Follow-Up Report of Children's Protective Services Investigations,
Michigan Department of Health and Human Services
Project Number: 431-1285-16F

FINDING 1
Improvement needed to ensure that investigations are commenced in a timely manner.

OAG FOLLOW-UP CONCLUSION
Partially complied – Material condition still exists.

AGENCY PRELIMINARY RESPONSE

MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.

MDHHS has exceeded the department's Modified Implementation, Sustainability, and Exit Plan (MISEP) commencement performance standards (section 5.2) that were approved by the U.S. District Court for the Eastern District of Michigan. MDHHS was required to commence all investigations of a report of child abuse or neglect within the timeframes required by state law. The designated performance standard was 95% and MDHHS achieved and exceeded that metric.

MDHHS is an agency devoted to an important and challenging mission: Keeping kids safe and families together. Our caseworkers balance these goals 24/7, sometimes in difficult conditions, as they investigate nearly 70,000 child abuse allegations per year. The department promised and delivered significant reforms and progress. In the last five years, MDHHS enacted these changes:

- Updated its commencement policy in December 2017 to align with practice and further clarified the policy in August 2018.
- Developed a Supervisory Control Protocol (SCP) to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements and verify that required documentation occurred, including supervisory verification of the timeliness of commencement.
- Created a Compliance Review Team (CRT) to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether sampled investigations were commenced within the required time frame.
- Developed a Peer Case Review (PCR) process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

As the OAG concluded in section b. above, the department commenced 100% of required investigations within the required timeframes for the OAG's review period based on the current commencement policy. The MDHHS commencement policy requirements exceed best practices in other jurisdictions such as Washington, North Carolina, and Oklahoma.

The department conducts an initial assessment of safety upon receipt of a referral of alleged child abuse and/or neglect by Centralized Intake. Upon receipt of an allegation, the department

immediately assesses whether imminent harm is likely based on the reported allegations. Examples include but are not limited to:

- Failure to respond immediately could result in death of, or serious injury to, the child within 24 hours.
- Child requires urgent or emergency medical or mental health care for injury or illness due to alleged child abuse and neglect within the next 24 hours.
- There is a sexual abuse allegation, and the alleged perpetrator will likely have access in the next 24 hours.

The department's current policy is applied to the nearly 200 assigned child abuse and neglect referrals received on average each day. The policy is designed and implemented to keep kids safe through risk assessments, timely investigations, and compliance with the Child Protection Law.

FINDING 2
Considerable improvement needed in documentation of Central Registry clearances.

OAG FOLLOW-UP CONCLUSION
Partially complied – Material condition still exists.

AGENCY PRELIMINARY RESPONSE

MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.

In the last five years, MDHHS enacted a number of reforms including the development of a Supervisory Control Protocol (SCP) to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements and verify that required documentation occurred.

MDHHS asserts that significant progress has been made in this area as demonstrated by an improvement of 28% to 86% compliance. A Central Registry clearance is only one factor case managers consider in their overall assessment of safety.

FINDING 3
Considerable improvement needed in completion of required criminal history checks.

OAG FOLLOW-UP CONCLUSION
Partially complied – Material condition still exists.

AGENCY PRELIMINARY RESPONSE

MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.

The Michigan Department of Health and Human Services is an agency devoted to an important and challenging mission: Keeping kids safe and families together. Our caseworkers balance these goals 24/7, sometimes in difficult conditions, as they investigate nearly 70,000 child abuse allegations per year. Guided by Director Hertel's "Keep Kids Safe Action Agenda," MDHHS

works with lawmakers, police, judges, and other child welfare system leaders to do everything in our power to make Michigan the safest place in America to raise kids and nurture families.

In the last five years, MDHHS enacted a number of reforms including the development of a Supervisory Control Protocol (SCP) to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements and verify that required documentation occurred.

MDHHS asserts that significant progress has been made in this area as demonstrated by an improvement of 48% to 73% compliance with current policy and disagrees that the finding should remain a material condition. A criminal history check is only one factor case managers consider in their overall assessment of safety.

