Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted]	[redacted]	[redacted]
Date of Birth: June 23, 2023	**Date of Birth: September 27, 2023**	**Date of Birth: February 27, 2011**
Date of Death: August 25, 2023	**Date of Death: December 27, 2023**	
Investigation Start: October 4, 2023	Investigation Start: February 1, 2024	Investigation Start: October 18, 2024

Case Objectives

The objective of this review is to identify areas for improvement in the child welfare system by looking at how CPS investigations involving [redacted] and [redacted] were handled by Kent, Wayne, and Calhoun County MDHHS, and the involvement of MDHHS staff, medical professionals, and law enforcement. This review reinforces the idea that the safety and well-being of a child is a shared responsibility of the family, community, law enforcement, and medical professionals aiding children and families. This report is not intended to place blame, but to highlight areas of concern regarding the handling of the investigations; inform policy, procedure, and practice of MDHHS and partners within the child welfare system; and advocate for changes within it on behalf of similarly situated children.

Case Backgrounds

[redacted] was two months old when he died on August 25, 2023. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatality. On October 4, 2023, the OCA opened an investigation into the administrative actions of CPS regarding [redacted] death.

[redacted] was three months old when he died on December 27, 2023. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatality. On February 1, 2024, the OCA opened an investigation into the administrative actions of CPS regarding [redacted] death.

The case involving [redacted] and her siblings came to the attention of the OCA with concerns about the children's safety while remaining in their home. On October 18, 2024, the OCA opened a full investigation to determine if a petition should be filed to safeguard the children.

The following report summarizes the information and evidence found during the OCA investigations. These cases are being presented together in a joint Findings and Recommendations Report given the similarities in the family history and the issues identified.

OCA Data

The OCA began tracking emerging trends when a new case management system, Michigan Child Advocate Investigation System (MiCAIS) was implemented at the OCA in July 2020. The OCA began tracking the emerging trends of unsafe sleep practices and infants born drug positive in July of 2020.

Since the OCA began tracking these emerging trends, the OCA has reviewed 1,714 child deaths. 256 of the child deaths reviewed included children who were born drug positive. 179 of these child deaths included children were born positive for marijuana only.

543 of the child deaths reviewed included the death of an infant who died in an unsafe sleep environment. 119, or 21.9% of the 543, children were born positive for substances at birth. 88, or 16% of 543 children were born positive for marijuana only.

Resources

Minnes, S., Lang, A., Singer, L., Mandel School of Applied Social Sciences, Case Western Reserve University, & School of Medicine. (2011). Prenatal tobacco, marijuana, stimulant, and opiate exposure: Outcomes and practice implications. In Addiction Science & Clinical Practice [Journal-article]. https://nationaldec.org/wp-content/uploads/214-Article.pdf

Teratology is "the study of congenital abnormalities, their causes and the treatment options available for those affected. These abnormalities are principally the result of infections, physical agents, metabolic conditions or chemicals and can cause death as well as physical, behavioral, and intellectual deficits." Belanger BG, Lui F. Embryology, Teratology TORCH. [Updated 2023 Jul 24]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK545148/

Jutras-Aswad, D., DiNieri, J. A., Harkany, T., Hurd, Y. L., National Abandoned Infants Assistance Resource Center, & University of California, Berkeley. (2009). Perinatal marijuana exposure. In European Archives of Psychiatry and Clinical Neuroscience (Vols. 259–7, pp. 395–412) [Journal-article]. University of California, Berkeley. https://nationaldec.org/wp-content/uploads/165-Article.pdf

Stephanie Anne Deutsch, Claire E. Loiselle, Jobayer Hossain, Allan De Jong; Sleep-Related Sudden Unexpected Infant Death Among Infants Prenatally Substance Exposed. Pediatrics December 2024; 154 (6): e2024067372. 10.1542/peds.2024-067372

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Recommendation Issued: July 30, 2025 - Response received from MDHHS: November 13, 2025

Findings	Responses
Finding 1: The child advocate finds the 2022 investigation concerning the [redacted] family did not follow the requirements for assessing threatened harm per, PSM 713-11. [redacted] had her rights previously terminated to children due to substance use and domestic violence, and there were concerns of both present during the 2022 investigation.	**MDHHS Response to Finding 1:** MDHHS Agrees.
Finding 2: The child advocate finds the 2023 investigation concerning the [redacted] family did not consider and apply threatened harm as it related to [redacted] substance use and her prior terminations. a. MDHHS did not identify an infant plan of safe care for [redacted] b. Staff did not accurately assess parenting capacity as it related to [redacted] substance use.	**MDHHS Response to Finding 2:** MDHHS agrees. The Infant Plan of Safe Care did not fully meet the expectations outlined in policy. While there were referrals to services to Maternal Infant Heath Program and Early On, the county did not follow through to document implementation of those services. **MDHHS Response to Finding 2b:** MDHHS agrees.
Finding 3: The child advocate finds MDHHS did not follow PSM 713-01, CPS Investigation-General Instructions and Checklist during the 2023 investigation by not observing and documenting a proper sleeping environment for [redacted] Additionally, CPS did not assist the family in obtaining a proper sleeping environment.	**MDHHS Response to Finding 3:** MDHHS agrees to the extent that the specialist did not verify that the family received nor assembled the bassinet.
Finding 4: The Child Advocate finds the 2023 investigation concerning the [redacted] family inadequately completed the vulnerable child assessment by asking the vulnerable child questions of [redacted] legal father, who was unaware of his medical needs or history.	**MDHHS Response to Finding 4:** MDHHS disagrees. Vulnerable child policy requires a specialist to contact one or more individuals, excluding the perpetrator, with knowledge of the child's needs. The specialist completed the vulnerable child policy questions with Mr. [redacted] who is the legal father of the child and not an alleged perpetrator. Mr. [redacted] demonstrated a comprehensive understanding of the child's needs. Although the documentation did state, "There are no unmet medical and/or safety needs [redacted] is aware of," this does not indicate a lack of knowledge or awareness. Rather, it indicates a certainty about the medical and safety needs that he does possess.
Finding 5: The Child Advocate finds the 2022 investigation concerning the [redacted] family, did not properly assess threatened harm following [redacted] birth. a. No threatened harm assessment was completed to determine the severity of the past behavior, length of time since the past incident, evaluation of services, benefit from services (including if conditions have been rectified), and vulnerability of child(ren).	**MDHHS Response to Finding 5:** MDHHS agrees.

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Recommendation Issued: July 30, 2025 - Response received from MDHHS: November 13, 2025

Findings	Responses
Finding 6: The Child Advocate finds the 2022 investigation concerning the [redacted] family did not follow MDHHS policy PSM 716-7. a. The infant plan of safe care was documented to be completed by an Early-On referral being made. No additional services were referred or implemented. b. Staff did not follow the guidance for assessing parenting capacity as it related to [redacted] substance use.	**MDHHS Response to Finding 6:** MDHHS Agrees.
Finding 7: The Child Advocate finds the 2023 investigation concerning the [redacted] family did not properly assess threatened harm following [redacted] birth. a. No threatened harm assessment was completed to determine the severity of the past behavior, length of time since the past incident, evaluation of services, benefit from services (including if conditions have been rectified), and vulnerability of child(ren).	**MDHHS Response to Finding 7:** MDHHS Agrees.
Finding 8: The Child Advocate finds the 2023 investigation concerning the [redacted] family did not follow MDHHS policy PSM 716-7. a. An infant plan of safe care was not completed following [redacted] birth, though required by Michigan's Plan of Safe Care Protocol and policy. b. Staff did not follow the guidance for assessing parenting capacity as it related to [redacted] substance use.	**MDHHS Response to Finding 8:** MDHHS Agrees.
Finding 9: The child advocate finds the May 2024 investigation concerning [redacted] did not consider and apply threatened harm as it related to [redacted] continued drug use and her prior release of parental rights for drug use.	**MDHHS Response to Finding 9:** MDHHS disagrees. Threatened harm as defined by policy is "An action, inaction or credible verbal threat by a person responsible and absent intervention, there is a high probability that harm will occur." The investigator thoroughly assessed all aspects of historical threatened harm. The investigator assessed [redacted] past behavior, the vulnerability of the child, her support system at the time of the investigation, her willingness to comply with services at the time of the investigation, and her criminal history. In this case, another appropriate adult, Ms. [redacted] was also living in the home and assisting in the care of [redacted] Ms. [redacted] also remained engaged and cooperative throughout the prevention case.

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Recommendation Issued: July 30, 2025 - Response received from MDHHS: November 13, 2025

Findings

Finding 10:
The child advocate finds the May 2024 investigation concerning [redacted] did not follow MDHHS policy PSM 716-7.

a. The infant plan of safe care was documented to be an Early On referral, [redacted] agreeing to not use substances in the home, utilizing safe sleep practices, the children being supervised by a sober caretaker, and ensuring [redacted] is taken to all doctor's appointments.

b. Staff did not follow the guidance for assessing parenting capacity as it related to [redacted] substance use.

