RESULTS-COMPLAINANT CASES

Release of Information to Complainants

Case Closure Types

- Affirmation
- Administrative Close
- Report of Findings and Recommendations

Analysis of Findings (Violations)

- Most Prevalent Findings – Children's Protective Services

Investigation Results by Agency

"The ombudsman may release information to a complainant…regarding the department's handling of a case.…The ombudsman shall prepare a report of the factual findings of an investigation and make recommendations to the department…."

Children's Ombudsman Act Sections 9 and 10

INVESTIGATION RESULTS – COMPLAINANT CASES

RELEASE OF INFORMATION TO COMPLAINANTS

When an investigation is completed, the OCO notifies the complainant in writing of the outcome of the investigation and any action taken by the involved agencies to address the complaint issues. The relationship a complainant has to the child, as described in the Children's Ombudsman Act, governs the information that can legally be provided to the complainant. In addition, the OCO adheres to state and federal laws governing confidentiality; therefore, there may be information that cannot legally be provided to a complainant about the results of the OCO's investigation. The Children's Ombudsman Act also prohibits the OCO from sending written results to a complainant if there is an ongoing CPS or law enforcement investigation at the time the OCO investigation is completed. In these cases, the OCO sends the complainant a letter stating that he or she will receive the OCO results once the CPS and/or law enforcement investigations are closed. Once those investigations are closed, the ombudsman may release the written results to a complainant.

CASE CLOSURE TYPES

Investigations are closed in three different ways:

Affirmations
Both full and preliminary investigations may be closed as an affirmation. A case that is closed as an affirmation is one in which no violations of law, policy, or procedure were found after analyzing the case based on the identified complaint issues. Below are examples of complaints and why the OCO affirmed the agency's actions and/or decisions:[4]

- *Complaint:* CPS had no justification to remove a child from home. *Reason affirmed:* Actions taken and decisions made by CPS were supported by case facts, in the best interest of the child to ensure safety, and clearly documented and justified in the removal petition filed with the court.

- *Complaint:* Several CPS complaints have been filed yet the children remain unsafe in the home. *Reason affirmed:* The CPS investigations were thorough and services provided to the family were commensurate with the identified safety risk and the needs of family members; therefore, there was no legal justification for CPS to file a petition requesting removal of the children.

- *Complaint:* The agency is not providing services to the parent whose children were removed and placed in foster care. *Reason affirmed:* Appropriate services were explained and offered to the parent by the agency handling the foster care case; however, the parent decided not to participate in the services.

The OCO affirmed DHS and/or a child-placing agency **43** times following full investigations and **29**[5] times following preliminary investigations.

[4]These examples are for illustration purposes only and are not intended to ensure a specific outcome.

[5]The number of *outcomes* (investigation results) will often be greater than the number of *cases* because multiple agencies may be involved in a single case. For FY 2013, there were 24 preliminary investigation cases, but 29 preliminary investigation outcomes.

Administrative Close

As with affirmations, both full and preliminary investigations may be closed administratively. Cases are closed in this manner because they cannot be affirmed; however, a Report of Findings and Recommendations is not warranted. There are two types of administrative closing. The first type is utilized under the following circumstances:[6]

- The agency is currently addressing the complainant's concerns. *Complaint example:* A parent complains that the caseworker had not made referrals for court ordered services (counseling, parenting classes, etc.) *Reason for administrative close:* The OCO determined that there was some delay in referring the parent to the appropriate services; however, the service referrals were completed and the parent began participating in services during the OCO investigation.

- A preliminary investigation revealed that further OCO involvement and/or a full investigation will not affect the outcome of the case. *Complaint example:* CPS received a complaint but had not commenced an investigation in accordance with law and policy. *Reason for administrative close:* Although the CPS investigation had not commenced timely, the supervisor was aware of the delay and assigned a new CPS worker to the case.

- A full investigation revealed that further involvement and/or action by the OCO will not affect the outcome of the case. *Complaint example:* A foster child had been in care for over a year and counseling and other required services were late or not provided at all. *Reasons for administrative close:* OCO determined that there were some minor delays in submitting the paperwork for counseling and other services but the complainant had also not clearly communicated to the caseworker why the complainant decided to discontinue taking the child to counseling. The OCO complainant and caseworker agreed to communicate via email to facilitate better communication and the foster care supervisor agreed to more closely monitor the provision of services.

- Other. *Reason for administrative close:* The complainant withdrew his or her complaint and requested that OCO end the investigation.

The second type of administrative close is used when minor violations were found and the OCO requested they be addressed by the involved agency during the OCO's investigation.

- All agency actions cannot be affirmed; however, the agency has addressed shortfalls in case handling identified by the OCO.

- The identified issues would not have altered the actions taken or the outcome of the case.

