OCA

Office of the Child Advocate

ANNUAL REPORT

2023

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Director's Letter

This past year brought big changes to the Office of the Child Advocate (OCA). For nearly 30 years, this office was better known as the Office of Children's Ombudsman or the OCO. I have previously served Michigan as the children's ombudsman. In December 2023, Lt. Gov. Garlin Gilchrist II signed Public Act 303 into law. In addition to adding new responsibilities to the OCA, the new law changed the name of the OCO to the Office of the Child Advocate. I am humbled to serve as Michigan's first child advocate.

Our mission has not changed — it has been enhanced. The OCA will be able to investigate the administrative actions of residential facilities, whether state, county, or privately owned, that provide juvenile justice services to Michigan's youth. Additionally, Michigan's governor and a judge for a juvenile receiving juvenile justice services were added to a list of individuals with whom I can discuss our investigative findings. The OCA can now mediate unresolved concerns between a complainant and a residential facility serving juvenile justice wards.

Our goals have always been and remain centered on improving Michigan's child welfare system. The OCA team works tirelessly throughout the year to educate the public, advocate on behalf of Michigan's children, raise awareness, and conduct thorough reviews of child welfare cases to make recommendations for improvement.

We operate from a national standard of ombudsman and advocate offices. This standard is based on four key principles: independence, impartiality, confidentiality, and a credible review process. I am forever grateful to the OCA staff for their professionalism, curiosity, diligence, and compassion. Every team member at the OCA wants to help. As you will find in this report, I am happy to inform readers that the OCA has been successful in 2023. We also recognize that this success could not be realized without the hard work of our partners at the Michigan Department of Health and Human Services, the medical community, law enforcement. and service providers across this state.

Sincerely,

Ryan Speidel

Ryan Speidel | Director, Michigan's Child Advocate

Mission

To improve Michigan's child welfare system by raising awareness, advocating for changes, educating the public, and conducting thorough reviews to make recommendations for improvement.

Vision

To support and speak on behalf of children, to make a positive impact on Michigan's child welfare system.

Values

Our agency will function as an independent and impartial entity by implementing credible review processes that prioritize confidentiality.

We are dedicated to promoting diversity, equity, and inclusion both internally and externally, and commit to cultural competency to make a difference and improve outcomes for children.

Authority

The Office of the Child Advocate was created by Michigan law in 1994 to improve Michigan's child welfare system by supporting and speaking on behalf of children throughout the state. The OCA is an independent agency housed in the State of Michigan's Department of Technology, Management & Budget.

The Legislature gave the OCA broad investigative authority regarding actions involving Children's Protective Services, foster care, adoption, child-caring institutions, entities contracted to provide these services, and residential facilities that provide juvenile justice services.

Advocacy: The OCA speaks on behalf of children as it works with state policymakers and elected officials to raise awareness of issues facing Michigan's child welfare system and make recommendations for improvement based on its casework and investigations

The child advocate can pursue all necessary action, including legal action, to protect the rights and welfare of a child under the jurisdiction, control, or supervision of a residential facility or a child who is the victim of a Children's Protective Services maltreatment in care investigation. .

Investigations: The OCA has the authority to investigate complaints regarding the child welfare system, which includes Children's Protective Services, foster care, adoption, child-placing agencies, child-caring institutions, and residential facilities providing juvenile justice services. When a complaint is filed, OCA staff conduct a preliminary investigation to determine if a full investigation is warranted. After a full investigation is completed, the OCA may present relevant recommendations to Michigan Department of Health and Human Services (MDHHS), the governor, the Legislature, or state officials.

The child advocate can review policies and procedures of the Department of Health and Human Services and certain residential facilities involved with children and may make factual findings and recommendations for improvement.

Compliance: The OCA is tasked with helping to ensure the child welfare programs listed above comply with Michigan law and administrative rules, as well as state policies and procedures.

Education: The child welfare system is a vast, interconnected set of institutions and agencies. The OCA can provide information to families involved in Michigan's child welfare system. In addition, the OCA intake staff can provide insight into the system's processes and help provide follow-up resources.

Message from Deputy Director

As the deputy director of Michigan's Office of the Child Advocate, I take great pride in the phenomenal work that our staff has completed, as showcased in our 2023 Annual Report.

Our dedication to investigating complaints and assessing policies and procedures in the children's services system has enhanced youth protection and family support.

Our staff members participate in various statewide committees focused on child welfare to ensure that the OCA remains supportive and up to date on changes affecting Michigan residents.

We are fully dedicated to enhancing diversity, equity, and inclusion practices both individually and as a team. In Michigan, there has been a consistent pattern of more children of color being separated from their biological families and placed in foster care. Recognizing the impact of implicit bias in child welfare decisions, we aim to bring about positive changes in outcomes for all children and diminish the concerning statistics related to minority children in foster care.

Our commitment to learning from other ombudsman offices and using best practices from across the U.S. to serve Michigan residents has allowed us to remain at the forefront of child advocacy. Together, we will continue to work tirelessly to ensure the safety and well-being of the children and families we serve.

Sincerely,

Kenyatta Lewis

Kenyatta Lewis | Deputy Director
Michigan Office of the Child Advocate

About the OCA

History

The **Office of the Child Advocate (OCA)** was established by the Michigan Legislature in 1994 as the Office of Children's Ombudsman. Its purpose was to bring greater transparency and accountability to Michigan's child welfare system.

In 2023, the Child Advocate Act was enacted, which changed the name to the Office of the Child Advocate (OCA). The OCA was established as an independent state agency within the Department of Technology, Management & Budget. Its primary responsibility is to advocate for children, educate the public on child welfare matters, ensure compliance with Michigan's child protection laws, and receive and investigate complaints regarding the administrative actions of the Michigan Department of Health and Human Services (MDHHS) and contracted entities that provide child protective services, foster care, and adoption, and state, county, court, or privately run residential facilities that provide juvenile justice services. The OCA is also responsible for reviewing administrative actions of MDHHS and residential facilities for children in cases where a child has died.

In addition to addressing citizen complaints, the OCA makes recommendations to the governor, the Legislature, certain residential facilities, and MDHHS for changes in child welfare laws, rules, and policies to improve outcomes for children. Michigan's child advocate is appointed by the governor with the advice and consent of the Michigan Legislature and is supported by a team of investigators from different disciplines.

Organizational Structure

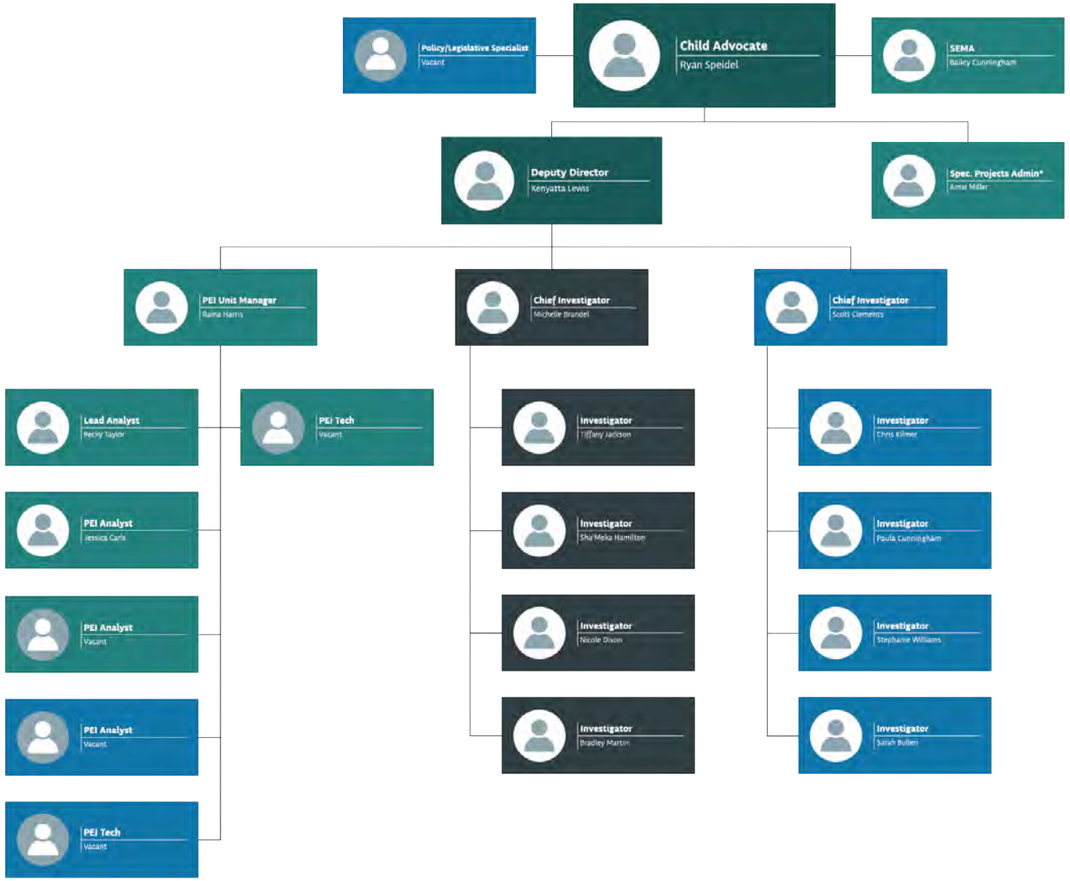
The Office of the Child Advocate plans to expand its services to address juvenile justice complaints in 2024. The office will be restructured to include additional staff who will work from two locations: the Romney Building in Lansing and the Cadillac Place building in Detroit.

Ryan Speidel, the child advocate, has been instrumental in implementing the vision of the previous ombudsman, Suzanna Shkreli. Ryan has hired a legislative and policy liaison to work at the Office of the Child Advocate. Along with the legislative and policy liaison, Ryan manages three direct reports: the deputy director, the special projects administrator, and the child advocate's executive management assistant.

Kenyatta Lewis, the deputy director, is responsible for managing the OCA's day-to-day operations. She also oversees the two divisions that make up the OCA. Two investigative units form the investigative division and are managed by two chief investigators, Michelle Brandel and Scott Clements. The Public Education and Intake (PEI) Unit is the second division and is managed by PEI Administrator Raina Harris.

Intake & Investigations Units: Each investigative unit is composed of four investigators while the PEI division has five departmental analysts and one departmental technician.

Organizational Structure Chart



Changes in Law

On December 12, 2023, Public Act 303 of 2023 changed the name of the Office of Children's Ombudsman to the **Office of the Child Advocate (OCA)**. Our core mission remains unchanged, which is to support and speak on behalf of children to improve Michigan's child welfare system. The OCA remains an independent state agency. Public Act 303 also added the following to the Child Advocate Act:

- **Defines residential facilities** for the purposes of the Child Advocate Act.
- **Authority to investigate** the administrative actions of residential facilities providing juvenile justice services.
  - Whether state, county, or privately owned and operated.
  - Residential facilities must provide a confidential area for the OCA staff to speak with juvenile justice wards.
  - Residential facilities providing juvenile justice services must make their records available to the OCA.
  - Residential facilities providing juvenile justice services must provide information the OCA deems necessary for its investigation.
  - The OCA must investigate the actions of the entities involved when a child has died in a residential facility.
  - Any findings and/or recommendations made to a residential facility will be submitted to the facility with a request for a response from the facility.
  - Allows the child advocate to mediate some situations in residential facilities.
- **Adds the governor and a judge** for a juvenile receiving juvenile justice services.
- Allows the child advocate to **send OCA staff to training** related to child abuse and neglect.