Responses

MDHHS Response to Finding 10:
MDHHS disagrees. Ms. [redacted] admitted to her past and current use of substances and agreed to a safety plan that included a provision in which she would always have a safe and sober caregiver for [redacted] Ms. [redacted] was also aware of and agreed to this safety plan, and there were no substance abuse concerns with Ms. [redacted] All records show that the family complied with this safety plan throughout the case. Furthermore, records indicated Ms. [redacted] would use substances only when she left the home. There was no evidence of Ms. [redacted] using substances in the home, nor of her providing care to [redacted] while under the influence. Ms. [redacted] agreed to participate in services to address her substance use, including random drug screens, as well as Families First, to which she was referred in October of 2024. This was in accordance with PSM 716-7 which states, "Substance use by a parent/caregiver may be a risk factor for child maltreatment. For cases involving known substance use, case managers must evaluate its impact on child safety. Substance abuse is a mental health disorder. Case managers should assist the parent/caregiver in accessing relevant supports and services."

Additionally, a referral involving only substance use is insufficient for investigation or confirmation of child abuse or child neglect. Ms. [redacted] presence in the home is a positive support and provided necessary care to the baby, ultimately mitigating the Department's immediate concerns of substance abuse and its effect on her ability to care. When Ms. [redacted] did not follow through with provided services, a petition was filed in accordance with policy, and removal of [redacted] was granted by the Court.

The infant plan of safe care stated only an Early On referral, yet the investigative report documented multiple other service referrals. In a contact dated 07/11/2024, Ms. [redacted] was provided with information on a substance abuse assessment; an intake date was confirmed on 08/01/2024. On 07/19/2024, a referral was made for a home visiting program. At the conclusion of the investigation, a referral was made to the local county's prevention team. A prevention specialist was assigned to the [redacted] family.

Finding 11:
The child advocate finds MCL 722.638 states the department shall submit a petition for authorization by the court if (b) The department determines that there is risk of harm, child abuse, or child neglect to the child and either of the following is true: (i) The parent's rights to another child were terminated as a result of proceedings under section 2(b) of chapter XIIA of 1939 PA 288, MCL 712A.2, or a similar law of another state and the parent has failed to rectify the conditions that led to the prior termination of parental rights.

a. [redacted] had previous terminations, and the issues that prompted those actions were not resolved.

MDHHS Response to Finding 11:
MDHHS Agrees.

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Recommendation Issued: July 30, 2025 - Response received from MDHHS: November 13, 2025

Findings	Responses
Finding 12: The child advocate finds MDHHS did not adhere to MCL 722.638 because threatened harm assessments were incomplete or not completed.	**MDHHS Response to Finding 12:** MDHHS Agrees.
Finding 13: The child advocate finds PSM 713-08, policy regarding how to conduct Birth Match investigations is inadequate and does not provide guidance to case managers on how to properly conduct these investigations.	**MDHHS Response to Finding 13:** MDHHS agrees in part. While birth match investigations must be conducted in accordance with PSM 713-01, like any other investigation, MDHHS will evaluate whether additional policy guidance is needed to specifically address birth match investigations.
Finding 14: The child advocate finds historical policy, 713-08 dated 06/10/2010, had guidance for case managers regarding what was required when a parent has a prior termination of parental rights, and a new child is born. This guidance provided more clear and direct questions to assess than the current questions within the threatened harm policy.	**MDHHS Response to Finding 14:** MDHHS agrees in part. Although many elements of the 2010 policy remain present in the current threatened harm policy (PSM 713-11), MDHHS will evaluate whether additional policy enhancements are needed to provide clearer guidance for staff assessing these situations.
Finding 15: The child advocate finds that additional efforts are needed to ensure the safety and well-being of children born to parents who have previous terminations of their parental rights.	**MDHHS Response to Finding 15:** MDHHS agrees in part. While the Department recognizes the opportunities for improvement in this specific case, the recommendation will be reviewed further to determine if this is a systemic issue and how best to mitigate the area of concern.
Finding 16: The child advocate finds PSM 713-08 changed and no longer requires the DHS-3 Sibling Placement Evaluation form be completed when a new child is born to a parent who has prior terminations of parental rights. This ceased the requirement for second line oversight and approval on birth match investigations.	**MDHHS Response to Finding 16:** MDHHS agrees.
Finding 17: The child advocate finds the OCA has reviewed 1,714 child deaths since MiCAIS was implemented in July 2020. a. 543, or 31.6% of these deaths involved an infant who died in an unsafe sleep environment. b. 256 of the total deaths reviewed involved children who were born positive for substances, with 179 of those being born with marijuana exposure only. c. 21.9% of the infants who died in an unsafe sleep environment, were born positive for substances. 16% of infants who died in an unsafe sleep environment were born with only marijuana exposure.	**MDHHS Response to Finding 17:** No response needed

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Recommendation Issued: July 30, 2025 - Response received from MDHHS: November 13, 2025

Recommendations

Recommendation 1:
The child advocate recommends MDHHS amend PSM 713-11 pertaining to threatened harm assessments to include the question: does the threatened harm include a prior termination of parental rights. If this is answered yes, the following additional steps should be required and answered by the case manager.

a. The prior case and court orders leading to the prior termination of parental rights should be reviewed and summarized by the case manager.
b. How has the parent addressed those specific issues?
c. What are the differences and similarities between prior and current child abuse and/or neglect allegations?
d. Detail specific facts that demonstrated whether the family has, or has not, resolved the risk and safety issues that resulted in the previous court actions.
e. Is a mandatory petition required per MCL722.638?

Recommendation 2:
The child advocate recommends MDHHS require second line or director approval on birth match investigations to provide additional oversight in decision-making on cases involving new infants born to parents who have previously lost their parental rights.

Recommendation 3:
The child advocate recommends MDHHS amend PSM 716-7 to add new language requiring CPS specialists to contact and speak with the substance exposed infant's treating medical provider.

a. When doing so, CPS specialists should determine the status of the infant's physical health, if they are receiving any medical treatment for withdrawal symptoms, what that medical treatment involves, and if the infant's exposure and any related symptoms meet the definition of serious physical harm.
b. Policy can further define medical staff or practitioners, to mean the child's treating medical provider who has received formal training to practice medicine. This should include individuals such as a physician, nurse, or a licensed medical provider who are qualified to report about the infant's physical health, medical treatment being provided to the child for withdrawal symptoms, and what the medical treatment involves.

Responses

MDHHS Response to Recommendation 1:
MDHHS agrees in part. Although this recommendation closely aligns with existing policy on threatened harm assessments, MDHHS will review it to determine whether further enhancements are needed to strengthen guidance for these investigations.

MDHHS Response to Recommendation 2:
MDHHS agrees in part. While the Department recognizes the opportunities for improvement in this specific case, the recommendation will be reviewed further to determine if this is a systemic issue and how best to mitigate the area of concern.

MDHHS Response to Recommendation 3:
MDHHS disagrees. PSM 716-7 already requires that investigations involving infants exposed to substances or alcohol also include the following:

- Contact with medical staff to obtain the following information, if available:
  - o Results of medical tests indicating infant exposure to substances and/or alcohol.
  - o The health and status of the infant.
  - o Documented symptoms of withdrawal experienced by the infant.
  - o Medical treatment the infant or birthing parent may need.
  - o Observations of the parent's care of the infant and the parent's response to the infant's needs.
  - o To be considered serious physical abuse, a medical practitioner must confirm the infant's exposure, and any related symptoms, meet the definition of serious physical harm.
  - o Interview with the infant's parents and any relevant caregivers to assess the need for a referral for substance use disorder prevention, treatment, or recovery services.

Furthermore, medical practitioner is defined in PSM 711-4 as follows:

- A physician or physician's assistant licensed or authorized to practice under part 170 or 175 of the public health code, MCL 333.17001 to 333.17088 and MCL 333.17501 to 333.17556.
- A nurse practitioner licensed or authorized to practice under section 172 of the public health code, MCL 333.17210.

MDHHS previously agreed to enhance PSM 716-7 to mirror or link the language reflected in PSM 711-4.

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Recommendation Issued: July 30, 2025 - Response received from MDHHS: November 13, 2025

Recommendations	Responses
Recommendation 4: The child advocate recommends all CPS case managers be trained on the Michigan Governor's Task Force on Child Abuse and Neglect Plan of Safe Care Protocol.	**MDHHS Response to Recommendation 4:** MDHHS agrees. MDHHS is actively partnering with MPHI and other critical partners to implement the enhanced Plan of Safe Care, with the support of a comprehensive training series and toolkit, to improve outcomes for infants and their families. The training series is expected to roll out in 2025/2026. The department's training unit will also train on the enhanced protocol moving forward.
Recommendation 5: The child advocate recommends MDHHS develop and implement additional training for case managers on how to conduct birth match investigations, and how to appropriately apply and assess threatened harm policy, PSM 713-11.	**MDHHS Response to Recommendation 5:** MDHHS agrees in part. While the Department recognizes the opportunities for improvement in birth match investigations, the recommendation will be reviewed further to determine if this is a systemic issue and how best to mitigate the area of concern.
Recommendation 6: The child advocate recommends MDHHS develop and implement additional training for case managers on how to appropriately apply the substance exposed infant policy, PSM 716-7.	**MDHHS Response to Recommendation 6:** MDHHS agrees in part. While the Department recognizes the opportunities for improvement in the [redacted] case, the recommendation will be reviewed further to determine if this is a systemic issue and how best to mitigate the area of concern.
Recommendation 7: The child advocate recommends MDHHS amend PSM 713-01 to require case managers immediately provide the family with a pack n play or other approved safe sleep environment when one is not observed in the home.	**MDHHS Response to Recommendation 7:** MDHHS agrees. PSM 713-01 will be amended to reflect the following: If items needed for safe sleep are not available in the home, case managers must ensure assistance is provided to obtain the necessary items.