The department's efforts for continuous quality improvement continue to result in progress with recent updates to the policy. Effective September 1, 2023, LEIN policy has been updated to require CPS case managers to request a LEIN clearance as early as possible in the investigation, but no later than seven calendar days after receipt of the referral by Centralized Intake, on all alleged perpetrators and all adults residing in the household of the alleged perpetrator. The case manager may also conduct a LEIN clearance during any investigation. And finally, LEIN clearance must be requested when there are allegations of: sexual abuse, physical injury, sex or labor trafficking, domestic violence, and/or substance use, sales, or production. These revised policies reflect the attitude of continuous improvement and align with the recommendation by the OAG.

FINDING 4
Documentation of a complete review of CPS history for family and household members needed.

OAG FOLLOW-UP CONCLUSION
Partially complied – Material condition still exists.

AGENCY PRELIMINARY RESPONSE

MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.

In the last five years, MDHHS enacted a number of reforms including the development of a Supervisory Control Protocol (SCP), Compliance Review Team (CRT), and Peer Case Review (PCR) to improve required documentation that supports investigators conducted a complete review of CPS history on all required investigation persons.

MDHHS asserts that significant progress has been made in two of the three areas identified by the OAG as demonstrated by an improvement from 59% to 80% and 76% to 88%, respectively. MDHHS agrees that documentation should demonstrate CPS investigators conducted a complete review of CPS history on all required investigation persons. MDHHS consistently reviews internal policies and procedures to determine if changes are needed to strengthen policy, practice, and documentation and will consider the OAG's observations in any future policy enhancements.

FINDING 5
Significant improvement needed in the documentation of communication with mandated reporters.

OAG FOLLOW-UP CONCLUSION
Partially complied – Material condition still exists.

AGENCY PRELIMINARY RESPONSE

MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.

In the last five years, MDHHS enacted a number of reforms including the development of a Supervisory Control Protocol (SCP), Peer Case Review (PCR), and Compliance Review Team (CRT) to improve documentation that it provided the mandated reporter with written notification of its disposition of the investigation that resulted from the reporter's complaint.
CPS investigators followed policy for the period under review in relation to contacting the mandated reporter. The department promised and delivered significant progress in providing written notification of case disposition to mandated reporters, from 31% to 90%. Building on these gains, MDHHS is consistently reviewing and improving policies to keep children safe and families together.

The OAG's observations will help shape future reforms. MDHHS maintains accountability with its internal reviews, learning from every case and designing new strategies to improve the entire child welfare system.

FINDING 6
Improvement needed in completing timely face-to-face contact with alleged child victims.

OAG FOLLOW-UP CONCLUSION
Partially complied – Reportable condition still exists.

AGENCY PRELIMINARY RESPONSE

MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding is a reportable condition.

MDHHS agrees the department needs to make face-to-face contact with all alleged child victims in a timely manner.

The department made face-to-face contact with alleged child victims within 24 to 72 hours for 95% of the cases reviewed by the OAG. At times, extenuating circumstances, such as the inability to locate youth after multiple attempts, impacted staff's ability to make timely face-to-face contact. CSA's top priority is protecting the safety and well-being of children. Department leadership will continue to provide consistent oversight to ensure timely contact is made whenever possible.

FINDING 8
Documentation of safety planning at initial contact with family and completion, accuracy, and timeliness of safety assessments need improvement.

OAG FOLLOW-UP CONCLUSION
Partially complied – Material condition still exists.

AGENCY PRELIMINARY RESPONSE

MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.

MDHHS agrees that child safety is of utmost importance. Based on the OAG's finding, MDHHS demonstrated a 94% accurate completion rate of the department's current Structured Decision Making (SDM) safety assessment and safety plans are clearly documented in 80% of CPS investigations. While MDHHS recognizes opportunities to improve documentation of safety assessments and any required safety planning within case service plans, insufficient documentation does not necessarily mean actions are not being taken to ensure child safety and family well-being. It should be emphasized that the SDM safety assessment is a tool and is not intended to supersede a case manager's investigative findings, experience, and/or judgement when it comes to assessing and ensuring child safety.
To ensure child welfare staff have the tools they need to continue assessing child safety timely and effectively, the department is actively redesigning and enhancing the current safety assessment to improve accuracy, equity, reliability, and utility.