If the issues are adequately resolved during the OCO investigation, the case is subsequently closed. Prior to notifying the complainant in writing of the investigation results, the DHS Office of Family Advocate is provided an opportunity to review the issues and how they were resolved and, if desired, may submit a follow-up, written response to accompany the OCO's closing letter

[6]These examples are for illustration purposes only and are not intended to ensure a specific outcome.

to the complainant. Examples of complaints and why they were closed in this manner are below:[7]

- *Complaint:* The CPS investigation of allegations of physical abuse was mishandled, resulting in the alleged perpetrator remaining in the home. *Reason for administrative close:* OCO addressed with the county the issue of not commencing the CPS investigation within 24 hours as required, and the OCO verified that law enforcement had commenced an investigation which included making contact with the children and arresting the alleged perpetrator.

- *Complaint:* A relative contacted the OCO about not being considered for placement of a child. *Reason for administrative close:* The OCO determined that the relative had been considered for placement, but had not been notified by the agency. OCO addressed with the agency that policy and law require written notice to relatives who were considered but denied placement. The involved agency provided the legally required notice to the relative and agreed to address this issue with the caseworker.

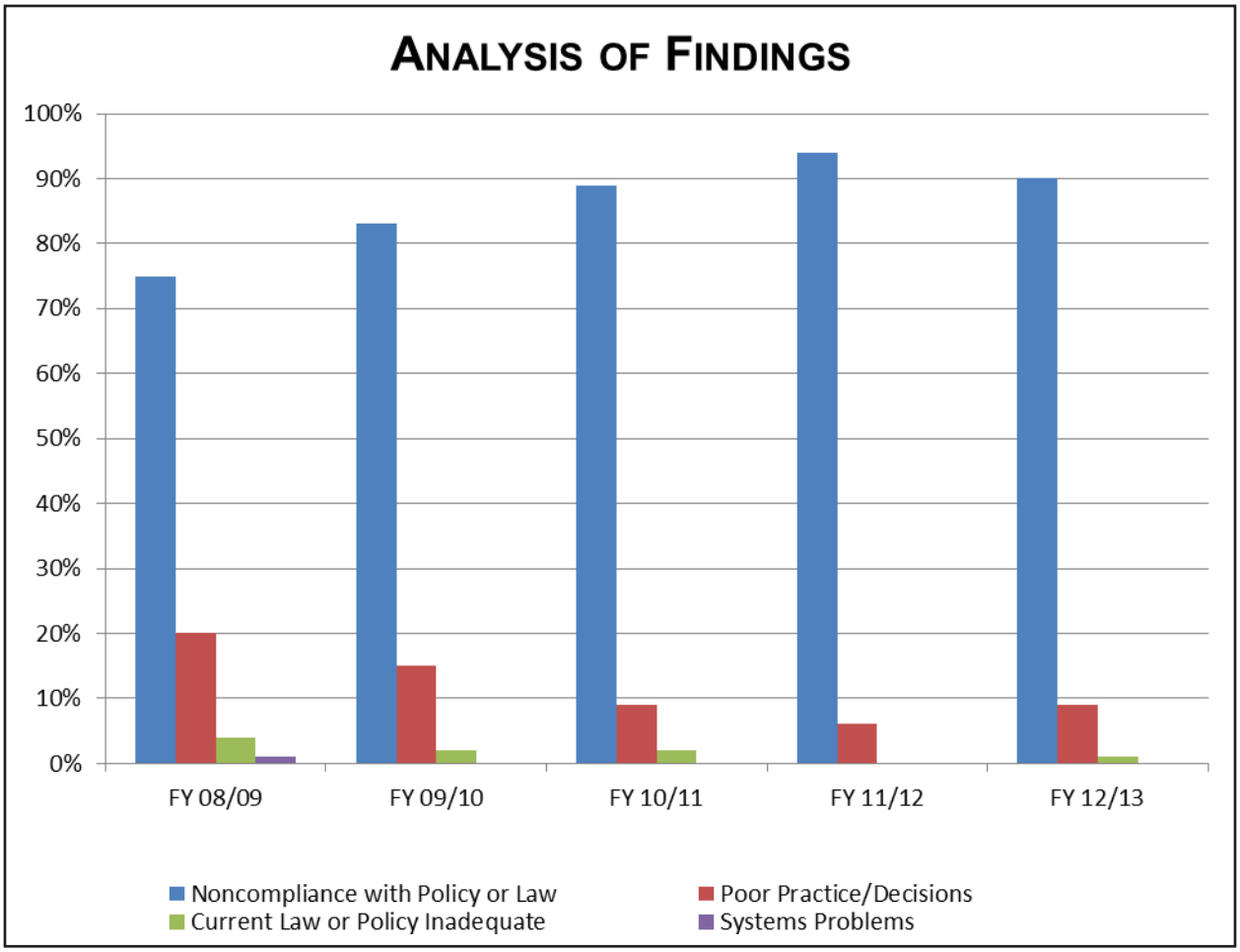
The OCO concluded **58** cases as administrative closings this fiscal year.

Reports of Findings and Recommendations (F&R)
Only full investigations can be closed via a Report of Findings and Recommendations. An F&R is issued by the OCO to DHS when major violations are found with respect to non-compliance with laws, rules, and/or policies, or agency actions and decisions were not consistent with the case facts or the child's best interests. The F&R submitted to DHS contains specific findings describing the violations and corresponding recommendations that certain actions be taken. The DHS Office of Family Advocate responds to the F&R in writing within 60 days on behalf of the involved agencies.