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted]	[redacted]	[redacted]
Date of Birth: June 23, 2023	**Date of Birth: September 27, 2023**	**Date of Birth: February 27, 2011**
Date of Death: August 25, 2023	**Date of Death: December 27, 2023**	
Investigation Start: October 4, 2023	Investigation Start: February 1, 2024	Investigation Start: October 18, 2024

Case Objective

The objective of this review is to identify areas for improvement in the child welfare system by looking at how CPS investigations involving [redacted] and [redacted] were handled by Kent, Wayne, and Calhoun County MDHHS, and the involvement of MDHHS staff, medical professionals, and law enforcement. This review reinforces the idea that the safety and well-being of a child is a shared responsibility of the family, community, law enforcement, and medical professionals aiding children and families. This report is not intended to place blame, but to highlight areas of concern regarding the handling of the investigations; inform policy, procedure, and practice of MDHHS and partners within the child welfare system; and advocate for changes within it on behalf of similarly situated children.

Case Backgrounds

[redacted] was two months old when he died on August 25, 2023. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatality. On October 4, 2023, the OCA opened an investigation into the administrative actions of CPS regarding [redacted] death.

[redacted] was three months old when he died on December 27, 2023. Pursuant to MCL 722.627k, MDHHS notified the OCA of the child fatality. On February 1, 2024, the OCA opened an investigation into the administrative actions of CPS regarding [redacted] death.

The case involving [redacted] and her siblings came to the attention of the OCA with concerns about the children's safety while remaining in their home. On October 18, 2024, the OCA opened a full investigation to determine if a petition should be filed to safeguard the children.

The following report summarizes the information and evidence found during the OCA investigations. These cases are being presented together in a joint Findings and Recommendations Report given the similarities in the family history and the issues identified.

[redacted] Family History and Background

[redacted] is the mother of [redacted] (11), and [redacted] (10). [redacted] is the father of [redacted] and [redacted] is [redacted] father and lived with [redacted] at the time of [redacted] death. [redacted] has two additional minor children, [redacted] (14) and [redacted] (10), who reside with their mother [redacted]

The scope of this investigation surrounded three CPS investigations, one which occurred prior to [redacted] birth, an investigation completed by CPS at the time of [redacted] birth, and [redacted] death investigation. The family has prior CPS history dating back to 2005, including a Category I removal in 2008 due to substance abuse and the family not participating with CPS. Ultimately, because of [redacted] continued substance use, concerns for domestic violence, and her lack of participation in the service plan, her parental rights were terminated to her children, [redacted] and [redacted] in May 2009.

[redacted] gave birth to [redacted] in March 2012. A birth match [1] investigation was completed. This investigation resulted in no finding of child abuse or neglect and was dispositioned as a Category IV. [redacted] was tested for substances at birth and was found to have no substances in his system. Additionally, [redacted] was no longer in the violent relationship she was involved with in 2008 when her children were previously removed, and her rights were terminated. A Category IV birth match investigation was also completed following [redacted] birth and there was no evidence suggesting [redacted] was using substances.

Between May 2013 and March 2022, [redacted] was the subject of three CPS investigations which resulted in no findings of child abuse or neglect. These investigations were dispositioned as Category IV investigations. These investigations concerned potential improper supervision and domestic violence. Prior to [redacted] involvement with [redacted] he was only the subject of one CPS investigation in 2013 involving physical neglect and improper supervision that was closed as a Category IV.

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[1] A birth match is defined by CPS policy as "an automated system that notifies Centralized Intake when a new child is born to a parent who previously had their parental rights terminated in a child protection proceeding, caused the death of a child due to abuse and/or neglect, or has committed a serious act of child abuse and/or neglect."

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Review of November 2022 Investigation (MiSACWIS ID: 136953016)

The focus of the OCA's investigation concerning the [redacted] family starts with a November 2022 CPS investigation. On November 14, 2022, CPS received a complaint which expressed concern [redacted] was drinking heavily to the point of intoxication. According to the complaint, on November 14, 2022, [redacted] woke up and found [redacted] intoxicated. [redacted] became upset and attacked [redacted] physically in front of the children. The children got an adult neighbor to assist but witnessed the domestic violence incident occur. The complaint stated [redacted] was observed with a "busted lip" and scratches to his back, neck and rib area. Additionally, the complaint stated [redacted] reported pain in his ribs due to [redacted] tackling him and holding him down while shoving her knees into his ribs. The referral source informed Centralized Intake [redacted] left the home prior to law enforcement arriving and an arrest warrant was being pursued. The complaint was accepted and assigned to Kent County CPS for investigation.

When CPS began their investigation, they contacted the school and were informed [redacted] had unenrolled [redacted] and [redacted] earlier that morning because she was moving to her mother's home in White Cloud (Newaygo County). Kent County CPS asked Newaygo County CPS to conduct a courtesy home visit [2] with [redacted] her mother, and the children to verify the children's wellbeing and to interview [redacted]

Newaygo County CPS conducted an unannounced home visit to [redacted] mother's home on November 16, 2022. CPS was able to see [redacted] and [redacted] from outside the home, but [redacted] would not allow CPS to enter the home. CPS did not interview the children during this visit. Newaygo County CPS interviewed [redacted] on the porch of the home. [redacted] advised CPS [redacted] was "psychotic", and he started saying "crazy things" when he became upset with her. She further advised [redacted] pushed her, so she pushed him back. [redacted] denied the children witnessed any physical altercation, informing CPS the children had been waiting in the car to be taken to school. [redacted] advised CPS of previous altercations between her and [redacted] which according to [redacted] occurred over the past summer. [redacted] denied being intoxicated the morning of the altercation and told CPS she had found out she was pregnant over the same weekend. [redacted] admitted to drinking alcohol Saturday prior to finding out she was pregnant. She admitted to having a history of substance abuse but denied any current issues with substances. CPS asked [redacted] to submit to a drug screen, but [redacted] refused. CPS created an initial verbal safety plan with [redacted] that said she planned to continue residing with her mother. CPS documentation of the interview states there was no further safety planning necessary at that time.

On November 23, 2022, White Cloud Elementary school staff informed CPS the children were not enrolled there as previously planned and the mother arranged for the children to return to their previous elementary school. On November 29, 2022, CPS interviewed the children at Cedar Springs Elementary. [redacted] advised CPS they returned home, residing with his mother's boyfriend, [redacted] [redacted] denied having any concerns or that anything happened prior to them going to their grandmother's home. During CPS' interview with [redacted] advised he does not like it when his mom drinks and smokes, that she argues with his stepdad ([redacted] and he tries to stay away from her when she is drinking. He advised CPS he had witnessed them arguing but denied anything physical happening.

During a home visit on December 6, 2022, [redacted] was interviewed and informed CPS the complaint allegations were accurate. He advised [redacted] had been drinking all night and all weekend, was acting hostile with him, and after he tried to push away from her, she assaulted him. [redacted] told CPS both children witnessed the altercation, and they have witnessed previous domestic violence incidents between the two of them. CPS created a written safety plan with [redacted] during this home visit. [redacted] agreed to work with services. Proactive steps were identified in the safety plan stating [redacted] would continue locking up marijuana and firearms. He further agreed to separate from [redacted] and walk to his sister's home if he and [redacted] began arguing. [redacted] agreed to reactive steps of calling 911 if a fight became physical and not smoking in front of the children. He also agreed to ensure a sober caretaker is present while smoking or under the influence of marijuana.

According to the CPS report, CPS completed a phone consultation with a YWCA liaison regarding the possible domestic violence between [redacted] and [redacted] The liaison advised CPS based on the information provided, there did not appear to be a pattern of coercive control, but [redacted] use of violence appeared related to her level of intoxication. It was explained to CPS the liaison's assessment indicated a significant substance abuse issue for [redacted] The liaison recommended a substance abuse evaluation/service be completed. The liaison also recommended CPS consider in-home services and create a detailed safety plan around [redacted] alcohol use. CPS documented attempting to offer services to [redacted] but she denied needing to participate in any substance abuse related services.

On December 13, 2022, CPS interviewed [redacted] other children, [redacted] and [redacted] Both children advised witnessing arguing between [redacted] and [redacted] and both adults smoke and drink.

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[1] In cases in which parents, caregivers, or children are in other counties, requests for assistance in other counties are made to complete interviews and home visits with the family, known as courtesy home visits.

[2] In cases in which parents, caregivers, or children are in other counties, requests for assistance in other counties are made to complete interviews and home visits with the family, known as courtesy home visits.

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Review of November 2022 Investigation (MiSACWIS ID: 136953016)

CPS reviewed the police report from the Kent County Sheriff's Office regarding the incident on November 14, 2022. The police report indicated [redacted] explained the incident the same way he explained it to CPS. The officers documented the injuries to [redacted] supported his claim of being assaulted by [redacted] Domestic violence charges were authorized against [redacted] and an arrest warrant was issued.

CPS documented reviewing policy around domestic violence and substance abuse, determining that there was not a preponderance of evidence supporting the allegation of improper supervision. The investigation was closed as a Category IV on January 6, 2023.

During this investigation, CPS did not consider threatened harm as a possible maltreatment. Evidence existed for both historical and current threatened harm. [redacted] had her rights terminated in the past due to substance use and domestic violence. This investigation had evidence of current domestic violence and concerns for [redacted] abusing alcohol. CPS was informed by the YWCA liaison that [redacted] would benefit from substance abuse evaluation and services.