OCA Training

Each year, the OCA staff participate in a variety of training offered virtually, around the state, and throughout the country. Training topics include Identifying Childhood Trauma; Understanding Vicarious Trauma; Multidisciplinary Teams; Abusive Head Trauma; Diversity, Equity, and Inclusion (DEI); and various other topics related to child abuse and neglect, investigations, and DEI. In 2023, OCA staff members were able to travel out of state to professional trainings and conferences.

2023 USOA Annual Conference: Michigan's child advocate is a member of the United States Ombudsman Association (USOA). This year, the child advocate traveled to the USOA conference in Atlanta, Georgia. The USOA conference is beneficial for the child advocate to allow in-person networking with other ombudsmen/advocates across the country and to learn national best practices. This year, a presentation from Alberta/Ontario Canada's Ombudsman Office on Strategic Planning provided additional guidance and ideas when creating the OCA's strategic plan. A highlight from the 2023 USOA conference was a plenary session presented by Dr. Bryant T. Marks Sr. on Implicit Bias. Dr. Marks Sr. is an award-winning educator and the founding director of the National Training Institute on Race and Equity.

National Alliance for Drug Endangered Children Conference: The OCA's Public Education and Intake Unit (PEI) staff attended the National Alliance for Drug Endangered Children Conference in Kansas City, Missouri. This conference highlighted topics including the continued dangers of marijuana, fetal/neonatal marijuana exposure, the facts of fentanyl, the impact of familial substance use on children, and supporting relatives caring for drug-endangered children. In addition to these topics, the conference included presentations on DEI as it relates to drug-endangered children, substance use impacts within tribal communities, and how to develop a statewide drug-endangered child handle-with-care collaborative. Staff listened to many stories on addiction, resiliency, and the effects on children.

The PEI unit brought back additional knowledge on the continued dangers of marijuana use during pregnancy with the increase in marijuana legalization and the long-term impacts prenatal marijuana exposure has on child development. Several members of the PEU unit provided training to the OCA regarding these topics.

CLEAR National Certified Investigator and Inspector Training: In 2023 the Child Advocate made the decision that all investigative staff would attend and become certified in a national model for conducting administrative investigations. The OCA's research led it to the Council on Licensure, Enforcement, and Regulation (CLEAR) National Certified Investigator and Inspector Training, in Salt Lake City, Utah.

The team attended the **three-day Basic Training Program** to further enhance their investigative skills as they relate to administrative investigations. The investigators learned techniques for interviewing and report writing and ways to further develop their investigative processes. These additional techniques will aid the OCA's investigative team in conducting thorough, unbiased, independent investigations. Following the training, the investigators all passed an examination providing certification from CLEAR as Certified Investigators and Inspectors.

Operations and Metrics

Public Education

TEN-4-FACESp

During a child death alert investigation, OCA team members were speaking with the medical director at KIDSTalk in Detroit. KIDSTalk is the Child Advocate Center (CAC) for Wayne County and its medical director is a child abuse/neglect specialist. The OCA team showed a photograph of a child with facial injuries. The investigative team explained to the KIDSTalk medical director that none of the medical practitioners who examined the child before her death believed the injuries to be the result of child abuse. The injuries shown in the picture were taken before the death. Postmortem, the injuries in the photograph were deemed by investigators to be the result of child abuse. There were bruises on the child's cheeks that were in the pattern of three fingers and a bruise along the jawline. These injuries are highly indicative of child abuse.

The KIDSTalk medical director informed the OCA team about a little-known clinical rule dubbed TEN-4-FACESp. The medical director described how "TEN-4" is an easy tool to train and apply, and if used correctly it can heighten a medical practitioner's awareness to injuries that are highly indicative of child abuse. TEN-4 stands for Torso, Ears, Neck, and children under 4 months rarely bruise; FACESp stands for Frenulum, Angle of the jaw, Cheeks, Eyelids, or Subconjunctivae (whites of the eyes), and Patterns.

The OCA team immediately saw the benefit TEN-4 offers Michigan's first responders and investigators. With an idea and a plan, the OCA administration partnered with Güd Marketing to produce a Michigan-made training video that explains TEN-4 to a broad audience. This training video is intended to allow those who interact with children, as mandated reporters of child abuse, to more easily identify injuries that are highly suspicious of child abuse. The training video will be available to child protective service case managers, foster care case managers, family preservation specialists, medical practitioners, law enforcement officers, and staff at Michigan's Child Advocacy Centers. It will be easily consumable on mobile devices and last approximately three to five minutes.

The OCA team spent the second half of 2023 bringing this project together with our contracted vendor. Filming took place in an Ingham County courthouse, the Michigan Historical Center, KIDSTalk, an ambulance bay, and a medical exam room. The team hopes to have the training video complete and dispersed to our child welfare partners in mid-2024.

Director's Public Presentations

The child advocate presented to attendees at the Michigan Association of Chiefs of Police's annual winter conference in Grand Rapids; staff of the Oakland County Prosecutor's Office; Michigan House of Representatives Families, Children, and Seniors Committee; several MDHHS Business Service Centers; and all three MDHHS district offices in Wayne County to provide an overview of the OCA, its authority, processes, and responsibilities under Michigan law.

Director Speidel also provided testimony on several bills before several Michigan House and Senate committees. (Committees provided testimony: Michigan House of Representatives Judiciary Committee and Families, Children, and Seniors Committee; Senate Civil Rights, Judiciary, and Public Safety Committee.)

Strangulation Versus Choking

In 2023 the OCA investigated several cases where there was an accusation of strangulation as part of the child abuse investigation. Strangulation is not necessarily always fatal; however, the potential lethality is extremely high. The OCA researched the differences between strangulation and choking and the common misconceptions. The OCA reviewed scholarly journals and resources from the Training Institute on Strangulation Prevention, and spoke with experts on the topic, including medical professionals and law enforcement.

The OCA learned there is a large misconception regarding strangulation. Choking is often the word used to describe this act. Strangulation and choking are very different, and strangulation is extremely dangerous. The OCA finds it important to provide this information to the public, in hopes of raising awareness.

Choking is an internal event that occurs when a foreign body, such as food, gets lodged in the esophagus and causes the trachea to get squeezed and cut off air supply to the lungs. Choking is accidental and is not caused by another individual.

Strangulation is an external event that occurs when enough pressure is placed on a person's airway or vascular systems in the neck to restrict airflow and/or blood flow to the brain and lungs. The act of strangulation can cause different kinds of injuries depending on how much pressure is applied and for how long that pressure is held to someone's neck. These injuries vary from person to person and the unique situation of each incident.

According to the experts, 50% of strangulation cases show no visible injuries. In another 35% of cases, the injuries are so faint they cannot be photographed, leaving only 15% of cases where photographs of injuries caused by strangulation can be taken. Other signs and symptoms of strangulation include voice changes such as hoarseness, change of pitch, raspy voice, etc.; swallowing changes including pain when swallowing, pain to the throat, difficulty swallowing, coughing, or clearing of the throat; and breathing changes including hyperventilation and having trouble catching breath.

It does not take much pressure or time to cause injury and/or death to a person who gets strangled. Approximately 4.4 pounds of pressure is required to cause injuries to the jugular, which is less pressure than opening a can of soda; 11 pounds to cause injuries to the carotid arteries; 33 pounds for injuries to the trachea; and 66 pounds to cause injuries to the vertebral arteries. It takes only an average of 6.8 seconds to render someone unconscious during the act of strangulation, 11-17 seconds to cause an anoxic seizure, and 62-157 seconds for respiration to cease.

Unfortunately, the OCA has observed an uptick in child abuse involving strangulation. Strangulation is a felony in Michigan, and when guilt is found, it is punishable for up to 10 years in prison, a fine up to $5,000, or both.

Additional Resources

Below are additional resources of information on strangulation and common misconceptions.

Child Strangulation Training PowerPoint, Brad Eith (Glendale Child Crimes), Chris Schopen (Forensic Interviewer Specialist), Cindy Nannetti (Retired Division Chief MCAO), and Jill Rable (RN, MSN ED, AFN BC, CPN, SANE A).

Bichard, H., Byrne, C., Saville, C.W.N., & Coetzer, R. (2021). ***The neuropsychological outcomes of non fatal strangulation in domestic and sexual violence: A systematic review.***

Neuropsychological Rehabilitation, 32(6), 1164 1192.

Physiological Consequences of Strangulation. Occlusion of Arterial Blood Flow: Seconds to Minutes Timeline.

Signs of Strangulation in Children, Strangulation Training Institute

Five Myths About Strangulation, Strangulation Training Institute

The Danger of Strangulation, Family Justice Center Alliance

Filing a Complaint with the OCA

Complaints can be filed with the OCA when there are concerns that an agency within Michigan's child welfare system (Children's Protective Services, foster care, adoption, and juvenile justice) has violated child protection law or agency-specific policies. The OCA can investigate these matters to determine whether the actions and decisions made by the agency comply with the laws, rules, and policies. **The OCA has no legal authority to investigate complaints that exclusively involve**:

- Worker misconduct
- Friend of the Court issues (custody, child support, parenting time)
- Guardianships
- School problems
- Law enforcement
- Attorneys
- Judges
- Court orders
- A court's placement decision

In the event the OCA cannot investigate a complaint, referral information can be provided for the appropriate agency that can assist.

How to File

Complaints can be filed online through the OCA website by completing a complaint form under the "File a Complaint" section.

Information needed:

- Name of the child(ren)
- Parent or caregiver information
- Agency name
- Complainant's information (complainants remain anonymous)
- Reason for the complaint

While the complainant's information is required to complete our online form, it should be noted that the complainant identity remains anonymous. The OCA can disclose a complainant's information only after gaining the complainant's written consent.

A complaint can also be filed along with the supporting information via fax or mail. Complaints can be taken over the phone by the intake coordinator when a call is made to the OCA main line. The same information outlined in the complaint form will be required for complaints processed via phone.

Whom We Got Complaints From

Adoptive Parent	15
Attorney	5
Biological Parent of the Child	213
Foster Parent of the Child	37
Guardian Ad Litem	1
Interested Party	26
Legally Appointed Guardian	9
Mandatory Reporter	42
Non-Sibling — Household Member	1
Non-Sibling — Non-Household Member	7
Ombudsman/Child Advocate	3
Other/Unknown	1
Prospective Adoptive Parent	13
Relation Within 5th Degree	56
Sibling — Household Member	3
Sibling — Non-Household Member	4
The Child	7

Intake & Preliminary Investigation Process

The intake process for the Office of the Child Advocate (OCA) starts when the Public Education and Intake (PEI) Unit receives communication in any of the following formats: phone, online, email, regular mail, or facsimile.

Child Death Alerts:

The OCA is informed about child death cases by receiving death alert notifications and secondary death alert notifications via email. Child death alert notifications from the Michigan Department of Health and Human Services (MDHHS) are received after CPS Centralized Intake receives a complaint regarding a child or children who have died. The secondary death alert notifications come from Michigan's Vital Records when they receive notice of a child's death. This process is designed to ensure that the OCA is notified even if MDHHS is not informed or if an error occurs within their record management system.

The child advocate serves as the complainant for all child death alerts received by the office.

Complaint Intake:

The OCA refers to these cases as complaint cases. The person who makes the complaint is referred to as a complainant. Upon receiving the communication, the OCA enters it into its record management system, known as the Michigan Child Advocate Information System or MiCAIS, and assigns a PEI analyst to perform a preliminary investigation. The preliminary investigation process allows the PEI analyst to gather information and case history in the MDHHS' record management system, and interpret law, policy, and administrative rules to complete their report.