The department has embarked on an expansive project with a nationally recognized child welfare organization to facilitate this work. This organization has worked with over 30 jurisdictions nationwide and overseas to implement the SDM safety assessment. Various, diverse stakeholders are actively contributing to the development of the enhanced assessment, including but not limited to, tribal governments, parents and young people with lived experience, race equity experts, child welfare staff and leadership, and service providers. There is a great deal of emphasis on ensuring language and application is consistent and equitable.

The design of the new safety assessment will require staff to complete the assessment within two working days of initial contact with the family, at critical decision points throughout the case, and/or prior to case closure. Additionally, a safety plan component will be built into the new assessment, designed to enhance documentation of required safety planning for any identified immediate harm factors. Prior to implementation of the new tool and practice, MDHHS policy will be updated to align accordingly.

In the interim, the department will continue to offer training, policy, and practice guidance to staff to ensure accurate completion of the SDM safety assessment and that documentation reflects the work being done to assess and ensure child safety and family well-being.

FINDING 9
Improvements needed to ensure compliance with CPL court petition filing requirements.

OAG FOLLOW-UP CONCLUSION
Complied

AGENCY PRELIMINARY RESPONSE
Not Applicable

FINDING 10
Significant improvements needed to ensure compliance with CPL-required referrals to county prosecuting attorneys.

OAG FOLLOW-UP CONCLUSION
Complied

AGENCY PRELIMINARY RESPONSE
Not Applicable

FINDING 13
Significant improvement needed to ensure accurate assessment of the risk of future harm to children.

OAG FOLLOW-UP CONCLUSION
Not complied – Material condition still exists.

AGENCY PRELIMINARY RESPONSE

MDHHS agrees that it must accurately assess a family's risk of future involvement with the child welfare system and recognizes there are always opportunities for improvement in this area.

MDHHS has implemented a number of strategies to increase risk assessment accuracy. MDHHS recognizes that our Children's Protective Services employees have been asked to use antiquated tools and technology to solve 2023 problems. MDHHS recently requested a $12 million appropriation from the Legislature to take another step toward implementation of our new electronic case management system, the Comprehensive Child Welfare Information System, commonly known as CCWIS. This appropriation will allow us to revise the department's current risk assessment to improve accuracy, consistency, and equity in providing services. Additionally, after several years of working with legislative partners, MDHHS accomplished a statutory change that took effect November 1, 2022. This change removed the current risk assessment as a consideration in determining the placement of someone on the child abuse and neglect Central Registry. This legislative action was necessary to allow the department to move forward with revising the risk assessment tool to address potentially subjective and ambiguous language that could result in inconsistent interpretation of risk assessment among other opportunities. In conjunction with the above efforts, MDHHS will continue to provide interim guidance and training to staff to ensure risk is accurately assessed and addressed.

FINDING 14
Impact assessments needed to identify and evaluate the effect of MiSACWIS risk assessment functionality changes.

OAG FOLLOW-UP CONCLUSION
Complied

AGENCY PRELIMINARY RESPONSE
Not Applicable

FINDING 16
Improvement needed in timely completion of CPS investigations.

OAG FOLLOW-UP CONCLUSION
Substantially Complied

AGENCY PRELIMINARY RESPONSE
Not Applicable

FINDING 17
Significant improvement needed in supervisory oversight of CPS investigations.

OAG FOLLOW-UP CONCLUSION
Not complied – Material condition still exists

AGENCY PRELIMINARY RESPONSE

The OAG found MDHHS in compliance with timely review of investigations in Finding 16, which the department believes is an important step for child safety along with supervisory oversight.

MDHHS disagrees Finding 17, regarding the supervisory review of investigations, should remain a material condition and MDHHS disagrees that compliance with the prior year recommendation was not achieved. As reported by the OAG's review of Finding 17, the following improvements have been demonstrated:

- 94% of investigations were reviewed by the supervisor within 14 days.
- With the implementation of the Supervisory Control Protocol, all case files are reviewed multiple times by the supervisor within the first month of receipt.
- 98% of the case file documentation demonstrated supervisors met with the investigator prior to disposition.
- Timely review and case file documentation compliance substantially increased as compared to 2018, as a result of newly implemented and ongoing remediations.