Review of June 2023 Investigation (MiSACWIS ID: 145953327)

On June 19, 2023, CPS received a complaint regarding allegations of physical abuse of [redacted] The complaint expressed concern [redacted] was born and his meconium tested positive for cocaine and THC metabolites. An additional concern was noted in the complaint for [redacted] parental rights being previously terminated to two of her children. The complaint was accepted and assigned to Kent County CPS for investigation.

An unannounced home visit was conducted on June 19, 2023, to the family home by the on-call CPS case manager. [redacted] and all three children were present. [redacted] admitted to CPS she used marijuana during her pregnancy and continued her use after discharge from the hospital despite breastfeeding. She denied using cocaine. [redacted] also advised CPS he smokes marijuana and denied the use of any other substances. [redacted] refused to drug screen and CPS did not document offering [redacted] a drug screen. During the home visit, CPS did not observe a safe sleep environment for [redacted] noting that an infant cradle and swing were identified as [redacted] sleeping area. CPS was advised by [redacted] that a bassinet had been ordered and would arrive later that week. There was also an unassembled crib observed in the home. CPS documented discussing safe sleep with the family and implemented a detailed safety plan around substance use. It is not documented whether the safety plan was verbal or written.

Additional home visits were attempted by the assigned case manager but were not successful and CPS had difficulty contacting [redacted] and [redacted] A collateral contact was made to White Pine Family Medicine on July 17, 2023. CPS was advised [redacted] first appointment was canceled and the family no showed for the rescheduled appointment.

On July 21, 2023, CPS spoke with [redacted] father of [redacted] and [redacted] is [redacted] legal father because [redacted] and [redacted] were still married when [redacted] was born. [redacted] advised CPS he was currently driving [redacted] to a court hearing which was regarding [redacted] violating a no-contact order with [redacted] denied being aware [redacted] was born positive for cocaine and marijuana, adding that he was also unaware [redacted] was using either substance. CPS completed the vulnerable child assessment[3] with [redacted] and he had no concerns for [redacted] CPS then spoke with [redacted] who acknowledged not adhering to the no contact order. [redacted] told CPS she had transportation issues, which is why the well-child appointments for [redacted] were missed. CPS informed [redacted] of their intent to refer her for Early-On and Maternal Infant Health Program (MIHP) services. Social work contacts in the investigation document referrals to both programs were made but there is no documentation that implementation of the services occurred prior to the investigation closure.

As a result of [redacted] not experiencing withdrawals and not needing medical intervention after being born positive for substances, CPS found no preponderance of evidence to support physical abuse of [redacted] The CPS investigation was closed on July 21, 2023, as a Category IV. The risk level was scored as high-risk level due to [redacted] prior CPS history, history of domestic violence, and substance use.

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[3] A vulnerable child assessment is required when a child has been identified as vulnerable. The case managers are required to contact one or more individuals, excluding the perpetrator, with knowledge of the child's needs and document concerns related to potential child abuse and/or neglect, the caregiver's ability to meet the needs of the child, and if the child has any unmet medical, mental health, or safety needs.

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Additional Evidence Regarding June 2023 Investigation (MiSACWIS ID: 145953327)

Interviews were conducted with MDHHS staff by the OCA investigator. MDHHS staff informed the OCA this case was difficult to disposition. MDHHS staff advised there were no other maltreatments explored during this investigation, and they were only looking at the maltreatment of physical abuse. MDHHS staff were aware of [redacted] rights being previously terminated due to substance abuse. MDHHS staff advised the OCA [redacted] and [redacted] were not cooperative with additional home visits after CPS on-call responded, stating this was taken into consideration when the decision was made to close the investigation. MDHHS staff felt that due to the parents not cooperating, they would not be able to service them properly in an open case.

Review of CPS Investigation of [redacted] death, August 2023 (MiSACWIS ID: 149773205)

On August 25, 2023, CPS Centralized Intake received a complaint regarding physical neglect of [redacted] The complaint expressed concern that the night prior (August 24, 2023), [redacted] and [redacted] went to bed with [redacted] was positioned between [redacted] and [redacted] When they woke up the morning of August 25, 2023, [redacted] was unresponsive. [redacted] was pronounced deceased. The complaint was accepted and assigned to Kent County CPS for investigation.

CPS began their investigation by contacting the assigned detective at the Kent County Sheriff's Department. The detective advised CPS it appeared [redacted] had been deceased for some time as rigor was in his arms and he was pale in color. The detective further informed CPS that [redacted] admitted to using marijuana and alcohol the previous night and an empty bottle of alcohol was observed as well as evidence of possible cocaine use.

On August 25, 2023, CPS went with the assigned detective to [redacted] mother's home where [redacted] was with her children. During the home visit, [redacted] admitted to violating the active no-contact order and co-sleeping together with [redacted] and [redacted] [redacted] told CPS she was drinking vodka and smoking marijuana the night of [redacted] death. [redacted] admitted to CPS she used cocaine prior to her knowing she was pregnant which resulted in [redacted] being born positive. [redacted] agreed to a safety plan for [redacted] and [redacted] to remain in the care of their father, [redacted] with supervised visits. [redacted] completed a drug screen for CPS.

CPS and the detective then went to [redacted] [redacted] home, where [redacted] death occurred. [redacted] spoke with them outside and did not allow entry to the home. [redacted] advised CPS he and [redacted] had both been drinking and that he had smoked marijuana as well. He advised CPS [redacted] drinks almost every night but did not drink while she was pregnant. He acknowledged [redacted] was not supposed to be in the home due to the no-contact order. CPS implemented a verbal safety plan with [redacted] that his children, [redacted] and [redacted] would remain in the care of their mother and he would have supervised visitations. He also completed a drug screen for CPS. CPS went back to the home on August 29, 2023, to observe the home conditions. CPS noted the home was cluttered and there was no crib, bassinet, or pack n play observed in the home.

The CPS investigation documents drug screen results for [redacted] and [redacted] both came back positive. [redacted] was positive for THC and hydrocodone while [redacted] was positive for THC and cocaine. CPS summarized the police report which documented charges for involuntary manslaughter related to [redacted] death were submitted to the prosecutor's office for [redacted]

[redacted] cause of death was ruled Probable Asphyxia by Suffocation and his death was ruled accidental. CPS found a preponderance of evidence supporting threatened harm of physical neglect of [redacted] by [redacted] and [redacted] CPS filed a petition against [redacted] [redacted] [redacted] [redacted] and [redacted] [redacted] on December 13, 2023. The children were removed from [redacted] and [redacted] [redacted] and [redacted] remained in their father's care while [redacted] and [redacted] remained in their mother's care. The CPS investigation was closed on 01/10/2024.

On January 27, 2025, [redacted] [redacted] pled guilty to Child Abuse Fourth Degree and Controlled Substance Use. On April 23, 2025, [redacted] was sentenced to 12 months of probation.

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Family History and Background

[redacted] is the mother of [redacted] (1) and [redacted] (3 months TOD). [redacted] is the father of both children but due to a legal marriage at the time of the children's births, [redacted] was the legal father of the children during case involvement prior to [redacted] death.

[redacted] and [redacted] also share three additional children, [redacted] II, [redacted] and [redacted] In 2014, the children were removed from [redacted] and [redacted] care due to medical neglect, physical neglect, maltreatment, substance abuse and threatened harm. Following the children entering foster care, [redacted] was substantiated for sexual abuse of [redacted] and [redacted] A mandatory supplemental petition was filed adding these allegations to the court case, however, this was later dismissed. The parents continued to struggle with substance abuse for the duration of the foster care case and failed to address the issues that brought the children into care. In 2016, parental rights were terminated. In April 2019, [redacted] and [redacted] had another child, [redacted] who was born positive for THC and cocaine. A petition was filed in May 2019 requesting their parental rights be terminated to [redacted] due to the parent's previous termination of parental rights, the current risk of harm to the child, and the parent's not rectifying the issues that led to the prior terminations. Parental rights were terminated in September 2019 with no additional services being provided to the parents.

The scope of this investigation begins with the birth of [redacted] next child, [redacted] the birth of [redacted] and [redacted] death. Both investigations following [redacted] and [redacted] births were considered birth match investigations but also investigations involving drug positive infants.

Review of 2022 CPS Investigation (MiSACWIS ID: 125632891)

On March 19, 2022, MDHHS Centralized Intake received a complaint regarding physical abuse, physical neglect, and threatened harm of [redacted] by [redacted] The complaint stated [redacted] gave birth to [redacted] and there was concern for her not receiving any prenatal care. Additionally, the complaint stated [redacted] was positive for marijuana upon admission, she admitted to smoking marijuana during her pregnancy, and the urine screen completed for [redacted] was positive for THC. The complaint was accepted and assigned to Wayne County MDHHS for investigation.

CPS met with [redacted] and [redacted] at the hospital on March 19, 2022. [redacted] admitted to CPS that she did not receive prenatal care during her pregnancy because she did not have health insurance. She also advised CPS she smoked marijuana during her pregnancy to help with her appetite and nausea. [redacted] advised CPS she previously had her rights terminated to her other children for medical neglect and now she wanted a chance to be a parent. CPS spoke with [redacted] who advised he did not know where [redacted] other children reside and told CPS he does not ask questions about her other children. He was aware she smoked marijuana during her pregnancy. Prior to leaving the hospital, CPS spoke with both parents about safe sleep practices and created a safety plan. The parents agreed to a relative, [redacted] providing supervision for [redacted] upon their release from the hospital.