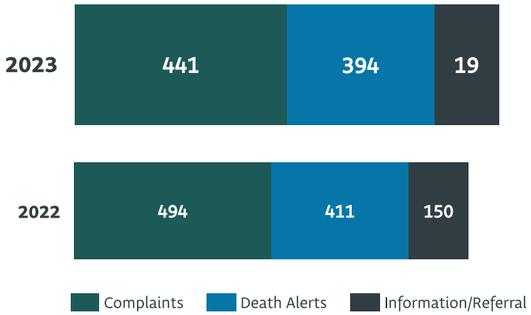
PEI analysts are required to review a new complaint within 10 days and contact the complainant to discuss their complaint in detail. Based on all the information gathered, the PEI analyst decides whether the complaint meets the criteria for a preliminary investigation. If not, the PEI analyst provides the complainant with specific guidance and education regarding the child welfare system. If it is determined a preliminary investigation is not needed, the case is closed as an information/referral. If the complaint meets the criteria for preliminary investigation, the PEI analyst has 10 days to perform the initial interview and 30 days to conduct a preliminary investigation. For child death cases received via the death alert notification or secondary death alert notification, the PEI analyst has 30 days to conduct a preliminary investigation.

The preliminary investigation report includes a fact-based narrative, analysis, conclusion, and recommendation. The recommendation is to either open the case for a full investigation or close it at the preliminary level. A full investigation is warranted if there are any issues or concerns that were identified. The PEI manager and deputy director then review the recommendation to determine the final preliminary investigation outcome.

During the preliminary investigation, if a concern regarding the safety of a child or children is identified, the PEI analyst brings it to the attention of the PEI manager, and the child advocate is made aware. Subsequently, appropriate contact with MDHHS or a child-placing agency is made in an attempt to mediate the safety issue(s) and ensure the safety of the children involved.

2023 Intake Statistics

In 2023, the OCA handled 441 complainant cases, 394 child death cases, and 19 requests for information for a total of 854 cases. The chart below shows the breakdown of each case type in comparison with other years. The number of total complaints in 2023 was down from 2022; however, the number of complaints and deaths was relatively close to previous years.



In 2023, 123 complaint cases were closed after a preliminary investigation was completed, and 41 cases were closed due to being duplicates.

Also, 229 complaint cases were closed as an information/referral — meaning the complaint was addressed by providing information to the complainant — and no investigation was needed.

The OCA was able to mediate five cases at the preliminary investigation level.

The OCA opened 40 complainant cases for a full investigation.

Cases Closed at Preliminary Investigation	123
Duplicate Complaints	41
Changed from Complaints to Information Referral	229

Accidental	93
Homicide	28
Indeterminate	57
Natural	75
Suicide	22

Preliminary MOD — Accidental	34
Preliminary MOD — Homicide	7
Preliminary MOD — Indeterminate	34
Preliminary MOD — Natural	13
Preliminary MOD — Suicide	3
Unknown at Time of OCA Case Closure	28

In 2023, the OCA received 307 child death alerts from MDHHS, while the other 87 child death alert cases resulted from the OCA's secondary death notification system. Of that total, 351 of the child death alert cases were closed following the preliminary investigation and four were closed due to the cases being duplicated. The OCA opened 31 child death alerts for a full investigation.

During the preliminary investigation process, the assigned analyst requests the autopsy report for the child from the appropriate medical examiner's office. This information is used to confirm the cause and manner of death.

Most preliminary investigations are closed before the autopsy is completed. Once the OCA receives an autopsy report, management reviews the preliminary investigation along with the autopsy report to determine if the case can remain closed or if the child advocate needs to review it for a possible full investigation. During this process, the cause and manner of death are also updated in the OCA's case system. The preceding charts identify the cause and manner of death, and the presumed cause and manner of death at the time of the preliminary investigation closure.

Investigations

Investigation Process Overview

Opening a Full Investigation: When it is determined a full investigation is needed, the case is assigned to an investigator in one of two investigation units. The OCA investigators are specialist-level employees with expertise in child welfare and conducting administrative investigations. A full investigation can be opened by the OCA for a complainant case, death case, or a systemic look at a specific issue identified by the child advocate.

The reasons for opening a full investigation for a complainant case vary depending on the case circumstances, the concerns that brought the case to the OCA's attention, and what information was available at the time of the preliminary investigation. The purpose of a full investigation for a complainant case can include determining agency missteps, attempting to mediate a current situation involving child safety, or determining if there are gaps within child welfare law and policy that could negatively affect the outcomes for children and families.

The Investigation: Throughout the OCA investigation, the investigator will review Children's Protective Services, foster care, adoption, and juvenile justice case history and case records deemed relevant to the investigation. The investigator details these case reviews as case summaries in MiCAIS.

In addition to the relevant child welfare history, an analysis of what occurred in the case is performed to identify CPS investigation and case management deficiencies that negatively affected the individual case. The OCA also identifies law, policy, or administrative rule deviations found.

OCA investigators completed 398 case summaries in 2023.

OCA investigators will also obtain and analyze medical records, police reports, court reports and orders, autopsy reports, and other documents necessary for their investigation.

In 2023, investigators completed 224 electronic record reviews and 296 document analyses/reviews.

An OCA investigator will conduct interviews as part of their investigation. An OCA investigator may interview a multitude of professionals and witnesses, including MDHHS and private agency staff, OCA complainants, law enforcement professionals, medical professionals, subject matter experts, and other individuals deemed necessary. Interviews are conducted to obtain a full understanding of the case dynamics, if missteps are present, why they may have occurred, to find out if any barriers were present, and to ask the interviewee what they believe would or could provide better outcomes.

The interview is often a two-way street and OCA investigators are encouraged to provide education on Michigan law and policy if needed, as well as provide advice on what can be done moving forward, in their current case or future cases. Additionally, interviews allow the investigator to build relationships with the child welfare partners and address any child safety concerns.

In 2023, the five OCA investigators conducted 256 interviews.

Throughout all OCA investigations, the assigned investigator remains alert to emerging threats to child safety. If a child safety issue is observed during an OCA investigation, immediate action is taken to alert MDHHS or local law enforcement to ensure the safety of the child. The child advocate is notified of all child safety concerns.

S.T.A.R. Analysis: Once an OCA full investigation is completed, the investigator completes a S.T.A.R. (Significance, Timing, Attention, and Recommendation) Analysis, which is included in their recommendation for how to close the case.

The S.T.A.R. Analysis aids OCA investigators in making case closure recommendations to the OCA administration and child advocate. Use of the S.T.A.R. Analysis was implemented in 2023 and tasks the investigator with analyzing the four S.T.A.R. elements when determining how to recommend the case proceed with closure.

How OCA Full Investigations Close

Full investigations can be closed in one of four categories:

- Administrative closure
- Successfully mediated
- Informal remedy
- Findings and Recommendations Report (Recommendations to MDHHS and their responses is located in Appendix B).

A full investigation may close as an administrative closure if the OCA investigator determines the actions or inactions of the agency involved did not cause negative outcomes or harm to the children/families involved if no law or policy violations were found, or if the timing of the case is not appropriate for further action by the OCA. Additionally, cases can close administratively if no case management deficiencies are found.

The OCA closed 33 complainant investigations and 36 death investigations as administrative closures in 2023.

During an investigation, when case management deficiencies are found, the investigator analyzes how the deficiencies affected the case and the children and families involved, and if the outcome could have been different had the violations not occurred.

The OCA now provides information to MDHHS regarding case deficiencies through what is known as an informal remedy. One informal remedy is to issue a memo to the Children's Services Agency (CSA), the local MDHHS county handling the case, and/or the private agency involved. An Information Memo includes the information discovered during the OCA investigation and provides suggestions on what may help improve best practices, or where additional review of MDHHS practices and policies by CSA may need to occur.

Another informal remedy identified when closing full investigations is a systemic investigation. This occurs when a systemic issue is identified by the child advocate. A systemic investigation is a deeper dive into an issue or issues presented on a systemic level. Systemic investigations attempt to find the root cause and make meaningful recommendations to positively affect change. In 2023, the OCA opened one systemic investigation, taking a deeper look into the foster care system, to determine where gaps and deficiencies in practice, law, and policies may be negatively impacting Michigan's foster children. This systemic investigation remains open at the time of this report.

In addition to closing cases as informal remedies through an Information Memo or a systemic investigation, the child advocate also presents statistics on law and policy violations identified during investigations when presenting to MDHHS Business Service Center meetings.

The OCA closed five full investigations through Information Memos, and eight investigations were added to the systemic investigation concerning the foster care system, for a total of 13 full investigations closed through an informal remedy.

Often the OCA investigator can mediate a situation during an investigation. In 2023, the OCA closed five cases as successfully mediated. If the OCA investigator is unable to mediate a concern, the child advocate is made aware and will attempt mediation with MDHHS administration.

The final type of full investigation closure is the formal Findings and Recommendations Report. A Findings and Recommendations Report contains factual findings concerning the agency's handling of a case and recommendations to improve practice, law, and/or policy. Multiple reviews of the report are performed before dissemination to MDHHS.

The child advocate may make a formal finding when one or more of the following is identified during an OCA investigation:

- A matter should be further considered by the department or the child-placing agency.
- An administrative act or omission should be modified, canceled, or corrected.
- Reasons should be given for an administrative act or omission.
- Other action should be taken by the department or the child-placing agency.

Michigan law requires the OCA to issue a draft report of the findings and recommendations to MDHHS before any public release. MDHHS is provided 60 days to respond in writing to the draft report.

Once the OCA receives responses and closes the case, the OCA will redact the report for public consumption. The OCA is required to publish redacted Findings and Recommendations Reports within 30 days of case closure. You can find the published reports of findings and recommendations here.

In 2023, the OCA published four Findings and Recommendations Reports concerning five investigations, which can be found in the public reports section of the OCA website.

Emerging Issues

During both a preliminary investigation and a full investigation, OCA staff are identifying and tracking emerging issues. An emerging issue is identified at the OCA as a continued problem or concern OCA staff see consistently or observe increasingly in an area of concern.

The emerging issues are tracked within the OCA's database. The OCA is then able to review the data to determine if a systemic investigation needs to be completed or if a systemic recommendation should be made.

2023 Top Emerging Issues Identified

In 2023, the OCA continued to see some of the same emerging issues identified in prior years, including unsafe sleep-related deaths, a substance- or drug-positive child at birth, medically fragile children, and child abuse. A total of 432 of the cases the OCA handled in 2023 did not have an emerging issue identified. The chart below identifies the top emerging issues seen in the OCA's cases in 2023.

Vulnerable Child(ren)	154
Unsafe Sleep	118
Child Abuse	81
Medically Fragile Child	75
Substance/Drug-Positive Child at Birth	70
Multiple Drug-Positive Births	33

The OCA also began tracking several new emerging issues, including:

- Child mental health affecting foster care placement
- Parental mental health affecting the health/safety/well-being of the child

These new emerging issues will be tracked starting in 2024.

The OCA also reviewed the deaths of nine young children with a cause of death related to drug intoxication from fentanyl, methamphetamine, methadone, and alcohol.

Unsecured Firearms

In June 2020 the OCA began tracking cases where children died due to firearms. In the OCA 2021 Annual Report, the OCA was aware of 29 child deaths involving firearms, with 14 of those deaths being a result of an unsecured firearm. The OCA made a recommendation for the Michigan Legislature to pass a safe firearm storage law to better protect Michigan's children from preventable death.