ANALYSIS OF FINDINGS (VIOLATIONS)

Most Prevalent Findings – Children's Protective Services
The most prevalent findings this fiscal year were in the CPS program area. The **41** F&Rs issued encompassed **295** findings and **238** recommendations. As in previous years, the majority of the findings for this fiscal year focused on noncompliance with existing law or policy.

[7]These examples are for illustration purposes only and are not intended to describe specific cases investigated by the OCO or ensure a specific outcome.



Children's Protective Services (CPS)

The Child Protection Law and DHS/CPS policy require numerous actions and decisions by caseworkers for every CPS investigation. There are more than 50 CPS policies that guide caseworkers through the investigation process and describe what must be documented. A brief description of the most frequently violated CPS policies and a few of the non-compliance issues the OCO found are listed below:

- PSM 713-1 CPS Investigation – General Instructions and Checklist. This policy describes the actions CPS must take for every investigation, such as contacting the mandated reporter who filed the CPS complaint, reviewing previous DHS records of a family's history of child abuse/child neglect, and contacting collateral sources that could provide information useful for assessing the family's current situation.

    - Failure to contact mandated reporters
    - Failure to evaluate previous complaints
    - Inaccurate completion of Safety Assessments

- PSM 713-3 Face-to-Face Contact. This policy requires, among other things, that face-to-face contact be made with parents and/or other persons responsible for the child's

health or welfare, the alleged perpetrator and alleged victims or documentation of why contact was not made.

  - Failure to contact all household members in the home at the time of the alleged abuse or neglect
  - Failure to make face-to-face contact with non-custodial parents

- PSM 713-9 Completion of Field Investigations. Policy requires, in part, that CPS workers request an extension if the CPS investigation cannot be completed within 30 days, and that the supervisor and worker meet to discuss the current complaint involving children three and under when there are multiple (three or more) past complaints about the family.

- Child Protection Law MCL 722.638 regarding the filing of mandatory petitions, and MCL 712A.14b regarding ex parte order requesting immediate protective custody of a child.

In addition to findings regarding specific policy violations, the OCO also identified as prevalent concerns issues about poor practices and poor decisions. Specific examples of findings in these areas include:

- Assessing and/or addressing parental substance abuse issues
- Recognizing risk to children when many factors, if properly evaluated, would have necessitated filing a petition requesting removal of the children from the parental home

INVESTIGATION RESULTS BY AGENCY

The **153** completed investigations involved **45** DHS county offices and **12** private child-placing agencies. Each investigated agency has an outcome, even when multiple agencies are involved in one case. For example, one investigation may result in affirming a county DHS office, in addition to an F&R regarding inadequate foster care services provided to the children in that case by a private child-placing agency.

One hundred and forty-one cases (**92**%) involved only DHS, **9** (**6**%) involved both DHS and one or more private child-placing agencies, and **three** (**2**%) involved only a private child-placing agency.

The following chart lists the outcome(s) by county DHS office and private child-placing agency for OCO investigations completed in Fiscal Year 2013:

Dept. of Human Services	Number of Investigations		Case Closure Type (Outcome) Distribution		
34 County Offices	Full (F)	Prelim (P)	**Affirmation**	Administrative	Findings & Recommendations
Alger	1		1		
Allegan	1			1	
Alpena	1			1	
Bay	1				1
Calhoun	2				2
Cass	2			1	1
Charlevoix	1	1	1F 1P		

INVESTIGATION RESULTS – COMPLAINANT CASES

Dept. of Human Services	Number of Investigations		Case Closure Type (Outcome) Distribution		
34 County Offices	Full (F)	Prelim (P)	**Affirmation**	Administrative	Findings & Recommendations
Centralized Intake	1	2	2P	1	
Eaton	2				2
Emmet	1			1	
Genesee	4	1	1F 1P	1	2
Grand Traverse		1	1P		
Gratiot	1	1	1P		1
Huron		1	1P		
Ingham	2			2	
Jackson	2			1	1
Kalamazoo	3			2	1
Kent	3	2	2F 2P	1	
Lake	1				1
Livingston		1	1P		
Macomb	2	3	1F 2P	1F 1P	
Marquette	1		1		
Mecosta	2		1		1
Monroe	2	2	1F 2P	1	
Montcalm	1			1	
Muskegon		2	2P		
Newaygo	1			1	
Oakland	4	1	1P	2	2
Ogemaw	1			1	
Osceola	1		1		
St. Clair	1	1	1F 1P		
St. Joseph	1	1	1P	1	
Tuscola	1				1
Washtenaw	1			1	
Wayne	9	5	2F 5P	4	3
DHS TOTALS	57	25	13 Full 24 Prelim	25 Full 1 Prelim	19