CPS conducted home visits with the family on March 20, 2022, and March 22, 2022, documenting no concerns with the household conditions. Safe sleep arrangements were documented by CPS to be appropriate with a bassinet identified as [redacted] sleeping area. CPS suggested [redacted] have [redacted] sign an affidavit of parentage as legally she remained married to [redacted] making [redacted] legal father. [redacted] stated her relationship with [redacted] is stable, noting she was in a different place than she was when her parental rights were previously terminated. She agreed to a drug screen for CPS on March 22, 2022. [redacted] drug screen came back negative for all substances.

CPS obtained the results of [redacted] meconium screen which came back positive for THC and opiates. CPS asked [redacted] about the use of opiates during pregnancy. [redacted] denied the use of any substance other than marijuana.

CPS spoke with staff from Woodhaven Pediatrics regarding [redacted] as this office was identified as [redacted] physician's office. CPS was advised [redacted] was seen on April 1, 2022, and was doing well. Woodhaven Pediatrics staff explained [redacted] formula had to be changed with rice added because [redacted] was not gaining weight. [redacted] was seen again on April 13, 2022, for a weight check and was progressing normally at that time. Woodhaven Pediatrics staff denied knowing [redacted] tested positive for any substances as they did not receive any communication from the hospital. CPS then contacted staff at Henry Ford Hospital and spoke with a nurse. CPS inquired on if [redacted] suffered withdrawals. The nurse advised CPS it was possible [redacted] experienced withdrawals after being discharged home because the meconium results had not been received prior to her discharge. CPS was further advised withdrawal symptoms could include tremors, sneezing, feeding difficulties, not sleeping, and seizures. CPS was also told infants born positive for substances usually struggle with feeding and weight gain. The nurse told CPS, [redacted] urine screen was negative for opiates which indicated [redacted] did not have any opiates in her system for the day or two prior to [redacted] birth.

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Review of 2022 CPS Investigation (MiSACWIS ID: 125632891) cont.

The investigation was closed on April 27, 2022, as a Category IV with no preponderance of evidence to support physical neglect, physical abuse, or threatened harm. There is no documented threatened harm assessment completed for this investigation, and the Infant Plan of Safe Care was only listed as "an early on referral was made." An Infant Plan of Safe Care is required [4] with cases involving an infant who tests positive for substances at birth, requiring additional assessment and implementation of services for the parents and child.

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[4] Protective Services Manual PSM 716-7 states "In an investigation involving an infant born exposed to substances or having withdrawal symptoms, or Fetal Alcohol Spectrum Disorder (FASD), the case manager must develop an infant plan of safe care that addresses:

- The health and safety needs of the infant.
- The health and substance use treatment needs of the birthing parent or caregiver.
- The needs of all household members, including caregivers who reside outside of the home. For example, a parent involved in the care of the infant who does not reside in the home or other consistent caregivers, like babysitters."

Additionally, the Child Abuse Prevention and Treatment Act requires a plan of safe care.

Review of September 2023 CPS Investigation (MiSACWIS ID: 151443186)

On September 28, 2023, MDHHS Centralized Intake received a complaint regarding [redacted] birth with concerns of physical neglect by [redacted] The complaint stated [redacted] urine drug screen was positive for marijuana and fentanyl. The complaint explained the fentanyl was provided to [redacted] during delivery. It was stated [redacted] was not showing any signs of withdrawal, was bonding appropriately with [redacted] and his meconium screen was pending. This complaint was accepted and assigned for investigation to Wayne County MDHHS.

CPS began their investigation by speaking with the Beaumont Hospital social worker on September 28, 2023. CPS was informed [redacted] was not showing any signs of withdrawal and was in the process of being discharged home with [redacted] The social worker advised [redacted] admitted to not obtaining prenatal care during her pregnancy and using marijuana. CPS completed the vulnerable child assessment with this social worker.

On September 29, 2023, CPS completed a scheduled home visit with [redacted] and [redacted] confirmed she used marijuana during her pregnancy and did not obtain prenatal care because she did not have insurance. She confirmed her parental rights were previously terminated to other children. CPS created a safety plan with [redacted] that she would not use marijuana in the presence of the children and ensure there was a sober caretaker. Records do not indicate if this was a written or verbal safety plan and there is no uploaded safety plan in MiSACWIS. [redacted] bassinet was observed in the home, and CPS documented safe sleep practices were discussed with [redacted]

On October 3, 2023, [redacted] meconium screen was received along with medical records from Beaumont Hospital. [redacted] meconium was positive for marijuana. CPS conducted an additional visit to the home on October 6, 2023, to meet with [redacted] informed CPS he was aware [redacted] was using marijuana during her pregnancy for nausea but denied knowing how often she was using it. He denied having any concerns for [redacted] or the children. During this visit, [redacted] mentioned she needed to find a new pediatrician because the current one was not accepting new patients. She planned to switch both children to the same pediatrician once she found one.

CPS sent a medical records request to Caring Pediatrics after being advised this was the new office that would see both [redacted] and [redacted] There was no documentation in the CPS investigation regarding any medical records received from this office. There are no documented efforts by CPS to obtain records from the previous pediatrician's office, Woodhaven Pediatrics, and no vulnerable child assessment was completed concerning [redacted]

The investigation was closed on November 8, 2023, as a Category IV with no preponderance of evidence supporting physical neglect of [redacted] by [redacted] The newborn toxicology section of the CPS history and trends was checked "not applicable" in the system; therefore, no plan of infant safe care was documented within the case as required by the Michigan Plan of Safe Care Protocol. Additionally, the OCA verified no threatened harm assessment was completed.

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Review of CPS Investigation of [redacted] death, December 2023 (MiSACWIS ID: 156213404)

On December 27, 2023, MDHHS Centralized Intake received a complaint regarding [redacted] death, with concerns of physical neglect, from two referral sources. The first referral source stated [redacted] was found unresponsive at the home and was not able to be resuscitated. According to [redacted] was last known to be alive around midnight, and she thought she may have rolled over on top of him. The second referral source advised [redacted] was found unresponsive after co-sleeping in bed with [redacted] Concerns were further expressed for pillows and blankets being in the shared bed. The referral source advised [redacted] admitted to drinking and her PBT test was 0.073. The complaint was accepted and assigned to Wayne County MDHHS for investigation.

On December 27, 2023, CPS began their investigation and was informed by the investigating detective from the Taylor Police Department that [redacted] was still intoxicated that morning at the hospital. CPS was able to confirm with the detective that [redacted] blood alcohol content was a 0.073. The detective advised charges would be pursued due to her being intoxicated at the time of the death and having a history with CPS.

On December 27, 2023, CPS made an unannounced home visit and spoke with [redacted] who is [redacted] mother. Records state [redacted] and the children resided with [redacted] during these events. During the interview, [redacted] advised CPS [redacted] was not home, and [redacted] resided with his uncle. [redacted] was unaware if [redacted] was under the influence of substances or intoxicated the night of [redacted] death, admitting that she herself was in her room under the influence. CPS noted [redacted] was slurring her words during the interview. [redacted] completed a drug screen for CPS. During the home visit, CPS documented observing a 750ml bottle of Seagram's 7 whiskey. There was a crib observed in the home containing items inside making it an unsafe sleep environment.

On December 28, 2023, CPS completed a scheduled home visit with [redacted] and [redacted] advised not seeing [redacted] or [redacted] since Christmas until [redacted] death occurred. He told CPS he had been living in and out of the home since January 2023 and was co-parenting well with [redacted] advised being with his girlfriend at the time [redacted] called him stating [redacted] was flipped over. He told CPS that when he got to his mother's home, [redacted] was already taken to the hospital, and he was informed [redacted] had passed. [redacted] denied knowing if [redacted] was under the influence of any substances and denied knowing how often his mother drank alcohol.

[redacted] advised CPS she consumed approximately four to five shots of Seagram's 7 Whiskey and stopped drinking around 9pm. She did not recall using her marijuana pen that night. She explained she went to bed around 12am and [redacted] was in his crib. A few hours later, he woke up fussy, so she brought him into bed with her and fell asleep. [redacted] advised CPS she woke up around 5am to find [redacted] face down in the bed and limp. [redacted] completed a drug screen which later came back positive for THC.

On December 28, 2023, [redacted] was placed in a Temporary Voluntary Arrangement (TVA) with her father, [redacted] CPS contacted [redacted] on January 26, 2024 due to him being legally married to [redacted] at the time the children were born, making him the legal father of both [redacted] and [redacted] confirmed still being legally married to [redacted] and advised CPS the children were not biologically his children. He advised CPS he has never assumed responsibility for the children as they are not his. CPS informed him that because he was legally the father, he would be included on the petition filed with the court concerning [redacted] CPS filed a mandatory termination petition on February 13, 2024. During the court case, [redacted] submitted to DNA testing to become the legal father of [redacted]

The investigation was closed on February 16, 2024, as a Category I with a preponderance of evidence to support physical neglect of [redacted] and [redacted] by [redacted] as well as placing a child at unreasonable risk of both children by [redacted]

The OCA obtained the autopsy completed for [redacted] cause of death could not be determined, and his death was ruled indeterminate.