In 2023, a Senate bill was introduced to require firearm owners to securely store their firearms to prevent needless deaths. This bill was codified into law and became effective on February 13, 2024.

Public Act 17 of 2023 requires individuals to keep unattended weapons unloaded and locked with a locking device or stored in a lock box or container if it is reasonably known that a minor is likely to be present on the premises. If an individual fails to store a firearm as required and a minor obtains the firearm and **any of the following occurs, they are guilty of a crime under the new law:**

- If the minor possesses or exhibits the firearm in a public place or possesses or exhibits the firearm in the presence of another person in a careless, reckless, or threatening manner: a misdemeanor punishable by imprisonment for up to 93 days or a fine of up to $500, or both.
- If the minor discharges the firearm and injures themselves or another individual: a felony punishable by imprisonment for up to five years or a fine of up to $5,000, or both.
- If the minor discharges the firearm and inflicts serious impairment of a body function on themselves or another individual: a felony punishable by imprisonment for up to 10 years or a fine of up to $7,500, or both.
- If the minor discharges the firearm and inflicts death on themselves or another individual: a felony punishable by imprisonment for up to 15 years or a fine of up to $10,000, or both.

As a result of the OCA's recommendation and the introduction of the Senate bill, MDHHS developed a Firearm Safety webpage. This webpage provides additional resources and education for families concerning gun safety and safe storage.

The OCA continues to track the deaths of children because of unsecured firearms. Since the OCA made the annual report recommendation in 2022, the OCA has identified **38 child deaths related to an unsecured firearm**. Nine of these unsecured firearm-related child deaths occurred in 2023. The OCA continues to track this issue.

HOW THE OCA ADVOCATES

The Child Advocate Act requires the OCA to ensure the MDHHS complies with applicable laws, policies, and/or administrative rules. This can be done only in real time during child welfare case reviews. To achieve this goal, the OCA staff builds and maintains a working relationship with all levels of MDHHS staff. In addition, OCA analysts and investigators are empowered to provide corrections as soon as they arise rather than waiting until the end of the OCA review. This is particularly important if an analyst or investigator is reviewing a case and sees actions or inactions that appear unsuitable for the children involved. In the OCA's experience, when cases are properly managed, and laws, policies, and rules are followed, there is a greater opportunity for safe and effective outcomes.

The cases outlined below are just a small sample of the work the OCA does every day.

Complaint 2023-0264 was opened to intervene in the child welfare case direction and ensure the safety of the children involved. The children had been placed into a power of attorney due to ongoing concerns of parental substance abuse, improper supervision, physical abuse, and physical neglect. Children's Protective Services involved the family in an ongoing services case that had been open for approximately two years. The open case was to provide services to the children's mother to reunite the family by teaching the mother better parenting skills and addressing her substance abuse. The mother was not complying with or benefiting from the services offered. MDHHS was planning to return the children to the mother's care and close their ongoing services case, despite her lack of participation. This would have led to the children being placed back into an unsafe home environment. The OCA met with MDHHS staff and leadership to voice our concerns and encouraged them to file a petition for removal. MDHHS filed a petition and placed the children into a safe foster care home to ensure their safety.

Complaint 2023-0157 came to the OCA's attention after a child's death. The mother of the deceased child was only 12 years old, and the baby was born prematurely. A complaint was made to MDHHS Centralized Intake at the time the young mother gave birth, due to the mother's age and the baby's father being unknown. The complaint was rejected for assignment by MDHHS Centralized Intake, stating the mother was 12 when she gave birth. The OCA contacted MDHHS Centralized Intake regarding our concerns that the mother would have barely been 12 years old when she became pregnant, the father was unknown, and the person who got her pregnant may still have access to her. It was also unclear if the mother was receiving services or any help to cope with the loss of a child at that age. Following the OCA's discussion with MDHHS Centralized Intake, a complaint was assigned for investigation. MDHHS was able to verify that the young mother was safe and had been enrolled in counseling services.

A CPS ongoing services case occurs when CPS has identified child abuse or neglect that is not serious, there is a low risk for recurrence, and there is no legal requirement for court involvement. CPS has determined there is a need for services for the family to help prevent future harm. CPS maintains the service case and coordinates needed services for the family. These responsibilities are not transferred to foster care.

Complaint 2023-0088 came to the OCA's attention with concerns that MDHHS closed their CPS investigation without verifying the safety of an autistic child in his mother's care. The mother had been struggling with her mental health and obtaining appropriate housing. MDHHS failed to observe the family's home before closing their investigation. The OCA investigator expressed concern to the previously assigned CPS case manager and CPS supervisor. After their discussion, the CPS case manager and CPS supervisor continued attempts to verify the child's safety, months after their investigation had closed. CPS was able to verify the child's safety and found that the home conditions were appropriate.

Complaint 2022-0993 was opened due to concerns about three separate complaints made to MDHHS Centralized Intake. The three complaints were rejected for investigation. The complaints were concerning the abuse of a young teenage girl while in the care of her father. During the OCA investigation, the OCA investigator found that while the complaints made to MDHHS Centralized Intake were appropriately rejected, concerns remained with the parenting choices made by the father and ongoing co-parenting issues between the parents. The OCA investigator was able to interview both parents, who agreed co-parenting issues were prevalent and that they could benefit from services. The OCA investigator completed a referral for prevention services in the county where the family resided.

Complaint 2022-1062 came to the attention of the OCA with concerns that MDHHS closed an investigation regarding a child being mentally and physically abused in their adoptive home. Before case closure, CPS was not able to interview the child involved or get the child a medical examination to assess whether any injuries were present. Due to the lack of an interview and medical evaluation, the OCA was concerned for the child's safety. Without an interview or a medical examination, it could not be determined if the child was safe in the home. Additionally, the child was homeschooled and had no regular contact with mandated reporters. Recognizing that an autistic child is more vulnerable to abuse and neglect, the OCA held discussions with MDHHS staff expressing the concerns. The OCA asked MDHHS to change the case to a Category II, with a substantiation for maltreatment. MDHHS agreed. The OCA investigation was extended to monitor the ongoing CPS services case to ensure appropriate actions were taken. During the OCA's monitoring, MDHHS opened a new investigation of physical abuse. It was determined the child was not safe. A petition was filed, and the court of jurisdiction agreed with MDHHS and ordered the child removed from the home and placed into a safe environment.

Complaint 2023-0221 came to the attention of the OCA after the OCA became aware of a single mother who was struggling with her three teenage triplets, who all have autism. Two of the triplets had violent behavior. The OCA opened an investigation to advocate for the mother and her children. At the onset of the full investigation, the investigator learned that Community Mental Health had placed two of the boys in Hawthorn Center, a state-managed psychiatric hospital. The OCA learned that long-term placements in a specialized residential facility would be sought once the triplets were stabilized. Due to the boys' extensive needs and behaviors, the mother's housing was not being renewed when her lease was over, and she was facing homelessness. The investigator was able to advocate for a CPS Prevention case to be opened, which provided the mother with assistance with her housing and facilitating services for the boys.

Complaint 2023-0809 came to the attention of the OCA with concern for a child who had severe burns and was taken out of the hospital against medical advice by the father. The OCA complainant had concerns CPS was not appropriately handling the investigation into the father's actions and refusal of medical treatment. The complainant expressed concerns as the father did not appropriately address the severity of the child's burns and the risk of infection, which could lead to sepsis and death. During the preliminary investigation, the OCA analyst could not determine if CPS was taking appropriate actions to ensure the child's safety. The OCA analyst contacted the CPS case manager assigned and expressed the OCA's concern that if the father failed to obtain further medical treatment for the child, a petition was needed. MDHHS agreed to contact the father again in an attempt to get him to take the child back to the hospital to prevent the filing of a petition to the court to order medical treatment. Once CPS met with the father and the significant risk for infection was explained to him, he took the child in for further medical treatment. The child was admitted to the hospital for further treatment due to an infection and the father agreed to cooperate with a safety plan and CPS ongoing services.

Complaint 2023-0569 came to the attention of the OCA after it received a complaint from a mandated reporter who had concerns for the safety of a newborn child. The mother recently had her rights terminated to a different child, while pregnant, and no plan was created for what would happen when the new baby was born. A complaint was made to MDHHS Centralized Intake following the birth of the new baby, but the investigation was closed as a Category IV finding no child abuse or neglect. However, upon the OCA's review, there was very little documentation in the case file and no in-person contact with the baby had been made. The OCA had significant concerns for the safety of the baby given the recent termination of parental rights and a lack of verification for the baby's well-being during the CPS investigation. Upon receiving the complaint, the OCA immediately began discussions with MDHHS staff and administration, who agreed there were notable concerns regarding the prior investigation. Due to the OCA's involvement, a new complaint was made and assigned for CPS investigation. The investigation resulted in a petition to the court for the removal and permanent custody of the child. The child was placed into a safe home as a result.

OCA COMMITTEE PARTICIPATION

Adoption Oversight Committee: Analyst Rebecca Taylor participates in the Adoption Oversight Committee (AOC), which comprises representatives from the Michigan Department of Health and Human Services (MDHHS) central and field offices, adoption contractors, the court, adoptive families, the Foster Care Review Board, and the Office of the Child Advocate. The committee's purpose is to examine adoption services in Michigan and make recommendations for improvements, to develop action plans to increase the number of child welfare adoptions and the recruitment of adoptive homes, to provide MDHHS with a long-term work group that represents a cross-section of partners in the adoption arena, and act as ambassadors to the larger field, educating colleagues regarding system changes and obtaining input on areas of need.

The AOC's work has been instrumental in the review of pre-adoption training requirements, research and presentation of national post-adoption models, and making recommendations on adoption and adoption subsidy policy and form changes.

Child Death State Advisory Team: Chief Investigator Scott Clements participates on the Michigan Child Death State Advisory Team. The team was established to identify and make recommendations on policy and statutory changes regarding child fatalities and to guide statewide prevention, education, and training efforts. The team also provides support to local child death review teams, recommends improvements in protocols and procedures for the Michigan Child Death Review Program, and reviews Michigan's child mortality data, as well as local child death review team findings and recommendations. The goal is to identify causes, risk factors, and trends in child deaths. As an adviser to the team, Scott provides feedback on policy and statutory changes and offers ideas for annual recommendations. The annual recommendations are presented to the governor and Legislature.

Citizens Review Panel: Paula Cunningham participates in the Citizens Review Panel (CRP) on Child Fatalities. The panel reviews cases of child deaths where the family had previous interaction with the child protection system. Michigan's process of in-depth case review with a multidisciplinary team of experts has proved an effective way to gain insight into the state's child protection system and to make meaningful and data-driven recommendations. The panel is made up of volunteer experts representing law enforcement, child welfare, medical examiners, hospitals, the courts, and other children's advocates, such as the Office of the Child Advocate.

The goal is to use the information found through the panel's reviews to improve the child protection system and prevent future child fatalities. The panel plans to meet quarterly. Once per year, the panel compiles its findings and recommendations in a report that is presented to the Michigan Department of Health and Human Services (MDHHS) for systemic change to MDHHS, the court, hospitals, and law enforcement, to provide additional protection and safety to prevent other child deaths.

Diversity, Equity, and Inclusion: Deputy Director Kenyatta Lewis holds the equity and inclusion officer (EIO) position at the OCA. Kenyatta is a member of various DEI statewide subcommittees, ensuring that OCA staff participate in and benefit from DEI-focused training and initiatives. Kenyatta has also collaborated with Michigan Department of Civil Rights DEI Director Alfredo Hernandez to facilitate a yearlong Intercultural Development Plan for all OCA staff. These sessions aim to help identify individual and collective cultural biases within the agency and to enhance cultural competency at the OCA.