INVESTIGATION RESULTS – COMPLAINANT CASES

Private Child-Placing Agency (PCPAs)	Number of Investigations		Case Closure Type (Outcome) Distribution		
11 PCPAs	Full (F)	Prelim (P)	**Affirmation**	Administrative	Findings & Recommendations
Bethany Christian Services		1	1P		
Catholic Charities	1	1	1P	1F	
Catholic Charities of West MI	1			1	
Child and Family Charities	1		1		
CMH and Substance Abuse Services		1	1P		
Ennis Center for Children	1		1		
Lutheran Adoption Services	1				1
Lutheran Child & Family Services	1				1
Lutheran Social Services	1			1	
Orchards Children's Services	1		1		
Wolverine Human Services	0	1	1P		
PCPAs TOTALS	8	4	3 Full 4 Prelim	3 Full	2
GRAND TOTALS DHS & PCPAs	65	29	16 Full 28 Prelim	28 Full 1 Prelim	21

INVESTIGATION RESULTS - CHILD DEATH CASES

Criteria

Analysis

Summary of Key Findings and Recommendations

- Prevalent Findings
- Recommendations to Clarify and Strengthen Policy

Investigation Results by Agency

"The ombudsman may …in relation to… a child who may have died as a result of suspected child abuse or neglect…investigate an administrative act…of the department…."

Children's Ombudsman Act Section 6

INVESTIGATION RESULTS – CHILD DEATH CASES

CRITERIA

The number of child death case investigations opened each fiscal year is dependent upon information in the Children's Protective Services Child Death Report, also known as the "child death alert," or separate information provided by the DHS Office of Family Advocate. DHS emails a child death alert to the OCO when DHS is notified that a child has died. In Fiscal Year 2013, the OCO received **270** child death alerts from DHS resulting in the opening of **77** child death case investigations.

Specific criteria are used to determine whether the OCO will open a child death case for investigation. Many children die because of an accident, medical condition or for other reasons that do not fit the criteria. The focus of an OCO investigation is to determine whether interventions by DHS and/or a private child-placing agency prior to a child's death were handled in accordance with policy and law. The OCO also determines whether a correlation existed between previous agency involvement with the family and the circumstances that led to the child's death.

An OCO investigation may be conducted when at least one of the following criteria is met:

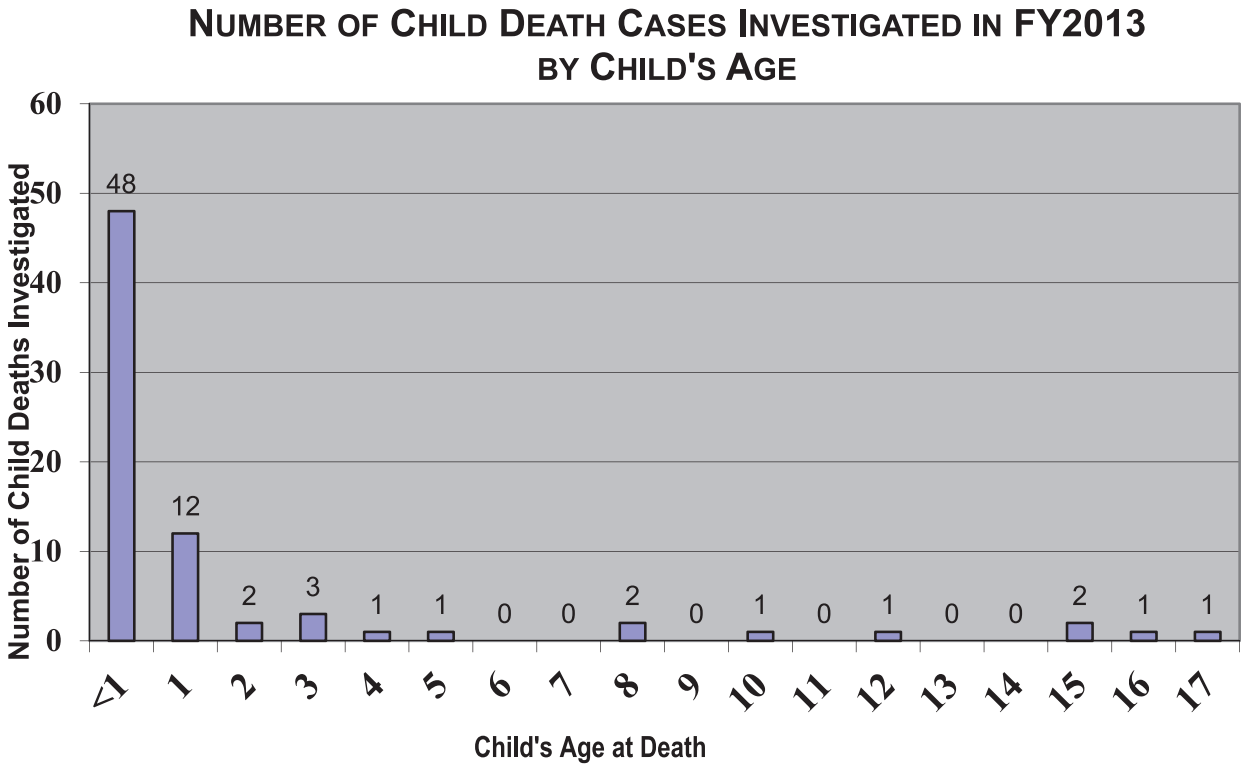
- A child died during an active CPS investigation or open services case, or there was an assigned or rejected CPS complaint within the previous 24 months
- A child died while in foster care, unless the death resulted from natural causes and there were no prior CPS or licensing complaints concerning the foster home
- A child was returned home from foster care and there is an active foster care case
- The foster care case involving the deceased child or sibling was closed within the previous 24 months
- Media interest
- Legislator request
- Ombudsman discretion