[redacted] Family History and Background

[redacted] is the mother of [redacted] (14), [redacted] (16), [redacted] (9) and [redacted] (1). In 2018, [redacted] and [redacted] were removed from [redacted] care due to concerns for improper supervision related to her substance abuse. After failing to participate in services through the foster care case and continuing to abuse substances, [redacted] released her parental rights to [redacted] and [redacted] and [redacted] were adopted by their maternal grandmother, [redacted] in 2021. [redacted] was placed in the care and custody of her father, [redacted] and the foster care case closed in 2022. On May 19, 2024, [redacted] gave birth to [redacted]

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Family History and Background cont.

This case originally came to the attention of the OCA with concerns for [redacted] ability to care for [redacted] and [redacted] due to them having extensive behavioral needs and both being involved in the Juvenile Justice system. There were additional concerns [redacted] was residing in [redacted] home with the children, and had given birth to a new baby, [redacted] who was positive for substances. There were concerns for the safety of [redacted] in [redacted] care.

Review of May 2024 CPS Investigation (MiSACWIS ID: 171823448)

[redacted] was born positive for high levels of cocaine, but she did not experience withdrawal symptoms. [redacted] admitted to using cocaine during her pregnancy prior to finding out she was pregnant and after finding out. A CPS investigation began on May 21, 2024, as a result of [redacted] being born positive for substances, and [redacted] losing custody of other children in the past. The complaint was assigned to Calhoun County for investigation.

During CPS' investigation, [redacted] completed two drug screens, both of which came back positive for marijuana and cocaine. The second drug screen was completed on July 1, 2024. The levels of cocaine were so high, forensic fluids contacted CPS to inform them of the high levels and concern for [redacted] as the level she tested positive for of cocaine can be lethal. CPS documented a safety plan was implemented as part of the Infant Safe Care Plan, noting that [redacted] agreed to not use illegal substances or keep them in the home, she will utilize safe sleep practices, the child will be placed in a crib/pack and play or bassinet, the children will be supervised by a sober caretaker, and [redacted] will attend all doctor appointments.

Due to [redacted] not experiencing any withdrawal from cocaine, CPS found no preponderance of evidence to support physical injury of [redacted] by [redacted] CPS also documented [redacted] was able to be a sober caretaker for [redacted] The investigation was closed on June 14, 2024, as a Category IV. CPS referred [redacted] to work with Early on and a maternal infant health program called Twenty Hands. [redacted] initially told CPS she was not willing to complete substance abuse services but later agreed to seek services herself through a provider called Summit Point.

During CPS' investigation, CPS did not complete an adequate Infant Plan of Safe Care for [redacted] per policy. Referrals were completed for Early On and a maternal infant health program, however, CPS did not ensure implementation of these services as required by law and policy. CPS also did not discuss [redacted] participation in substance abuse treatment with her service provider, as required by law and policy.

Additionally, CPS did not consider the maltreatment of threatened harm of placing a child at unreasonable risk and only investigated the complaint as identified by Centralized Intake, which was physical injury. Protective Services Manual (PSM) 712-1 states if CPS investigators "learn of a new allegation, suspects new maltreatments or identifies additional household victims, they must thoroughly investigate those allegations as part of the active investigation and document the findings in the disposition". Though there was evidence of threatened harm of placing a child at unreasonable risk, no additional maltreatment was added to the CPS case.

Because [redacted] previously voluntarily terminated her parental rights to her other children, a legally mandated petition was not required. However, the OCA believes a petition was necessary to safeguard [redacted] given [redacted] extensive, continued drug use and her CPS history. Although [redacted] was utilizing [redacted] as support, [redacted] had her own set of issues and concerns that needed her attention relating to her legal minor children, [redacted] and [redacted]

Review of the September 2024 CPS Investigation (MiSACWIS ID: 187053487)

A new complaint was received on September 26, 2024, with concerns [redacted] was physically neglecting and placing [redacted] at unreasonable risk. There were concerns [redacted] was leaving [redacted] while she continued to use drugs. The complaint was assigned to Calhoun County for investigation. [redacted] admitted she last used cocaine two weeks earlier, she used on the weekends, was using drugs less often and said she used outside of the home away from the children. [redacted] advised when she would leave the home to use drugs, she would leave [redacted] in the care of [redacted] During this time, [redacted] was continuing to have her own CPS investigations, and concerns related to [redacted] and [redacted]

CPS made a referral for [redacted] to work with Families First and a separate referral for [redacted] to work with Families First. When the OCA began their investigation, Families First was not working with [redacted] and was only working with [redacted] [redacted] continued to leave [redacted] in [redacted] care for days at a time while she went and used substances. The OCA conducted a meeting with Calhoun County on October 21, 2024, expressing concern for [redacted] being left in the home. The OCA expressed a petition was likely needed due to [redacted] continued drug use and her prior CPS history.

On October 24, 2024, CPS filed a petition removing [redacted] from [redacted] care. [redacted] was not approved for placement due to her own CPS investigations and the needs of [redacted] and [redacted] [redacted] was placed in an unrelated, unlicensed foster home. A supplemental petition was filed on February 11, 2025, requesting to terminate the parental rights of [redacted] to [redacted] as [redacted] had not had contact with the department or seen [redacted] since the day [redacted] was removed. A termination trial was held on March 12, 2025, and [redacted] parental rights to [redacted] were terminated.

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

OCA Analysis

In all three OCA investigations, the OCA observed case managers did not assess or investigate threatened harm. In each of the family circumstances, threatened harm existed as the parents had prior terminations for substance use and there were current concerns for ongoing substance use. In the [redacted] case, [redacted] also had a history of domestic violence which was another factor that led to her prior terminations. The circumstances during CPS' involvement were related to domestic violence.

Additionally, the OCA noticed investigations involving birth match complaints were not adequately completed, and infant safe care plans were not put into place as required.

Policy Review

As part of the OCA investigations, the OCA investigator reviewed historical and current MDHHS policy manuals regarding the issues identified in the cases involving [redacted] and [redacted] The following section is a review of what MDHHS policy says regarding birth match investigations, threatened harm, the DHS-3 Sibling Evaluation Form, and investigations involving substances/substance exposed infants.

Birth Match: When reviewing PSM 713-08, Special Investigation Situations, birth match is defined as an automated system that notifies Centralized Intake when a new child is born to a parent who previously had their parental rights terminated in a child protection proceeding, caused the death of a child due to abuse and/or neglect, or has committed a serious act of child abuse and/or neglect. Additionally, policy explains how to manually add a birth match. There is no guidance or outlined policy for case managers on how to investigate a birth match nor is there reference to PSM 711-2 which identifies a birth match as historical threatened harm. This policy refers case managers to PSM 713-11, Assessments, for additional guidance on assessing threatened harm

Threatened Harm: PSM 711-2, Definitions, Responsibilities and Maltreatment Types, defines threatened harm as "an action, accidental or non-accidental, inaction or credible verbal threat by a person responsible and absent intervention, there is high probability that harm will occur." The policy further states a child found in a situation where harm is highly probable to occur based on a current or historical circumstance; historical circumstance examples include a confirmed case that included an egregious act of child abuse and/or neglect, a confirmed case that included threatened harm, prior termination of parental rights and conviction of crimes against children. Current circumstance examples include allegations of threatened harm in the current referral, child left home alone, domestic violence, a residence where drugs are manufactured and/or sold. Case managers are directed to PSM 713-11 for guidance on assessing threatened harm.

PSM 713-11 Assessments, dated 08/01/2023, details five areas that the caseworker must assess when threatened harm has been discovered, alleged, or confirmed. These five areas include the "…severity of the past behavior, length of time since the past incident, evaluation of services, benefit from services (including if conditions have been rectified), and vulnerability of child(ren)." The policy also directs caseworkers to PSM 715-3 Family Court: Petitions, Hearings, and Court Orders for more information on potential mandatory legal action.

DHS-3 Sibling Evaluation Form: Prior to 12/01/2019, PSM 715-2 required a DHS-3 Sibling Evaluation Form be completed on all cases where a child remains in the home when sibling(s) are/were permanent wards because of a child abuse and/or neglect court action. Policy also required the DHS-3 to be reviewed and signed by a second-line approver prior to the approval of the investigation, which ensured upper management oversight on birth match investigations.

Current policy no longer requires the DHS-3 to be completed when a child is left in the home when sibling(s) were permanent wards, removing the second-line oversight on these decisions.

Investigations involving substances/substance exposed infants: PSM 716-7, Cases Involving Substances, effective 08/01/2023, discusses parental substance use and/or positive toxicology in an infant does not in and of itself indicate child abuse and/or neglect has occurred or that the infant has experienced serious harm. Policy states case managers must reach conclusions based on the presence or absence of evidence of child abuse and/or neglect as defined in PSM 711-4. PSM 716-7 then provides case managers with things to consider when determining if child abuse and/or neglect occurred to assist with their assessment.

Case Numbers: 2023-0593, 2023-0866 & 2024-0618

[redacted] & [redacted]

Policy Review cont.

This policy also provides the following list of additional requirements case managers must complete for investigations involving infants exposed to substances:

- Contact with medical staff to obtain the following information, if available:
  - Results of medical tests indicating infant exposure to substances and/or alcohol.
  - The health and status of the infant.
  - Documented symptoms of withdrawal experienced by the infant.
  - Medical treatment the infant or birthing parent may need.
  - Observations of the parent's care of the infant and the parent's response to the infant's needs.
  - To be considered serious physical abuse, a medical practitioner must confirm the infant's exposure, and any related symptoms meet the definition of serious physical harm.
  - Interview with the infant's parents and any relevant caregivers to assess the need for a referral for substance use disorder prevention, treatment, or recovery services.
- Assessment of the parent's capacity to adequately care for the infant and other children in the home.
- Coordination between the case manager, medical professional(s) and family to co-develop an Infant Plan of Safe Care (POSC) if necessary.
- Contact with substance use treatment providers, if applicable, to determine the parent's level of participation.