USOA Welcoming Committee: Director Speidel participates in the United States Ombudsman Association Welcoming Committee for the Children and Families Chapter. This committee was formed to introduce new members to the USOA and the chapter.

Committee on Pediatric Emergency Medicine (CoPEM): Director Speidel attends the regularly scheduled committee meetings. The committee hears and discusses issues in pediatric emergency medicine.

Foster Care Review Board Advisory Committee: Director Speidel is an active member of the Foster Care Review Board Advisory Committee. The committee meets quarterly to receive updates from the state's various foster care review board members. The committee discusses issues and barriers the foster care review boards see in case reviews and hears how other committee members adjust their practices based on what is shared.

Annual Report Recommendations:

Michigan's Child Welfare Staffing Crisis

Child welfare work is undeniably challenging. The stressors of a child welfare professional's job range from witnessing deceased children, and how they died, listening to children speak about how they were sexually assaulted, to hearing constant criticism from external critics of the workforce. Child welfare professionals often receive criticism from families they serve, news entities, and public and government partners. Child welfare professionals are expected to conduct themselves to the highest expectations, keep a calm, professional demeanor, and provide accurate family-specific and need-based services with an ever-increasing caseload that does not cease. Individuals who choose this profession should be treated with respect, viewed as professionals, well-trained, prepared appropriately, and fully supported in their professional roles. Currently, and as evidenced by the many cases the OCA reviews, child welfare staffing levels are at crisis levels in many areas of Michigan. The Michigan Department of Health and Human Services (MDHHS) handles a large number of cases related to children and families. However, only a small fraction of these cases are reviewed by the Office of Children's Ombudsman (OCA). It's important to note that despite widespread criticism, the MDHHS staff works tirelessly to create a positive impact on the people they serve. The OCA doesn't always have access to well-investigated and serviced cases. The case managers, supervisors, section managers, and district managers who work with families, courts, law enforcement, and service providers in the community are real heroes. Although their victories are not celebrated, their missteps are scrutinized.

Michigan's Children's Protective Services (CPS) is **85% staffed** statewide. Wayne County, home to **1.7 million people**, also serves as Michigan's most populous county. Wayne County MDHHS has **176 CPS employees** but has room for 256, leaving CPS in Wayne County only **69% staffed**. Adding in Genesee, Kent, and Oakland counties shows a staffing rate of **77%**, or **470 positions** filled out of **603 available**.

The annual turnover rate in Michigan's CPS programs is approximately **24%**, resulting in about one-quarter of the CPS workforce being new to the job every year.

Listening to Learn

In conducting OCA investigations and in visiting local MDHHS offices the OCA has learned from staff that does this work in the community. The OCA has also listened to parents and jurists. The consistent messaging received is that the training provided to new child welfare employees has not prepared them for what lies ahead in this profession. CPS and foster care staff are left feeling unsupported by training. This is evidenced in the cases we review. The OCA has gathered evidence showing that once a new employee arrives at a county office, they are often left to figure out the CPS or foster care profession through trial and error, placing more undue stress upon a job that is inherently one of the most stressful fields one can employ in. Due to these conditions, many newly hired CPS staff leave the profession within the first year.

In addition, the State of Michigan is under a consent decree with the United States Federal Government regarding MDHHS' management of child welfare programs. This creates an unseen layer of stress as local office administrators work to achieve specific metrics the court sets. Those metrics do not measure the quality of CPS investigations.

Reviewing to Learn

The OCA often reviews cases that result in the worst-case scenarios, child sexual assault, serious child abuse or neglect, and child death. In these worst-case scenarios, the OCA has increasingly observed serious child abuse that was missed in the CPS investigations conducted mere months before the child's death. Our interviews and investigations show the level of investigative knowledge and investigation policy requirements within CPS have steadily decreased. The investigations conducted by the OCA have shown the investigations before a child's death that are attributed to child abuse or neglect, are often done poorly, haphazardly, and are void in some essential investigative functions. The OCA cannot fault any individual for this downward trajectory in investigative skillset. When OCA investigators ask why simple investigative tasks are not performed, our investigators often learn that the CPS investigator did not know about an investigative action or how to go about that action. Additionally, the OCA investigators find that if the CPS investigator did know what investigative actions were appropriate, they are typically short on time to follow through.

If we train those who are responsible for helping to protect our most vulnerable children with dignity and respect, and train and prepare them well, we will see better outcomes for children.

Supporting Our Child Welfare Workforce

MDHHS has taken positive steps to recruit and retain new child welfare staff. MDHHS has partnered with Michigan's public universities to set up programs guiding students to a child welfare path and has found a way to utilize federal dollars to incentivize employment as a State of Michigan child welfare professional. However, as evidenced by the conversations had with the OCA, and the ongoing low staffing levels, these steps have not been enough to bring the child welfare workforce to full capacity.

How can the State of Michigan support its child welfare workforce?

1. Enhanced new employee training to include experiential learning.
2. Defined retirement benefits for Child Protective Services and foster care program staff.
3. Over-time pay offered to supervisors.
4. Develop statewide advertisements to highlight the newly acquired benefits of becoming a child welfare professional.

Child Welfare Training Academies that include experiential learning have become best practices for training new CPS and foster care employees.

Increasingly, child welfare entities across the United States are starting to employ a training academy model to train and support child welfare professionals. Recently the Child Welfare League of America asked pioneers of an Illinois training academy and simulations lab to write a national training standard for the profession. That standard is based on empirical data and peer-reviewed research. The State of Michigan needs to look no further than our neighbors in Illinois where a CPTA model, inclusive of experiential learning, has led to increased employee satisfaction and retention.

The OCA recommends the Michigan Legislature:

1. Codify the requirement for a Child Welfare Training Academy (CWTA) and simulation labs that incorporate experiential learning.

Sample Legislation:

The Department of Health and Human Services Child Protection Training Academy.

- Michigan's Legislature finds and declares all of the following:
  - A Child Protection Training Academy represents an innovative approach to training front-line child protection investigators using experiential learning through simulations. Simulations provide a safe learning environment that bridges the gap between policy and practice, increases staff engagement, and accelerates learning.
- Research indicates that traditional classroom training results in less than a 15% transfer of knowledge once in the field.
- Subject to appropriation, the training efforts of the Child Protection Training Academy shall include, but not be limited to, the following:
  - The continued development of simulation training for all child protection investigators, including those newly hired and seasoned investigators.
  - The continued development and implementation of simulation training for investigation, foster care, adoption, and program supervisors.
  - The development of simulation training for child welfare programs both in the Department and private agencies.
  - The development of simulation-based training curricula on recognizing and responding to child abuse or neglect cases for mandated reporters.
  - The development of simulation-based training for multidisciplinary teams in partnership with the Department, including, but not limited to, the use of mock medical and mock forensic facilities.
  - Cultural competency training for child welfare staff that provides tools and other supports to ensure that a child welfare provider's response to and engagement with families and children of color are:
    - » Conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of the individuals who are receiving services; and
    - » Conducted or provided in a manner that is most likely to ensure maximum success or participation in the child welfare program or services being provided.
  - Laboratory training facilities that may include, but not be limited to, mock houses, mock courtrooms, mock medical facilities, and mock forensic interview rooms that allow for simulated, interactive, and intensive training.
  - The Department shall set minimum standards of competence before designating new employees as Child Welfare Employees.
- By (insert date), the Department of Health and Human Services must adopt procedures for the administration of the Child Protection Training Academy that not only establish statewide competence, assessment, and training standards for persons providing child welfare services, but also ensure that persons who provide child welfare services have the knowledge, skills, professionalism, and abilities to make decisions that keep children safe and secure. The Department shall continue to arrange for an independent evaluation of the Child Protection Training Academy through the first five years of operation.
- Nothing in this Section prohibits the Department from administering simulation training with other entities. The Department may contract with any entity to provide all aspects of child welfare training.

The OCA recommends the Michigan Legislature:

2. Provide a reliable funding source for the CWTA and simulation labs.

3. Invest in the state's child welfare workforce by reinstituting a pension-based retirement system for MDHHS staff who remain employed in the child protective services and foster care programs with vesting in the defined benefit after a specified period.

The State of Michigan has moved away from a defined benefit retirement program, commonly referred to as a pension system, for most of its workforce. The Michigan State Police and the Michigan Department of Corrections utilize defined benefit retirement for their staff who serve in the most dangerous and stressful jobs.

4. Provide funding to MDHHS that allows the Department to pay first-line supervisors of child welfare program staff for the overtime and on-call time worked.

The Michigan Department of Health and Human Services has set up several programs to incentivize college students to work toward employment with the department in child welfare rolls, including providing financial incentives for agreeing to work in certain child welfare programs.

The OCA recommends MDHHS:

5. Develop and provide multimedia advertisements to inform the public about child welfare employment with the state, highlighting and informing prospective applicants of the various benefits of child welfare employment with the Department.

The Michigan Department of Health and Human Services has set up several programs to incentivize college students to work toward employment with the department in child welfare rolls, including providing financial incentives for agreeing to work in certain child welfare programs.

Appendix A

MDHHS Response to Recommendation 1: The MDHHS Office of Workforce Development and Training agrees that simulation and experiential learning should be enhanced and further incorporated into child welfare training for new hires, experienced specialists, and supervisors. However, some of the parameters of the proposed academy in the draft legislation present hurdles that could impede implementation. Specifically, the department does not currently provide simulation training to mandated reporters and multidisciplinary teams (1.c.iv. and 1.c.v.). Mandated reporters and multidisciplinary teams represent a large population of people from a broad scope of professions. The department is not in a regulatory or contractual relationship with this much larger audience.

MDHHS Response to Recommendation 2: Funding for simulation labs would need to be allocated in addition to the current child welfare training allocation. Many resource and logistical issues would need to be considered, including the procurement of lab facilities, location of simulation labs, hiring simulation training expertise, identifying a regular supply of actors, and travel costs. MDHHS estimates that there would be significant new costs to establish and operate simulation labs as the department would not be reducing the current training, but rather enhancing what is currently trained with additional experiential practice opportunities.

MDHHS Response to Recommendation 3:

MDHHS has no comment for this recommendation.

MDHHS Response to Recommendation 4:

MDHHS has no comment for this recommendation.

MDHHS Response to Recommendation 5: MDHHS launched a paid campaign September 2022 that ran through January 2023. The primary focus was statewide with an emphasis on southeast Michigan. Our goal was to get MDHHS open positions filled for Family Independence Specialists, Eligibility Specialists, Foster Care and CPS Specialists. The campaign included digital ads, social media, LinkedIn video posts, and paid search.

In order to achieve this, MDHHS used actual specialists in testimonial-style videos. They told the story about how they were proud to work for MDHHS, why they enjoyed their jobs, and why they felt their work was important. MDHHS would recommend rerunning this campaign again if funding becomes available.

Produced Video Links:

- ***Assistance Payments Worker*** –
- ***Child Welfare Specialist*** –
- ***Eligibility Specialist*** -
- ***Foster Care Service Specialist*** –
- ***Needed*** -

In addition, during FY24, MDHHS has partnered with five Michigan universities to leverage federal funds that support social work students focusing their concentration on child welfare. Not only do the Title IV-E funds reimburse educational costs that the university incurs, but also allows partner universities to issue stipends to participating students. As a condition of receiving this stipend, students enter into an employment agreement with either MDHHS or a private child welfare agency, in which they agree to a term of employment in return for non- repayment of the financial support received from the university. Universities currently participating are the University of Michigan, Michigan State University, Western Michigan University, Central Michigan University, and Wayne State University. MDHHS expects partnership to grow in future fiscal years to include other universities around the state. The goal of the program is to increase the financial support to both universities and students while also supporting the department's recruitment and retention goals.