ANALYSIS

Statistical information regarding the **74** completed child death case investigations (involving **75** child deaths) indicates:

- 64 percent (48 children) of the child deaths involved a child under the age of one year.
- 86 percent of the child deaths occurred in the parental home.
- 6 percent (five children) of the child deaths were caused by child abuse and/or child neglect.
- In 44 percent (33 children) of the child death investigations, the child's sleep environment was identified as a factor associated with the death.
- 18 percent (14 children) of the children died from natural causes.
- 25 children (33%) died while in parental care during an active CPS investigation or an open CPS services case.
- Five children (6%) died during an open foster care case.[8]

[8]These children did not die as a result of abuse or neglect.



SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

Twenty-three of the **74** completed child death investigations[9] resulted in a report of findings and recommendations. As noted above, the focus of an OCO child death investigation is to determine whether interventions by DHS and/or a private child-placing agency prior to a child's death were handled in accordance with policy and law. It should be noted that in many instances, the deceased child was not involved in the agency's pre-death interventions because the child had not yet been born. The most prevalent findings pertaining to CPS involvement with a family prior to a child's death were:

- CPS workers failed to make face-to-face contact with an alleged child-victim within the required time.
- CPS workers failed to contact or interview a parent, guardian, or other caretaker.
- CPS workers inaccurately scored risk or needs assessment tools.
- CPS workers failed to reach the correct disposition of the complaint based on evidence gathered during the investigation.
- CPS failed to file a legally mandated petition.
- CPS workers failed to ensure child safety during an open CPS services case, including failure to meet standards for maintaining contact with families, make appropriate service referrals, and monitor parental compliance with services.

[9]Seventy-five children were involved in the 74 child death investigations because two children died in one case.

INVESTIGATION RESULTS – CHILD DEATH CASES

Prevalent Findings
The most prevalent findings pertaining to CPS child death investigations were:

- CPS workers failed to refer complaints to law enforcement agencies and/or conduct a joint investigation with law enforcement agencies.
- CPS workers failed to ensure that surviving siblings obtained medical examinations.
- CPS workers failed to reach the correct disposition of the complaint based on evidence gathered during the investigation.
- CPS failed to file legally mandated petitions.

Recommendations to Clarify and Strengthen Policy
In addition to case-specific recommendations to the agencies involved in both pre-death and death investigations, the OCO recommended that DHS central office clarify and strengthen policy in many areas, including:

- Viewing the sleeping arrangements of children under one year of age in all CPS investigations.[10]
- Using voluntary out-of-home placement of children and powers of attorney to ensure child safety during CPS investigations.
- Filing legally mandated petitions when parents fail to comply with services.
- Interviewing alleged child-victims during the first CPS contact with the child; and
- Receiving documentation from service providers before closing a CPS services case.

[10]DHS central office amended policy in September 2013 to implement this requirement.

CHILD DEATH CASE INVESTIGATION RESULTS BY AGENCY

The **74** completed child death investigations[11] involved **25** DHS county offices and **1** private child-placing agency.

Agency	# of Child Death Alerts	Number of Investigations		Case Closure Type (Outcome) Distribution		
DHS		Full	Prelim	**Affirm**	Administrative Closings	F&R
Berrien	8	3		1	1	1
Branch	2	1			1	
Calhoun	5	1		1		
Clinton	2	1		1		
Crawford	2	1		1		
Centralized Intake	2	3			2	1
Genesee	16	8		3	4	1
Ingham	15	1				1
Ionia	1	1				1
Isabella	1	1			1	
Jackson	5	1			1	
Kalamazoo	17	2		1		1
Kent	8	3		1	1	1
Lenawee	6	1		1		
Manistee	*	1		1		
Marquette	2	2		1	1	
Midland	2	1		1		
Monroe	3	3		2		1
Muskegon	5	1			1	
Oakland	17	10		4	4	2
Saginaw	6	1			1	
St. Clair	5	4	1	2F 1P	1	
St. Joseph	3	1			1	
Washtenaw	5	2				2
Wayne	88	26		4	11	11
DHS TOTALS		80	1	25 Full 1 Prelim	31	23
Alternatives for Children		1		1		
PCPA TOTALS		1		1 Full		
GRAND TOTALS DHS & PCPA		81	1	27	31	23

* The child death alert for this investigation was received in the previous fiscal year.

[11] Several of the investigations involved more than one agency and resulted in 82 separate outcomes.