PSM 716-7 also identifies guidance for case managers to assist with assessing parenting capacity related to a parent's substance use, whether child abuse and/or neglect occurred and how to best address safety. This guidance states case managers should consider the following:

- Does the use extend to the point of intoxication, unconsciousness, or inability to make appropriate decisions for the safety of their child(ren)?
- Does the use of substances cause reduced capacity to respond to the child's cues and needs?
- Is there evidence to demonstrate difficulty regulating emotions or controlling anger?
- Are the following emotions regularly demonstrated?
  - Aggressiveness.
  - Impulsivity.
- Is there an appearance of being sedated or inattentive?
- Is there demonstrated ability to consistently nurture and supervise the child(ren) according to their developmental needs?
- Do co-occurring issues exist which would impact parenting or exacerbate risk such as:
  - Social isolation.
  - Poverty.
  - Unstable housing.
  - Domestic violence.
- Are there supports such as family and friends who can care for the child(ren) when the parents are not able to? Are the parents willing to use their supports when necessary?
- Has the use of substances caused substantial impairment of judgement or irrationality to the extent the child was abused or neglected?
- Any other factor which demonstrates inability to protect the child(ren) and maintain child safety.

PSM 716-7 further requires case managers to document an Infant Plan of Safe Care during investigations involving an infant born exposed to substances or having withdrawal symptoms, or Fetal Alcohol Spectrum Disorder (FASD). It is required for the plan to address the health and safety of the infant, the treatment needs of the substance using parent or caregiver, and the needs of other household members or caregivers. Regardless of the case disposition, an Early On referral is required to be referred in addition to another service provider. It is required the referrals and implementation of these services be documented in the Newborn Toxicology section located in CPS History and Trends of the case management system.

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[redacted] & [redacted]

Additional Research

During the OCA's investigation, additional research was conducted concerning prenatal drug exposure and the effects on children. There are numerous research studies that show prenatal drug exposure can have long term effects on children that can continue well into their childhood.

One research study, Prenatal Tobacco, Marijuana, Stimulant, and Opiate Exposure: Outcomes and Practice Implications in Clinical Perspectives-Prenatal Drug makeup [5], discusses Neurobehavioral Teratology [6], which is the "…framework used to study prenatal drug exposure to a foreign agent on a child's central nervous system (CNS) and behavior. An important principle of teratology is that the harm caused by a toxic agent is a function of several factors, including the individual's genetic makeup, the fetal and postnatal environment, the dose of the agent, and the developmental state of the fetus at the time of exposure" (Sonia Minnes, July 2011). The article continues to discuss that the "…damage to the child's CNS during the prenatal period continues to have effects through fetal, neonatal, infant, and childhood development; and CNS injury may result in behavioral impairments rather than physical birth defects." The research article continues to discuss how "…the child's CNS disruption can hinder their ability to reach full developmental and academic potential directly and in combination with parental and environmental factors."

According to the research article, "drug metabolites interact with an individual's genetic makeup to influence cognitive development and behavior", and "active metabolites can penetrate the fetal blood-brain barrier and interfere with early neuronal cell development or cause neuronal death (Lee et al., 2008)." Research conducted has also shown maternal drug abuse also has indirect effects on the fetus, "…for example, crack cocaine, heroin, tobacco, and marijuana cause vasoconstriction that restricts the fetal oxygen supply." "Neonatal abstinence syndrome (NAS), occurs after opiate use during pregnancy, puts the infant under physiological stress that increases the risk of health and possibly developmental problems. Neuroimaging studies have revealed evidence of physiological brain changes in prenatally drug-exposed children, some of which correlated with the results of behavioral assessments."

The research article includes information on the potential effects on birth and pregnancy outcomes by substance. For marijuana, mild withdrawal symptoms and poor autonomic control (ability to adjust one's level of alertness as required for a task) were some observations made. "Prenatal marijuana exposure had persistent negative effects through age 16 on higher-order thinking, including problem solving, memory, planning, impulsivity and attention (Fried, 2002, Fried, Watkinson, and Gray 2003, Goldschmidt et all., 2008, Richardson, Goldschmidt, and Larkby, 2007). Another concern noted in the research is "prenatal marijuana exposure may have long-term emotional and behavioral consequences. At age 10, children who have been exposed to the drug during their first and third trimester of gestation reported more depressive symptoms than those unexposed controls (Gray, 2005)." Prenatal marijuana exposure also at least doubled the risk of both tobacco and marijuana use in 16–21-year-olds.

For cocaine, neonatal/infancy observations included early neurobehavioral deficits related to orientation, state regulation, autonomic stability, attention, sensory and motor asymmetry, jitteriness, poor clarity of infant cues during feeding interaction, delayed information processing and general cognitive delay. Childhood observations included lower nonverbal perceptual reasoning, lower weight for height, lower weight curve trajectories, attention problems, and disruptive behaviors by self-report and caregiver report. According to the research article observations were made that prenatal exposure to methamphetamine results in poor movement quality (with third trimester exposure), lower arousal, increased lethargy, increased physiological stress, and no mental or motor delay in infants and toddlers. Opiates, have effects on the neonatal abstinence syndrome, result in less rhythmic swallowing, possible delays in general cognitive functioning, result in anxiety, aggression, feelings of rejection and disruptive or inattentive behavior.

The research article also explored interventions for drug exposed children, noting most of the studies conducted have been on services provided to the substance-abusing mothers by community nurses designed to educate and support mothers in improving their parenting skills, their home environments, and the child's development. The research article noted one study in particular which had "…nurses visiting substance-abusing mothers and their infants every other week for the first 18 months of a child's life (Black et al., 1994)" discussing "…child development, child care and safety, modeling parent child activities that promote child development; addressed mother's concerns, such as relationship problems, affordable housing, and financial issues; and provided information about community resources and advocacy." The study found "…mothers who received the

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[5] Minnes, S., Lang, A., Singer, L., Mandel School of Applied Social Sciences, Case Western Reserve University, & School of Medicine. (2011). Prenatal tobacco, marijuana, stimulant, and opiate exposure: Outcomes and practice implications. In Addiction Science & Clinical Practice [Journal-article]. https://nationaldec.org/wp-content/uploads/214-Article.pdf

[6] Teratology is "the study of congenital abnormalities, their causes and the treatment options available for those affected. These abnormalities are principally the result of infections, physical agents, metabolic conditions or chemicals and can cause death as well as physical, behavioral, and intellectual deficits." Belanger BG, Lui F. Embryology, Teratology TORCH. [Updated 2023 Jul 24]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK545148/

Additional Research cont.

intervention were marginally more likely than a control group to be drug-free, keep primary health appointments, be more emotionally responsive, provide a stimulating home environment, and score lower on a measure of child-abuse potential at the end of the 18-month study period."

The OCA also received the National Abandoned Infants Assistance Resource Center's fact sheet on Perinatal Marijuana Exposure[7] (PME). This document raises concerns about the impact of maternal marijuana use on the developing fetus, through early childhood, noting that "marijuana is the most common illicit drug used by pregnant women." Tetrahydrocannabinol (THC) is the major psychoactive component of marijuana that crosses the placental barrier. "One-third of THC in the mother's blood is estimated to cross the placental barrier." THC can also be transferred through the mother's breast milk. THC content of marijuana has substantially increased over the past 20 years, resulting in the fetuses of marijuana-using mothers being exposed to significant amounts of THC. The fact sheet discusses "…recent research findings point to some adverse biological and developmental consequences of PME, including:

- an association between aspects of nervous system functioning and prenatal exposure to marijuana resulting in compromised patterns in infancy (e.g., poor sleep patterns, easily startled into agitation) and in childhood (e.g., hyperactivity, inattention, impulsivity);
- persistent negative effects (birth through age 16) on executive functioning, in particular, on attention, problem solving, memory and planning;
- increased levels of depressive symptoms at age 10,· greater likelihood to initiate and use marijuana at higher levels by age 14 and a doubled risk of marijuana and tobacco use at ages 16-21
- possible harm to embryonic development, as early as two weeks after conception
- possible higher risk of exhibiting a compromised immune system; and
- possible low birth weight or preterm birth.

In December 2024, the American Academy of Pediatrics issued an article,Sleep-Related Sudden Unexpected Infant Death Amount Infants Prenatally Substance Exposed[8] which explored maternal substance use during pregnancy and the risk of sudden unexpected infant death (SUID), including through unsafe sleep practices. The study used data concerning SUID with sleep-related deaths of infants between 2015 and 2020 and included both infants who were born with prenatal exposure to substances or infants non-exposed. The study found that "of 2010 infants who experienced sleep-related deaths, 283 (14%) were prenatally exposed. More than half of deaths involved an adult bed (52%, n=1045) or surface sharing with an adult (53%, n=1074). Supervisors of prenatally exposed infants were disproportionately impaired at infant death versus nonexposed (34%, n= 97 vs 16%, n=279). Statistically significant associations between prenatal exposure history and vulnerability factors (insurance, child welfare involvement, intimate partner violence, health care barriers) were identified (p <.05)." The study concluded "sleep-related SUID across infants prenatally exposed versus nonexposed differ in sleep environment characteristics and contributory social vulnerability. Disproportionate sleep environment hazards (surface sharing, supervisor impairment) are identified amount prenatally exposed infants that should compel targeted prevention efforts, including safe sleep messaging, discouraging surface sharing, and engaging support persons during impairment periods."