Other Projects:

LinkedIn/ Handshake

- **LinkedIn** – actively posting news within MDHHS.
- Actively posting positions on **Handshake** and **LinkedIn** along with any info sessions we will be holding.
- Following up with students that have checked in with us at an event.

Virtual and In Person Career Fairs:

- Registered for **28** Fall 2023 Career Fairs.
- Registered for **42** Winter/Spring 2024 Career Fairs.
- Presented **information sessions** to EMU and CMU and hosted our own through Handshake platform.

Information Sessions:

- Virtual with **HBCU colleges** to be held 11/6, 11/7 and 11/8/23.
- Virtual Session with **Muskegon County** and **surrounding Colleges** 10/17/23.
- Virtual Session with **Eastern Michigan Social Work** students on 1/24/24.
- In person information sessions (**Davenport RNs Midland, Grand Rapids, Lansing and Westland campus**)
- Isabella County Ambassador **Tasha Britton** hosted information sessions with **CMU** on 10/4/23, 10/18/23 & 2/14/24.
- Individual meetings with students interested in MDHHS. Met with **15 students on Zoom** and **56 on Handshake.**

Appendix B

Recommendations from Case 2020 0225 and 2021 0416 published May 12, 2023:

1. **Regarding the use of safety plans or power of attorney in lieu of a petition for removal, the OCA recommends Marquette County DHHS adhere to MCL722.628d in determining when to file a petition.** Safety plans, temporary voluntary arrangements altering custody, powers of attorney, and guardianships, both limited and full, be used when appropriate, but not as a replacement for filing apetition.

MDHHS Response to Recommendation 1: Agree.

MDHHS Annual Update: Marquette County conferences cases in monthly meetings and provides ongoing coaching to supervisors and specialists regarding why alternates to petitioning are not in the best interest of families.

2. **Regarding the findings surrounding the multidisciplinary team, the OCA recommends that child welfare partners in Marquette County set astanding monthly or bi-monthly meeting to:**

   - Clarify local policies and procedures to determine the role andresponsibilities of each child welfare partner regarding the use of formal and informal dispositions and identifying when formal proceedings shouldbe used to achieve the goals of obtaining safe and timely permanency forchildren.
   - Discuss case specific information with all child welfare partners.
   - Develop partnerships and communicate openly and freely with each other regarding child welfare policy and work to agree on how each profession,including but not limited to, law enforcement, DHHS CPS/ Foster care, the courts, medical professionals, mental health professionals, and child advocacy centers, will work together to keep children safe in Marquette County.

MDHHS Response to Recommendation 2: Monthly meetings occur between Marquette DHHS and all law enforcement agencies in Marquette County and open dialogue and collaboration occur on all joint investigation. County administrators will continue to encourage discussion and support to ensure mandated reporters complete required referrals.

MDHHS Annual Update: The local county office participates in county-wide monthly meetings with local law enforcement administrators and the prosecuting attorney. See attachment A for the schedule of upcoming meetings in 2024. Ongoing discussion regarding the importance of timely reporting by mandated reporters is routinely discussed at these meetings.

As incidents arise, discussion occurs between the department and local law enforcement, along with the prosecutor, to identify and reduce barriers for reporting. Marquette DHHS has provided local law enforcement a copy of the CPS on-call schedule of staff available to assist officer's after-hours. The department also coordinates with the local child advocacy center to enhance the relationship between the two agencies.

Lastly, the Marquette director reviews all arraignments that occur within the county, cross-referencing them with history for the department to determine if there is a potential of abuse/neglect, and verifies that a report was made to Centralized Intake. She also monitors all rejected/linked intakes that come into the county, reviewing, and verifying they do not meet criteria for assignment under the **Child Protection Law**. Although situational with new staff or officers, there has been a reduction of observed incidents where referrals have not been made overall.

3. **Regarding Rejected Complaints During an Open Investigation or Ongoing Services Case, the OCA found that the ability for Centralized Intake to reject oraccept and link to the current case allows the new allegations to go uninvestigated.**

   The OCA recommends that DHHS develop a new process to ensure case specialists are adequately investigating and addressing new allegations that come in during an open investigation or open services case.

MDHHS Response to Recommendation 3: CPS specialists receive notificationof rejected referrals through an automated email notification process and CPS policy provides detailed guidance for responding to "accept and link" referrals including requiring contact with the victims, identified perpetrators, and other relevant collateral contacts. However, DHHS agrees to further review and assess the need for policy enhancements to ensure CPS clearly addresses, assesses, and documents rejected and transferred referrals. DHHS will also explore enhanced technical solutions as they develop the new CWIS technology.

MDHHS Annual Update: MDHHS reviewed current policy and practice in relation to the process for rejected and transferred referrals in CPS investigations and ongoing cases to determine if enhancements were needed. To improve documentation, oversight, and child safety, the Children's Services Administration updated the following:

*Effective August 1, 2023, **PSM 712-1**, CPS Intake, states the following:*

Careful attention must be given to documenting the intake dispositions of new referrals received during a pending investigation or an open case. When a new referral is received on a pending investigation or open case, the new allegations must be evaluated by the same standards as other referrals to determine assignment of the new referral.

If there is an open case or pending investigation, contact should be made with the assigned case manager to identify if the new allegations are known or being addressed with the family. If the new allegations are being addressed with the family or do not meet criteria for assignment, the referral should be transferred to the assigned case manager for any necessary follow-up. A social work contact must be entered into the active investigation or case for each intake ID, documenting review of the new allegations, and that the information was transferred to the assigned case manager.

If the new referral contains allegations not already addressed in the active investigation, the allegations meet criteria for assignment, and it is within fifteen days of receipt of the intake for the active investigation, the new referral should be screened in as an accept and link investigation; see **PSM 713-08**, Special Investigative Situations in the accept and link section. If the new referral is received after fifteen days of receipt of the intake for the active investigation, it should be screened in as an accept and assign investigation.

*In addition to other guidance related to accept and link and transferred referrals, **PSM 713-08**, Special Investigative Situations, states the following effective August 1, 2023:*

Case managers must add accept and link alleged maltreatments and findings to the allegation/finding tab in electronic case record, and include a **summary of the following in the disposition narrative**:

- Allegations for the initial and the accept and link referral(s).
- Findings and dispositions for each alleged maltreatment.
- A summary of investigation activities for the initial and accept and linked allegations.

*In addition to other guidance related to new investigations during an open, ongoing case, **PSM 714-1**, Post-Investigative Services, states the following regarding screened out referrals effective August 1, 2023:*

The case manager must review screened out referrals to determine if any new or additional safety planning may be needed based on screened out allegations. The case manager must document in a social work **contact the following**:

- Intake ID(s) of screened out allegations.
- Acknowledgement that new allegations have been reviewed.
- Whether additional safety planning is needed.

Recommendations from Case 2020 0440 published June 7, 2023:

1. **The OCA recommends PSM 713-04* be amended to:**

    a. Remove the provision that allows the CPS caseworker to provide information to a professional at the medical facility when the medical practitioner is not available. It is critical that the examining practitioner be provided with case details directly from the CPS caseworker before the exam is conducted.

MDHHS Response to Recommendation 1a: MDHHS recognizes for anycase where CPS requests a medical exam, speaking directly with the examining practitioner is ideal; however, medical professionals are not always immediately available to respond to a CPS specialist.

Avoiding delays is important for the department to take quick action toprotect the safety and well-being of children. Policy allows specialists to speak to other professionals at the medical facility to gather and relay information to avoid potentially critical delays in examination and treatmentof children.

MDHHS Annual Update: *Effective August 1, 2023,* ***PSM 713-04*** *requires the following:*

Initial Consultation with Medical Professional

Case managers must consult with a medical practitioner immediately when an examination is needed. Consultation should include the child's parent whenever feasible. When contacting the medical practitioner, case managers should request an examination of the child and **provide the following information**:

- The reason the medical examination is being requested.
- The reason(s) for suspicion of abuse and/or neglect.
- All known health/medical information regarding the child and family.
- Any additional pertinent case information including:
    - History of alleged and confirmed abuse/neglect.
    - Household/family makeup.
    - Home environmental factors.
    - Parent's behavior toward the child.
    - Explanations provided for an injury.

Case managers must make efforts to speak directly with the examining medical practitioner; however, if the medical practitioner is not available, the case manager may provide the information to a professional at the medical facility and provide case manager contact information for any questions the medical practitioner may have. Attempts must be made throughout the duration of the investigation to speak to the examining medical practitioner.

Results of a Medical Examination

A case manager must contact the medical practitioner or other medical professional familiar with the medical exam, to have them interpret the medical-examination findings. Case managers should ask the medical practitioner if the medical examination findings are consistent with the caregiver's explanation. If the findings or implications are unclear, the case manager must seek clarification.

2. **The OCA recommends PSM 713-01* be amended to require that case conferences between CPS caseworkers and their supervisors be documented in narrative format in the case's social work contacts.**

MDHHS Response to Recommendation 2: MDHHS is working with appropriate experts to assess this recommendation. The department will thoughtfully research potential revisions to policy to provide additional guidance around documentation of case conferences between specialists and supervisors to avoid any unintended consequences that would negatively affect children.

MDHHS Annual Update: MDHHS is actively finalizing policy language requiring specific documentation of case conferences between a case manager and their supervisor. It is expected the enhanced policy will be implemented in 2024.

3. **This issue of not documenting narratives in case conferences has proven to be material in the OCA investigation into the administrative actions before Trinity's death.** Case conferences are the critical point in a CPS investigation where "gut" feelings are discussed and where knowledge from more experienced child welfare staff is passed onto new staff. It is these conversations where learning can occur, and critical thinking skills developed. The lack of documentation present for these case conferences can create a lack of priority and accountability for CPS supervision. Ensuring **MiSACWIS*** has adequate notes from case conference discussions is integral to the exchange of information if a new CPS caseworker or supervisor joins the case.

    a. Because of this, the OCA recommends **PSM 713-01*** be amended to specify the importance of initial case conferences taking place soon after a new investigation is assigned, provide a guide that details a list of issues in the case to be discussed, viewed, and decided at the initial conference, and require that the initial case conference and all subsequent case conferences provide a detailed narrative in the investigative report. Anything less leaves room for recollection error and lack of accountability which is not in the best interest of Michigan's children.

MDHHS Response to Recommendation 3a: The MDHHS Children's Services Administration has begun researching potential revisions to policy to include a timeframe for an initial case conference and further guidance around documentation. MDHHS has developed an intervention tool that requires regular communication between caseworkers and their supervisors during key points of an investigation as part of the department's **Keep Kids Safe Action Agenda**. The department is also developing an ongoing quality assurance process focused on providing independent feedback to investigators to improve investigation quality.

MDHHS Annual Update: MDHHS is actively finalizing policy language requiring specific documentation of case conferences between a case manager and their supervisor. It is expected the enhanced policy will be implemented in 2024.