OCO FY 2013 Annual Report Recommendations and DHS Responses

Recommendation 1: Unsafe Sleep

Recommendation 2: Medical Marijuana

Recommendation 3: Substance Abuse

Recommendation 4: Improving Compliance with Medical Policies

Recommendation 5: Forensic Interviews

Recommendation 6: Petitions

"The ombudsman shall submit to the governor, the director of the department, and the legislature an annual report on the ombudsman's conduct, including any recommendations regarding the need for legislation or for change in rules or policies."

Children's Ombudsman Act Section 10(6)

When violations of policy, law, and/or procedure are identified, new policy should be created, or existing policy should be modified, the OCO issues a Report of Findings and Recommendations to DHS and/or a private child placing agency. Each fiscal year recommendations from individual case investigations are reviewed by OCO staff and the most prominent issues are featured in this section of the annual report.

Below are the OCO's six recommendations and DHS' responses on the topics of unsafe sleep, medical marijuana, substance abuse, and improving compliance with medical policies, forensic interviews, and petitions.

UNSAFE SLEEP

OCO Recommendation 1:
The OCO recommends that DHS seek an amendment to the Child Protection Law (CPL) to provide a legal basis for its policy of assigning for investigation CPS complaints alleging **only** that "an unsafe sleep environment may have been a factor in a child's death."

Rationale: CPS policy PSM 712-6, p. 13 requires Centralized Intake to assign for field investigation all complaints "where an unsafe sleep environment may have been a factor in a child's death." This policy requires assignment of complaints involving a child's death and alleging only a failure to follow safe-sleep practices. Because this policy does not require an allegation of "child abuse" or "child neglect" before CPS conducts an investigation, it does not comport with the CPL.

CPS policy PSM 711-3, p. 1 states that the CPL requires all of the following circumstances to be present before a case may be assigned for a field investigation:

- 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 nonaccidental physical or mental injury, sexual abuse or exploitation, maltreatment, negligent treatment, or failure to protect[12]

Another CPS policy, PSM 713-1, p. 2, explicitly states that the failure to follow "the tenets of infant safe sleep" does not alone constitute "child abuse" or "child neglect." Thus, unless there are other allegations of "child abuse" or "child neglect," Centralized Intake should not assign the complaint for field investigation.

To be clear, the OCO recommends only that DHS have a legal basis, in the CPL, for investigating a complaint involving a child's death and alleging **only** a failure to follow infant safe-sleep practices. Because safe-sleep practices are not mandated by law, the policy decision to subject families to a CPS investigation based solely on an alleged failure to follow those practices should be made by the Michigan Legislature, not by DHS. This would allow the general public input into the decision.

[12] This policy summarizes the definitions of "child abuse" and "child neglect" contained in MCL 722.622(f) and (j). These definitions should be construed to exclude harms not expressly stated in them. *Michigan Ass'n of Intermediate Special Ed Administrators v DSS*, 207 Mich App 491, 497–98 (1994).

As noted above, current CPS policy does not comport with the CPL and is internally inconsistent. Through our investigations of these cases, the OCO has identified the following additional problems resulting from the policy:

- It permits an intrusion into family life at a time when parents are typically very emotionally distraught.[13] A CPS worker typically questions parents within hours of a child's death.

- CPS workers often ask parents to "voluntarily" place surviving siblings in a relative's or friend's care and have no contact with their children pending completion of the investigation.

- CPS investigations often take months to complete because CPS is simply waiting for autopsy results or a law enforcement report. When the family has been separated, extended investigations are particularly damaging.

DHS Response to Recommendation 1:
The Michigan Child Protection Law provides the legal authority for the department to investigate suspected abuse or neglect of a child. DHS is responsible for setting policy based on the law. DHS policy provides for an investigation when CPS receives a report that a child has died and there is no known cause for the death, or the death was sudden and unexplained. Such a report meets the DHS policy definition of threatened harm. In response to these complaints, a CPS investigation is necessary to determine whether abuse or neglect was a factor in the infant's death. Complaints to CPS reporting the death of an infant do not typically include definitive information describing the infant's sleep position or sleep environment.

In many cases, CPS determines after completing an investigation that abuse or neglect was a factor in the death and that protective intervention is needed to assure the safety of siblings. Policy recognizes that an investigation of a child death is complex and can be emotionally charged. Regardless of the circumstances surrounding the death, CPS staff are trained to conduct investigations in a manner that is professional and objective, yet empathetic and respectful of the loss and grief suffered by the family.

MEDICAL MARIJUANA

OCO Recommendation 2:
The OCO recommends that DHS create policy addressing the application of the Michigan Medical Marijuana Act (MMMA) to CPS investigations and related court actions.

Rationale: The MMMA became effective in late 2008, and there are approximately 122,000 certified medical marijuana users in Michigan. A provision of the MMMA, MCL 333.26424(c), states:

> *A person shall not be denied custody or visitation of a minor for acting in accordance with this act, unless the person's behavior is such that it creates an unreasonable danger to the minor that can be clearly articulated and substantiated.*

[13] PSM 713-8, p. 14 acknowledges this ("Investigation of a child death is a complicated and emotionally charged event.")