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[7] Jutras-Aswad, D., DiNieri, J. A., Harkany, T., Hurd, Y. L., National Abandoned Infants Assistance Resource Center, & University of California, Berkeley. (2009). Perinatal marijuana exposure. In European Archives of Psychiatry and Clinical Neuroscience (Vols. 259–7, pp. 395–412) [Journal-article]. University of California, Berkeley. https://nationaldec.org/wp-content/uploads/165-Article.pdf

[8] Stephanie Anne Deutsch, Claire E. Loiselle, Jobayer Hossain, Allan De Jong; Sleep-Related Sudden Unexpected Infant Death Among Infants Prenatally Substance Exposed. Pediatrics December 2024; 154 (6): e2024067372. 10.1542/peds.2024-067372

OCA Data

The OCA began tracking emerging trends when a new case management system, Michigan Child Advocate Investigation System (MiCAIS) was implemented at the OCA in July 2020. The OCA began tracking the emerging trends of unsafe sleep practices and infants born drug positive in July of 2020.

Since the OCA began tracking these emerging trends, the OCA has reviewed 1,714 child deaths. 256 of the child deaths reviewed included children who were born drug positive. 179 of these child deaths included children were born positive for marijuana only.

543 of the child deaths reviewed included the death of an infant who died in an unsafe sleep environment. 119, or 21.9% of the 543, children were born positive for substances at birth. 88, or 16% of 543 children were born positive for marijuana only.

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[redacted] & [redacted]

Factual Findings

Introduction:

The child advocate shall prepare a report of the factual findings of an investigation and make recommendations to the department or the child placing agency if the child advocate finds one or more of the following:

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

The Child Advocate believes their findings should be further considered by the department, and additional actions by MDHHS and other child welfare partners are necessary.

Findings

Each finding below is applicable to the [redacted] investigations, unless otherwise noted.

1. The child advocate finds the 2022 investigation concerning the [redacted] family did not follow the requirements for assessing threatened harm per, PSM 713-11. [redacted] had her rights previously terminated to children due to substance use and domestic violence, and there were concerns of both present during the 2022 investigation.

2. The child advocate finds the 2023 investigation concerning the [redacted] family did not consider and apply threatened harm as it related to [redacted] substance use and her prior terminations.
   a. MDHHS did not identify an infant plan of safe care for [redacted]
   b. Staff did not accurately assess parenting capacity as it related to [redacted] substance use.

3. The child advocate finds MDHHS did not follow PSM 713-01, CPS Investigation- General Instructions and Checklist during the 2023 investigation by not observing and documenting a proper sleeping environment for [redacted] Additionally, CPS did not assist the family in obtaining a proper sleeping environment.

4. The Child Advocate finds the 2023 investigation concerning the [redacted] family inadequately completed the vulnerable child assessment by asking the vulnerable child questions of [redacted] legal father, who was unaware of his medical needs or history.

5. The Child Advocate finds the 2022 investigation concerning the [redacted] family, did not properly assess threatened harm following [redacted] birth.
   a. No threatened harm assessment was completed to determine the severity of the past behavior, length of time since the past incident, evaluation of services, benefit from services (including if conditions have been rectified), and vulnerability of child(ren).

6. The Child Advocate finds the 2022 investigation concerning the [redacted] family did not follow MDHHS policy PSM 716-7.
   a. The infant plan of safe care was documented to be completed by an Early-On referral being made. No additional services were referred or implemented.
   b. Staff did not follow the guidance for assessing parenting capacity as it related to [redacted] substance use.

7. The Child Advocate finds the 2023 investigation concerning the [redacted] family did not properly assess threatened harm following [redacted] birth.
   a. No threatened harm assessment was completed to determine the severity of the past behavior, length of time since the past incident, evaluation of services, benefit from services (including if conditions have been rectified), and vulnerability of child(ren).

8. The Child Advocate finds the 2023 investigation concerning the [redacted] family did not follow MDHHS policy PSM 716-7.
   a. An infant plan of safe care was not completed following [redacted] birth, though required by Michigan's Plan of Safe Care Protocol and policy.
   b. Staff did not follow the guidance for assessing parenting capacity as it related to [redacted] substance use.

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[redacted] & [redacted]

Findings

9. The child advocate finds the May 2024 investigation concerning [redacted] did not consider and apply threatened harm as it related to [redacted] continued drug use and her prior release of parental rights for drug use.

10. The child advocate finds the May 2024 investigation concerning [redacted] did not follow MDHHS policy PSM 716-7.
    a. The infant plan of safe care was documented to be an Early On referral, [redacted] agreeing to not use substances in the home, utilizing safe sleep practices, the children being supervised by a sober caretaker, and ensuring [redacted] is taken to all doctor's appointments.
    b. Staff did not follow the guidance for assessing parenting capacity as it related to [redacted] substance use.

11. The child advocate finds MCL 722.638 states the department shall submit a petition for authorization by the court if (b) The department determines that there is risk of harm, child abuse, or child neglect to the child and either of the following is true: (i) The parent's rights to another child were terminated as a result of proceedings under section 2(b) of chapter XIIA of 1939 PA 288, MCL 712A.2, or a similar law of another state and the parent has failed to rectify the conditions that led to the prior termination of parental rights.
    a. [redacted] had previous terminations, and the issues that prompted those actions were not resolved.

12. The child advocate finds MDHHS did not adhere to MCL 722.638 because threatened harm assessments were incomplete or not completed.

13. The child advocate finds PSM 713-08, policy regarding how to conduct Birth Match investigations is inadequate and does not provide guidance to case managers on how to properly conduct these investigations.

14. The child advocate finds historical policy, 713-08 dated 06/10/2010, had guidance for case managers regarding what was required when a parent has a prior termination of parental rights, and a new child is born. This guidance provided more clear and direct questions to assess than the current questions within the threatened harm policy.

15. The child advocate finds that additional efforts are needed to ensure the safety and well-being of children born to parents who have previous terminations of their parental rights.

16. The child advocate finds PSM 713-08 changed and no longer requires the DHS-3 Sibling Placement Evaluation form be completed when a new child is born to a parent who has prior terminations of parental rights.This ceased the requirement for second line oversight and approval on birth match investigations.

17. The child advocate finds the OCA has reviewed 1,714 child deaths since MiCAIS was implemented in July 2020.
    a. 543, or 31.6% of these deaths involved an infant who died in an unsafe sleep environment.
    b. 256 of the total deaths reviewed involved children who were born positive for substances, with 179 of those being born with marijuana exposure only.
    c. 21.9% of the infants who died in an unsafe sleep environment, were born positive for substances. 16% of infants who died in an unsafe sleep environment were born with only marijuana exposure.

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[redacted] & [redacted]

Recommendations

1. The child advocate recommends MDHHS amend PSM 713-11 pertaining to threatened harm assessments to include the question: does the threatened harm include a prior termination of parental rights. If this is answered yes, the following additional steps should be required and answered by the case manager.
    a. The prior case and court orders leading to the prior termination of parental rights should be reviewed and summarized by the case manager.
    b. How has the parent addressed those specific issues?
    c. What are the differences and similarities between prior and current child abuse and/or neglect allegations?
    d. Detail specific facts that demonstrated whether the family has, or has not, resolved the risk and safety issues that resulted in the previous court actions.
    e. Is a mandatory petition required per MCL722.638?

2. The child advocate recommends MDHHS require second line or director approval on birth match investigations to provide additional oversight in decision-making on cases involving new infants born to parents who have previously lost their parental rights.

3. The child advocate recommends MDHHS amend PSM 716-7 to add new language requiring CPS specialists to contact and speak with the substance exposed infant's treating medical provider.
    a. When doing so, CPS specialists should determine the status of the infant's physical health, if they are receiving any medical treatment for withdrawal symptoms, what that medical treatment involves, and if the infant's exposure and any related symptoms meet the definition of serious physical harm.
    b. Policy can further define medical staff or practitioners, to mean the child's treating medical provider who has received formal training to practice medicine. This should include individuals such as a physician, nurse, or a licensed medical provider who are qualified to report about the infant's physical health, medical treatment being provided to the child for withdrawal symptoms, and what the medical treatment involves.

4. The child advocate recommends all CPS case managers be trained on the Michigan Governor's Task Force on Child Abuse and Neglect Plan of Safe Care Protocol.

5. The child advocate recommends MDHHS develop and implement additional training for case managers on how to conduct birth match investigations, and how to appropriately apply and assess threatened harm policy, PSM 713-11.

6. The child advocate recommends MDHHS develop and implement additional training for case managers on how to appropriately apply the substance exposed infant policy, PSM 716-7.

7. The child advocate recommends MDHHS amend PSM 713-01 to require case managers immediately provide the family with a pack n play or other approved safe sleep environment when one is not observed in the home.

Conclusion

Under authority pursuant to The Child Advocate's Act, MCL 722.903, the OCA respectfully submits this report of findings and recommendations.

The matters addressed in this report must be further considered by MDHHS and the Michigan Legislature. These recommendations may effectuate positive change and can improve the lives of similarly situated children involved in Michigan's child welfare system.

Before publishing, MDHHS has 60 days to provide a written response to this report in defense or mitigation of the action. The published report will include any statement of reasonable length made to the OCA by MDHHS.

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