4. **The OCA recommends that DHHS require local county directors to:**

    a. Develop processes in coordination with the local **Multi-Disciplinary Team(MDT)*** to include detailed direction on how to request and access asecond medical opinion.

    a. Develop a county specific protocol on how to obtain a second medicalopinion in accordance with **PSM 713-04.***

    a. Train CPS caseworkers on the county specific protocols on how to obtain a second medical opinion in accordance with **PSM 713-04.***

    a. Train CPS caseworkers and supervisors about the impact of obtaining asecond medical opinion in a timely manner so the injuries can be viewed by the medical practitioner before healing.

MDHHS Response to Recommendation 4 a-d: The Children's Services Administration will collaborate with regional directors to determine what actions their local county directors can take to address these opportunities.

Completing multiple real-time reviews of physical abuse cases to evaluatesafety planning and ensure decision-making was appropriate is part of the **Keep Kids Safe Action Agenda**.

MDHHS Annual Update: All local MDHHS offices are activelycollaborating with their MDTs to ensure detailed processes and directionon how to request, access, and obtain a second medical opinion inaccordance with 713-04 is outlined in the local Model Child Abuse and Neglect Protocol Utilizing a **Multidisciplinary Team Approach** (MCA protocol).

All local MDHHS offices are developing a working list of medical practitioners who have specialized training in detecting child abuse andneglect, examining, and interviewing children in accordance with **PSM713-04** in coordination with their local MDT. A local contact list is being developed and maintained for CPS case managers and supervisors. A statewide contact list is also updated annually and posted to the MDHHS public website for use by staff and partners.

In addition, all local MDHHS offices are developing a plan to train their child welfare staff on the revised local MCA protocol and will ensure staff have a copy readily available for reference. Training will cover, among other topics, county specific protocols for how to obtain a second medical opinion in accordance with **PSM 713-04**, the impact of obtaining a second medical opinion in a timely manner so injuries can be viewed by the medical practitioner before healing, and the critical importance of using the child abuse medical expert list when scheduling initial and second opinion medical examinations. Training will also instruct CPS case managers on what medical practitioners, who have specialized training in detecting child abuse and neglect, are available to conduct medical assessments after hours within their respective counties.

All local MDHHS offices have been strongly encouraged to invite local medical practitioners from the child abuse and neglect list to local MDT meetings and case reviews.

All actions above are slated to be complete by the end of 2024 to allow time for thorough collaboration and approval.

5. ***(Recommendation 5 was issued to a separate state agency)***

6. **Child welfare investigations require law enforcement and CPS caseworkers be proficient in detecting abuse and neglect.** Physical abuse may be overlooked or misdiagnosed in children under the age of 4 due to their vulnerable characteristics. Training enhancements to better equip our investigators iscritically needed to best protect Michigan's children.

   a. The OCA recommends ***SRM-103**** be amended to mandate the annual in-service training include objectives on the detection of injuries attributableto child abuse.

MDHHS Response to Recommendation 6a: The Children's Services Administration is exploring a mandate for annual in-service training to include objectives on the detection of injuries attributable to child abuse.

MDHHS Annual Update: Services Requirements Manual (SRM) 103,Staff Qualifications and Training, will be updated in 2024 to reflect this new requirement. Until the revised policy item is formally released, acommunication will be issued to staff that states the following: As outlined in **Services Requirements Manual (SRM) 103**, initial and ongoing training is essential for Michigan Department of Human Services (MDHHS) and private agency child welfare staff and supervisors to provide quality services to children and families while ensuring safety, permanency, and well-being. This policy applies to caseload-carrying staff, specialized support staff, and supervisors, both public and private.

Effective immediately, at least one hour of annual in-service training each year must be focused on the detection of injuries attributable to child abuse. Supervisors should have an active role in driving what trainings case managers attend. Trainings should be centered around the case manager's unique skill set and areas in which there is opportunity for development.

Examples of available trainings that meet these criteria will also be offered. Additionally, ongoing efforts will be made to expand training availability and topics related to the detection of injuries attributable to child abuse.

7. **The OCA recommends that DHHS assist families when a safety plan* removesthe support system currently in place.**

   a. DHHS could independently search for and seek out relatives, other thanthose provided by the parent or caretaker, who can provide support for families with open CPS investigations and ongoing cases.

   a. DHHS could provide state-available support including, but not limited to, achildcare subsidy for families with open CPS investigations and ongoingcases.

MDHHS Response to Recommendation 7 a-b: The Children's Services Administration will explore this recommendation further and consider opportunities to enhance safety planning; however, there may belimitations to federal eligibility for benefits to meet the need for some typesof services.

The department does refer families to supports such as childcaresubsidies; however, parents may not always follow through with thesereferrals. The department is developing a pilot program to help enhancecollaboration between CPS staff and the department's benefits eligibility services staff to enhance economic supports to families.

As part of its **Keep Kids Safe Action Agenda**, MDHHS is investing millionsof dollars to create more Family Resource Centers. The number of Family Resource Centers recently expanded by five for a total of 11 in local communities. Family Resource Centers work with families who are at-risk of abuse and neglect to meet their needs sooner and strengthen their protective factors.

MDHHS Annual Update: On January 8, 2024, a communication was issued that provides guidance for CPS case managers when a safety plan or court order is implemented that removes a family's primary support person, people, or network. Case managers were advised they must ensure resources and alternative childcare arrangements are made available to the family if the family's primary support system is removed as part of a safety plan or court order and encouraged to engage with the family to identify another parent, relative, or support person to assist with immediate needs.

Staff were offered various resources to consider if the family lacks adequate support, including but not limited to:

- Collaboration with the **Economic Stability Administration (ESA)**,including **Family Impact Team (FIT)** if available in the respective county, to offer economic concrete supports, address poverty-related challenges, coordination of soft hand-offs to community resources, and assistance with applying for MDHHS resources/ programs, including child care assistance.
- Other information was provided **for Family Resource Centers, Community Action Agencies, 211, Bridges resource finder**, coordination with **Community Resource Coordinators** within the local office, and the **Kinship Care Resource Center**.

8. **The OCA recommends that DHHS require local county directors to:**

   a. Collaborate with their MDT to develop a working list of medicalpractitioners who have specialized training in detecting child abuse andneglect, examining, and interviewing children in accordance with **PSM713-04.***

   a. Maintain and update the list of statewide and local child abuse medicalexperts with CPS caseworkers and supervisors.

   a. Train CPS caseworkers and supervisors on the critical importance ofusing the child abuse medical expert list when scheduling initial and second opinion medical examinations.

   a. Instruct CPS caseworkers on what medical practitioners, who havespecialized training in detecting child abuse and neglect, are available toconduct medical assessments after hours within their respective counties.

   a. Invite the medical practitioners from the child abuse and neglect list to MDT meetings and case reviews.

MDHHS Response to Recommendation 8 a-e: The Children's Services Administration is collaborating with regional directors to determine whatactions county directors can take to address these opportunities.

MDHHS Annual Update: All local MDHHS offices are activelycollaborating with their MDTs to ensure detailed processes and directionon how to request, access, and obtain a second medical opinion inaccordance with **713-04** is outlined in the local Model Child Abuse and Neglect Protocol Utilizing a Multidisciplinary Team Approach (MCA protocol).

All local MDHHS offices are developing a working list of medicalpractitioners who have specialized training in detecting child abuse andneglect, examining, and interviewing children in accordance with **PSM713-04** in coordination with their local MDT. A local contact list is beingdeveloped and maintained for CPS case managers and supervisors. A statewide contact list is also updated annually and posted to the MDHHS public website for use by staff and partners.

In addition, all local MDHHS offices are developing a plan to train their child welfare staff on the revised local MCA protocol and will ensure staff have a copy readily available for reference. Training will cover, among other topics, county specific protocols for how to obtain a second medical opinion in accordance with **PSM 713-04**, the impact of obtaining a second medical opinion in a timely manner so injuries can be viewed by the medical practitioner before healing, and the critical importance of using the child abuse medical expert list when scheduling initial and second opinion medical examinations. Training will also instruct CPS case managers on what medical practitioners, who have specialized training in detecting child abuse and neglect, are available to conduct medical assessments after hours within their respective counties.

All local MDHHS offices have been strongly encouraged to invite local medical practitioners from the child abuse and neglect list to local MDT meetings and case reviews.

All actions above are slated to be complete by the end of 2024 to allow time for thorough collaboration and approval.

9. ***(Recommendation 9 was a legislative recommendation)***

10. **The OCA recommends anyone identified as a person with firsthand knowledge ofthe allegations when the complaint is called into Centralized Intake*** must becontacted directly by the CPS caseworker in a timely manner. These individuals should be identified as a primary reporting source.

MDHHS Response to Recommendation 10: The MDHHS Children's ServicesAdministration will explore a potential revision to policy requiring CPS specialists to contact the primary reporting source in a timely manner in all active CPS investigations. The department wants to ensure this practice would result in the intended benefits for children and families.

MDHHS Annual Update: A policy enhancement of this nature is actively being discussed. Consideration is being given to policy that requires efforts be made to contact the primary referral source, or other source with firsthand knowledge of the allegations, in all active CPS investigations.

Recommendations from Case 2022-0263 published December 15, 2023:

1. ***(Recommendation 1 was a recommendation to Michigan's Legislature)***

2. **The OCA recommends MDHHS require local county directors develop processesin coordination with the local MDT**

   a. This process could include detailed direction for case specialists on medical assessments, local child abuse medical experts, when to access a second medical opinion, and to obtain firsthand information from the medical provider directly involved in the examination of a child.

   a. MDHHS could encourage the assigned county completing the disposition of the case, to have direct contact with the medical professionals and/or review the medical records to confirm accuracy of any prior informationgathered from other specialists.

   a. Invite medical practitioners involved in child abuse and neglect cases toMDT meetings and case reviews.

   a. When multiple counties are involved in a case, both counties should bepresent at MDT meetings to ensure all information discovered is shared between all MDT members.

MDHHS Response to Recommendation 2a-d: MDHHS actively works with local offices across the state to continue enhancing their MDT processes and partnerships. MDHHS has required local offices to review their county protocol in collaboration with their MDT, ensure they consider the OCA recommendations included in this Report of Findings and Recommendations, and make any enhancements by July 2024.

MDHHS Annual Update: All local MDHHS offices are actively collaborating with their MDTs to ensure detailed processes and direction on how to request, access, and obtain a second medical opinion in accordance with **713-04** is outlined in the local Model Child Abuse and Neglect Protocol Utilizing a **Multidisciplinary Team Approach** (MCA protocol).

All local MDHHS offices are developing a working list of medical practitioners who have specialized training in detecting child abuse and neglect, examining, and interviewing children in accordance with PSM 713-04 in coordination with their local MDT. A local contact list is beingdeveloped and maintained for CPS case managers and supervisors. Astatewide contact list is also updated annually and posted to the MDHHS public website for use by staff and partners.

In addition, all local MDHHS offices are developing a plan to train their child welfare staff on the revised local MCA protocol and will ensure staff have a copy readily available for reference. Training will cover, among other topics, county specific protocols for how to obtain a second medical opinion in accordance with **PSM 713-04**, the impact of obtaining a second medical opinion in a timely manner so injuries can be viewed by the medical practitioner before healing, and the critical importance of using the child abuse medical expert list when scheduling initial and second opinion medical examinations. Training will also instruct CPS case managers on what medical practitioners, who have specialized training in detecting child abuse and neglect, are available to conduct medical assessments after hours within their respective counties.

All local MDHHS offices have been strongly encouraged to invite local medical practitioners from the child abuse and neglect list to local MDT meetings and case reviews. All actions above are slated to be complete by the end of 2024 to allow time for thorough collaboration and approval.