A person who acts in accordance with the MMMA may invoke the protections of the MMMA in a child protective proceeding under the Michigan Juvenile Code, subject to the exception quoted above for a "clearly articulated and substantiated" "unreasonable danger." Opinion of the Michigan Attorney General, #7271 (May 10, 2013). The Michigan Attorney General has stated that "the medical use of marijuana alone does not create an unreasonable danger to a child." However, "if the marihuana use affects the parent or caregiver's ability to adequately care for a child, or if the marihuana use presents a particular danger, say to an asthmatic child, such circumstances could create an unreasonable danger to the child."

Other than a brief mention of medical marijuana in PSM 716-7, CPS policy does not address the issue. New policy should clarify how CPS workers should investigate a parent's compliance with the MMMA, provide CPS workers with clear guidance on what constitutes an "unreasonable danger" to children from parental use of medical marijuana (thus allowing denial of custody or visitation), state whether current policy in PSM 716-7 on newborn drug exposure applies to older children exposed to marijuana through its medical use, and specify documentation requirements in cases involving medical marijuana.

DHS Response to Recommendation 2:
Current DHS policy governing CPS investigations and initiation of court involvement in cases involving parental use of substances, including but not limited to marijuana, is consistent with all applicable state laws. Regardless of whether a person responsible for a child uses medical marijuana or another type of substance, legally or illegally, the most pertinent factor influencing the CPS investigation disposition and the decision to seek protective intervention is whether the person responsible can safely care for the child. In response to each assigned complaint, CPS arrives at a disposition after examining available evidence and applying the legal definitions of child abuse and neglect as provided in the Child Protection Law. The Child Protection Law requires CPS to focus on the danger and harm to a child as a result of parental behavior. Attorney General opinions such as the one cited by the OCO, do not have the force of law and are not binding on courts. However, it is widely recognized that an Attorney General opinion provides valuable insight and research on an issue, particularly those affecting the operation of state government. While current CPS policy does not contradict the Attorney General opinion, the CPS program office has identified opportunities to enhance policy to clarify expectations and promote practice consistency among field staff. Policy enhancement will include the areas identified by the OCO, including specific steps that CPS must take when investigating complaints involving medical marijuana use, and further guidance on factors that must be considered when reaching dispositions. Above all, any enhancements to department policy will be consistent with the powers and duties prescribed of CPS in the Child Protection Law, to safeguard and enhance the welfare of children and preserve family life.

SUBSTANCE ABUSE

OCO Recommendation 3:
The OCO recommends that DHS strengthen substance abuse policy by amending the Substance Abuse Cases policy (PSM 716-7) to include identical wording currently in CPS Intake-Special Cases policy (PSM 712-6).

Rationale: CPS Intake-Special Cases policy (PSM 712-6) contains a directive about investigating cases alleging the abuse of prescribed medications. This policy states: *"When*

parents or caregivers report the use of prescribed medications that may contain mood-altering properties (including, but not limited to anti-depressants, anti-psychotics, methadone, medically prescribed marijuana and pain-killers), the worker must confirm those prescriptions with the medical professional who prescribed them." Although this information is useful for Centralized Intake staff, it is relevant to CPS workers assigned to investigate the complaint and contact the medical professional.

CPS Substance Abuse Cases policy (PSM 716-7) does not direct CPS workers to contact medical professionals about a parent or caregiver's use of prescribed medications as clearly as it is stated in the above-referenced intake policy. This policy mentions that parents may use legal or illegal drugs and directs the worker to carefully evaluate whether a child may be at risk.

DHS Response to Recommendation 3:
In 2014, CPS Program Office will amend the Substance Abuse Cases policy (PSM 716-7) to be consistent with the wording in the CPS Intake Special Cases policy (PSM 712-6).

IMPROVING COMPLIANCE WITH MEDICAL POLICIES

OCO Recommendation 4:
The OCO recommends that MDHS increase efforts to comply with policies governing medical exams, consultations, and assessments.

Rationale: The OCO continues to review cases where policies regarding mandatory medical exams, consultations, and assessments are not applied during CPS investigations. The OCO has identified the following applicable CPS policies where policy non-compliance has been cited:

PSM 713-6 – Obtaining medical and mental health records –

> The Child Protection Law, the Public Health Code (1978 PA 368, MCL 333.2640 & 333.16281) and the Mental Health Code (1974 PA 258, MCL 330.1748a) provide the legal authority and obligation for these providers to share their records with CPS, even without the client's consent. CPS investigations often require the investigator to obtain "*Information from medical and mental health records [is] frequently necessary to complete a CPS investigation, to provide information to the court, or to develop a more comprehensive services plan in a CPS case."*

PSM 713-4 – When medical exams are mandatory, investigations should include immediate consultation with medical personnel; provision of critical information to the physician prior to the examination; communication with medical personnel following the examination; documentation of medical results; and action steps that must be taken when a parent refuses to comply with securing a medical examination.