The improved outcomes were achieved as the result of the following corrective actions implemented by MDHHS since the last audit:

- Assured supervisors are meeting with investigators multiple times during an investigation to discuss child safety, safety planning, and other critical items.
- Implemented a Supervisory Control Protocol to increase the effectiveness of the review process.
- Created a Compliance Review Team to continually evaluate processes and implement practices as needed.
- Developed a Peer Case Review to provide independent oversight of CPS investigation practice within each jurisdiction.
- Created a team of CPS supervisors to provide ongoing supervisor training.

CPS supervisors have significantly improved the effectiveness and timeliness of CPS investigation reviews and the consistency of case consultations with investigators.

FINDING 18
Monitoring of families' participation in post-investigative services needed for all Category III investigations.

OAG FOLLOW-UP CONCLUSION
Not complied – Material condition still exists.

AGENCY PRELIMINARY RESPONSE

Five years ago, the OAG issued an audit of MDHHS's Children's Protective Services that found the department did not adequately monitor families' participation in post-investigative services.

MDHHS disagrees with the OAG's recommendations. Following the OAG's CPS audit in 2018, the Children's Services Administration (CSA) reviewed the category III open/close practice further internally to assess the need for legislative clarification. When MCL 722.628d was enacted (1998 PA 484; analysis in 1998-SFA-0603), there was a reporting requirement by the department to the legislature which included the number and percentage of category III cases where the person/family did not participate in services. Arguably, at that time, the department had to monitor cases to accurately report back to the legislature. However, the 2006 amendments to MCL 722.628d (2006 PA 618; analysis 2005-SFA-1254) changed the reporting requirement to include "[t]he number of cases referred to voluntary community services and closed with no additional monitoring." Thus, by January 3, 2007, there was legislative recognition that category III cases were being closed without any additional monitoring. Further amendments did not appear to address the reporting requirement issue.

CSA's top priority is protecting the safety and well-being of children. A category III classification means there is a preponderance of evidence of child abuse and/or neglect, and the risk of future harm is low or moderate. In all category III cases, staff are required to refer the family to services commensurate with the risk level and any identified safety factors. Prior to closure of the investigation, staff assess a family's willingness and need to voluntarily participate in services through engagement and a strength-based Family Team Meeting. If it's determined the child/ren is/are safe and ongoing CPS monitoring is not needed, the staff may open/close the category III investigation. If there is an ongoing safety matter requiring services and a family will not voluntarily participate, or does not appear to be making progress, the staff must consider escalating the case. Additionally, implementing the OAG's recommendation could create a situation where the department is involved in families' lives far longer than necessary. The Department believes that additional monitoring would not significantly benefit children who are identified as low to moderate risk.

FINDING 20
Improvement needed in appropriately adding confirmed perpetrators to the Central Registry as required by the CPL.

OAG FOLLOW-UP CONCLUSION
Complied

AGENCY PRELIMINARY RESPONSE
Not Applicable

FINDING 21
The notification process to inform individuals whose names MDHHS adds to the Central Registry needs significant improvement.

OAG FOLLOW-UP CONCLUSION
Partially complied – Reportable condition still exists.

AGENCY PRELIMINARY RESPONSE

MDHHS disagrees that the finding is a reportable condition because MDHHS fully complied with the prior audit recommendation.

MDHHS agrees that documentation demonstrates required central registry notification was provided to identified perpetrators in 100% of investigations. MDHHS consistently reviews internal processes to determine if improvements are needed to strengthen policy, practice guidance, and documentation and will continue to do so moving forward

FINDING 24
Improvement needed to ensure that MDHHS captures complete, accurate, and valid MiSACWIS data related to investigation commencement.

OAG FOLLOW-UP CONCLUSION
Complied

AGENCY PRELIMINARY RESPONSE
Not Applicable

OBSERVATION 1

Evaluation of the CPL's commencement requirement is likely needed.

No Response Required

OBSERVATION 2

Further guidance may be needed to investigate allegations of physical abuse.

No Response Required