3. ***(Recommendation 3 was a recommendation to Michigan's Legislature)***

4. **The Children's Ombudsman recommends MDHHS amend PSM 712-3 and the Michigan Model Child Abuse Protocol to require in person or phone contact with law enforcement when MDHHS is required to submit a LEN.**

MDHHS Response to Recommendation 4: PSM 712-3, Coordination with Prosecuting Attorney and Law Enforcement, outlines required collaboration between CPS and law enforcement, including efforts to coordinate and communicate with law enforcement in mutually conducted investigations, how to handle delays in starting an investigation, and when to request law enforcement reports. Collaboration between CPS and law enforcement is clearly outlined in department policy and is sufficient for investigative purposes.

MDHHS Annual Update: **PSM 712-3,** Coordination with Prosecuting Attorney and Law Enforcement, outlines required collaboration between CPS and law enforcement, including efforts to coordinate and communicate with law enforcement in mutually conducted investigations, how to handle delays in starting an investigation, and when to request law enforcement reports. Collaboration between CPS and law enforcement is clearly outlined in department policy and is sufficient for investigative purposes.

Recommendations from Case No. 2018 CAS 02825 V7H4W6 published December 15, 2023:

1. **The OCA recommends MDHHS implement units within the Children's Services Administration that specialize in the handling of foster care cases involving vulnerable children.** The OCA recommends that caseworkers assigned to vulnerable children's cases have a predetermined minimum amount of case management experience, more specialized training, and a reduced number of cases. This may allow a case manager to service a vulnerable child more appropriately; document and ensure all their needs are being met; make the required contacts with medical professionals; identify and address all needs of the child and caregiver; document and accurately report all concerns of a child's placement to the court; and act upon information received which indicates a child's safety and wellbeing is at substantial risk in their current placement.

MDHHS Response to Recommendation: Agree, improvements are needed related to vulnerable children's cases, and this is currently being assessed, enhanced, and redesigned pertaining to how child welfare professionals, including supervisors and specialists, are trained initially upon hiring into child welfare and continuously throughout their careers to improve interactions with children and families and strengthen teaming and engagement approaches.

MDHHS Annual Update: Condition 6.19-3 of the Michigan Implementation, Sustainability, and Sustainability, and Exit Plan (MISEP) Corrective Action Plan (CAP) outlined a commitment from MDHHS **Children's Services Administration (CSA)** to train and coach staff on the principles of the MiTEAM practice model to improve worker engagement and assessment skills. MDHHS also agreed through item **6.19-4** to increase participation in Motivational Interviewing training. In July 2022, CSA issued guidance regarding the expectation for all public and private child welfare supervisors are required to complete the Engagement and Assessment modules through the **Learning Management System (LMS)** or on the **MiTEAM Virtual Learning Site** by July 31, 2022. Although these modules are typically completed as part of initial training, a "refresher" is required for supervisors to help coach staff and reiterate the best practices associated with these competencies.

MDHHS also agreed through item **6.19-4** to increase participation in Motivational Interviewing training as in dedicated engagement practice model. Motivational Interviewing is an evidence-based, client-centered method designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes. Motivational Interviewing aims to identify ambivalence for change and increase motivation by helping clients progress through the stages of change. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of those goals. This training has rolled out across the state in phases with **over 1,300 staff** completing the training.

Recommendations from Case 2022-0076 published January 10, 2024:

Recommendations: In cases of parental mental health, particularly those with serious mental health diagnoses like psychosis and schizophrenia, incidents such as this tragic death of a child and injury to another, may not be 100% preventable, however, CPS can make amendments to policy to ensure that proper assessments and collateral contacts are being completed to help ensure families can remain safe together.

1. **The children's ombudsman recommends MDHHS amend CPS policy 713-01, requiring caseworkers to make collateral contact with mental health professionals when there is evidence of psychosis in a parent during a CPS investigation.** This required contact would aid CPS in determining if mental health professionals believe the parent is compliant with treatment, and services and if there is any concern for harm to the children.

MDHHS Response to Recommendation 1: Current CPS policy does recommend case managers make collateral contacts to thoroughly assess child safety during an investigation, including contact with mental health providers. However, MDHHS will work with medical and mental health experts and other key stakeholders to determine when specific collateral contacts should be required based on the unique circumstances of a case to better assess parents' and caregivers' mental health and the potential impact on safety. MDHHS is proactively working to identify behavioral health services across the state to better connect families to services.

MDHHS Annual Update: MDHHS continues to recognize the challenges with hiring and retaining behavioral health service providers across the state and is actively leading various efforts related to expansion of the behavioral health workforce. On January 10, 2023, MDHHS released a request for proposal (RFP) for implementation of an **Internship Stipend Program**, supporting stipend payments to students participating in internships in the behavioral health field. On January 24, 2024, MDHHS released a request for proposal (RFP) soliciting a vendor to implement a **Capacity Building Center (CBC)**, a platform housing training opportunities to support expansion and maintenance of children's behavioral health service providers across the state. Implementation of the CBC will ensure consistent access to required trainings and professional development for behavioral health service providers. MDHHS is also leading behavioral health workforce expansion efforts in the form of a Student Loan Repayment Program. **$4.4m** was obligated to support student loan repayment of eligible behavioral health service providers in fiscal year 2023, and the program is ongoing for fiscal year 2024.

2. **The children's ombudsman recommends CPS policy manual define psychosis. MDHHS**

MDHHS Response to Recommendation 2: MDHHS agrees and will work with mental health experts to define psychosis in CPS policy.

MDHHS Annual Update: Policy will be updated in 2024 to include a definition of psychosis.

3. **The children's ombudsman recommends MDHHS amend CPS policy 711-2 relating to threatened harm, expanding the definition of this to include the mental health of a parent.** This can require a threatened harm assessment when the parent has history of mental health diagnosis in previous CPS investigations and the current case involves concerns relating to the parents' mental health and ability to meet the child's needs.

MDHHS Response to Recommendation 3: MDHHS agrees and will review the current threatened harm assessment with medical and mental health experts, other key stakeholders, and child welfare case managers and their supervisors to determine how best to utilize the assessment in cases involving a parent or caregiver's mental health to ensure the safety and well-being of children. Policy will be updated to reflect any recommendations.

MDHHS Annual Update: MDHHS is actively discussing all aspects of policy and practice as it relates to assessing mental health in CPS investigations and has engaged the **Governor's Task Force on Child Abuse and Neglect** to assist. In addition, MDHHS has sought feedback from members of the Child Death State Advisory Team and will consider these recommendations as enhancements to policy and practice are made. Final recommendations will be fully informed by mental health and medical experts, other key stakeholders, and child welfare staff and their supervisors. Policy and tools will be updated accordingly.

4. **The children's ombudsman recommends CPS amend policy 713-11 pertaining to the threatened harm assessment.** An amendment to require an assessment by the case manager when mental health is present in one or both caregivers and the prior history relates to concerns surrounding mental health. The threatened harm assessment would then require the worker to evaluate and assess the "severity of past behavior, length of time since past incident, evaluation of services, benefit from services (including if conditions have been rectified) and vulnerability of child(ren)." This information can aid CPS in comprehensively determining if threatened harm remains a factor for maltreatment and/or if CPS should request court involvement.

MDHHS Response to Recommendation 4: MDHHS agrees and will review the current threatened harm assessment with medical and mental health experts, other key stakeholders, and child welfare case managers and their supervisors to determine how best to utilize the assessment in cases involving a parent or caregiver's mental health to ensure the safety and well-being of children. Policy will be updated to reflect any recommendations.

MDHHS Annual Update: MDHHS is actively discussing all aspects of policy and practice as it relates to assessing mental health in CPS investigations and has engaged the **Governor's Task Force on Child Abuse and Neglect** to assist. In addition, MDHHS has sought feedback from members of the **Child Death State Advisory Team** and will consider these recommendations as enhancements to policy and practice are made. Final recommendations will be fully informed by mental health and medical experts, other key stakeholders, and child welfare staff and their supervisors. Policy and tools will be updated accordingly.

5. **The OCA recommends CPS amend policy 713-11 to add a question to the safety assessment specifically surrounding parental mental health similar to those found in New York and Ohio CPS safety assessments.**

MDHHS Response to Recommendation 5: MDHHS is actively revising the department's safety assessment in partnership with **Evident Change** and will consider this recommendation during development. CPS policy will be amended to reflect the questions and other assessment items within the revised safety assessment upon completion.

MDHHS Annual Update: MDHHS is actively revising the department's safety assessment and is in ongoing discussion with Evident Change regarding this recommendation. At this time, the department is exploring how the behaviors, actions, or inactions of a parent or caregiver, attributed to their mental health, will be best captured in the safety assessment to align with the intent of the tool. One consideration being explored is the identification of complicating factors, like mental health, to drive the need for further assessment.

In addition to revisions to the department's safety assessment, MDHHS is actively pursuing enhancements to the risk assessment and risk reassessment. Mental health will be discussed in depth to ensure these assessments carefully consider the likelihood of future risk as it relates to a parent or caregiver's mental health as well.

While a final draft of the safety assessment may be available by the end of 2024, implementation and utilization by case managers is largely dependent on the transition from MiSACWIS to CCWIS.

Recommendations from Case 2022-0581 published January 10, 2024:

1. **The OCA recommends MDHHS amend 'PSM 713-04 Medical Examination and Assessment', to require the assigned case manager conduct interviews with treating medical professional(s) as part of an investigation into physical abuse, sexual abuse, and/or severe physical injury.**

MDHHS Response to Recommendation 1: MDHHS agrees that a policy change requiring the assigned case manager to pursue interviews with the treating medical professionals would be beneficial. Current policy allows case managers to speak to other professionals at the medical facility to gather and relay information to avoid potentially critical delays in examination and an update to require staff to pursue interviews with the treating physician will be explored.

MDHHS Annual Update: Effective August 1, 2023, **PSM 713-04 requires the following:**

Initial Consultation with Medical Professional

Case managers must consult with a medical practitioner immediately when an examination is needed. Consultation should include the child's parent whenever feasible. When contacting the medical practitioner, case managers should request an examination of the child and provide the following information:

- The reason the medical examination is being requested.
- The reason(s) for suspicion of abuse and/or neglect.
- All known health/medical information regarding the child and family.
- Any additional pertinent case information including:
  - History of alleged and confirmed abuse/neglect.
  - Household/family makeup.
  - Home environmental factors.
  - Parent's behavior toward the child.
  - Explanations provided for an injury.

Case managers must make efforts to speak directly with the examining medical practitioner; however, if the medical practitioner is not available, the case manager may provide the information to a professional at the medical facility and provide case manager contact information for any questions the medical practitioner may have. Attempts must be made throughout the duration of the investigation to speak to the examining medical practitioner.

Results of a Medical Examination

A case manager must contact the medical practitioner or other medical professional familiar with the medical exam, to have them interpret the medical-examination findings. Case managers should ask the medical practitioner if the medical examination findings are consistent with the caregiver's explanation. If the findings or implications are unclear, the case manager must seek clarification.

2. **The OCA recommends MDHHS amend PSM 713-01 to require that case conferences between CPS case managers and their supervisors be documented in narrative format in the case file's social work contacts.**

MDHHS Response to Recommendation 2: MDHHS agrees, has prepared draft policy language, and is soliciting final feedback before implementation.

MDHHS Annual Update: MDHHS is actively finalizing policy language requiring specific documentation of case conferences between a case manager and their supervisor. It is expected the enhanced policy will be implemented in 2024.

Office of the Child Advocate

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