- Medical examination and assessment regarding medically fragile children - policy requires that the child's needs be evaluated and documented in the CPS Investigation Report. Documentation must include an assessment of the caregiver's ability to adequately provide for the physical and medical needs of a medically fragile child. Policy also requires contact with child's primary care physician.

- Medical exams of siblings in child death investigations - policy requires CPS to obtain medical examinations of "any other children residing in the household" if "a child is under the age of 6" and "[t]here has been a . . . Death of a sibling during the current investigation . . . ."

- Medical exams in repeated physical abuse cases – a medical exam is required if the complaint alleges, or the department's investigation indicates, that a child has been seriously or repeatedly physically injured as a result of abuse and/or neglect. There may not be obvious physical evidence, but information from the reporting person or other contacts made during the investigation may raise concerns and result in a decision to have the child examined, such as blows to the head or abdomen, resulting in internal injuries or a brain injury.

PSM 716-7 – Cases involving drug exposed infants – In complaints alleging that a newborn has been exposed to alcohol or drugs, the investigation must include contact with medical staff to determine whether laboratory tests confirm that the newborn has been exposed to alcohol or drugs, to identify any medical treatment which the child or mother needs, to assess the mother's attitude and behavior with the infant, to determine the expected discharge dates of the mother and infant and to determine whether there are other children in the home.

DHS Response to Recommendation 4:
CPS Program Office agrees that adherence with policy governing medical exams, consultations, and assessments must be a priority. In 2014, CPS Program office will take the following steps to increase understanding and compliance with these policies, including:

1. Consult with Child Welfare Field Operations management to consider potential strategies to improve policy compliance.
2. Provide additional communications to the field emphasizing the policy requirements and importance of compliance.
3. Address the policy and expected practice through the monthly child welfare supervisory teleconference.
4. Request that the Child Welfare Training Institute prioritize this policy and practice in training (both in new worker training and ongoing training) and that they consider additional training approaches, such as web-based trainings and podcasts, as possible ways to improve performance.
5. Focus on this issue during the Medical Child Abuse Conference in April 2014 and at the CPS Advisory Conference in September 2014.

FORENSIC INTERVIEWS

OCO Recommendation 5:
The OCO recommends DHS strengthen CPS policy regarding The Forensic Interviewing Protocol by:

a) Providing an electronic link in policy to the Protocol. Although CPS policy 713-1 directs CPS workers to "Follow the Forensic Interviewing Protocol (DHS Pub-779 – revised 10/07) when interviewing children and document the content of the interview," there is no link to the

Protocol or information included in policy regarding how to conduct a basic forensic interview.[14]

b) Providing specific information in CPS policy regarding how to document the contents of a forensic interview.

c) Providing guidelines regarding when a Child Assessment Center (CAC) should be contacted to conduct the forensic interview.

Rationale: The OCO continues to review cases where there is no documentation regarding the process used by a caseworker while conducting a forensic interview or the content of the interview. Often times, cases reviewed by the OCO document only that a child was forensically interviewed. When a caseworker conducts a forensic interview, documentation should include an example of each phase of the interview and all pertinent information the child disclosed. The Forensic Interviewing Protocol specifically states that *"if the interview is not being videorecorded or audiorecorded, it is paramount that the interviewer or designated person accurately document what the child says. Beginning with introducing the topic, the interviewer should try to write down the exact wording of each question as well as the child's exact words."*[15]

DHS has indicated that there are four situations that warrant a CAC forensic interview:

1. Sexual Abuse
2. Severe Physical Abuse (as defined in DHS policy)
3. Severe Neglect (as defined in DHS policy)
4. Witness to a violent crime

The OCO suggests these criteria be included in policy.

DHS Response to Recommendation 5:
Additional guidance on the Forensic Interview Protocol may be beneficial to investigators and strengthen practice. CPS Program Office plans to meet with those responsible for training on the protocol, including the Child Welfare Training Institute and The Prosecuting Attorneys Association of Michigan. CPS Program Office will determine what changes to policies and enhancements to training are needed. Following this meeting, a timeline will be identified to accomplish identified changes.

PETITIONS

OCO Recommendation 6:
The OCO recommends that DHS ensure agency staff comply with Child Protection Law Sections 17 and 18 (MCL 722.637) (MCL 722.638) respectively, as well as corresponding CPS policy PSM 715-3, regarding the filing of mandatory court petitions. Section 17 describes circumstances when a petition for court jurisdiction must be filed within 24 hours and Section 18 deals specifically with court jurisdiction and termination of parental rights.

[14] The Forensic Interviewing Protocol was revised in 4/2011.
[15] The Forensic Interviewing Protocol, page 3.

Rationale: Agency staff should be familiar with these CPL requirements. The OCO continues to find that caseworkers are not filing petitions when required (i.e. within 24 hours) or a petition is filed but lacks the mandatory request (i.e. request for jurisdiction or termination of parental rights).

DHS Response to Recommendation 6:
CPS Program Office will meet with the Office of Family Advocate, along with other DHS child welfare departments and identify potential action steps that should be taken to enhance policy understanding and field practice.

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