Case Number: 2023-0379 [redacted]

Investigation Start: August 23, 2023

Recommendation Issued: April 28, 2025

Case Background

[redacted] was fourteen years old when the first complaint about her adoptive father, [redacted] strangling her was made to CPS Centralized Intake (CI) on May 12, 2023. On August 23, 2023, the OCA opened an investigation into the administrative actions of MDHHS concerning eight different CPS complaints made about [redacted] strangling [redacted] The following report summarizes the information and evidence found during the OCA's investigation.

Case Objective

The objective of this review is to identify areas for improvement in the child welfare system by looking at how CPS complaints involving the strangulation of [redacted] were handled by CI and CPS staff, 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, MDHHS, 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 complaints about strangulation; 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.

Research Source Materials

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3 Strack GB, McClane GE, Hawley D. A review of 300 attempted strangulation cases. Part I: criminal legal issues. J Emerg Med. 2001 Oct;21(3):303-9. doi: 10.1016/s0736-4679(01)00399-7. PMID: 11604294.

4 Sorenson SB, Joshi M, Sivitz E. A systematic review of the epidemiology of nonfatal strangulation, a human rights and health concern. Am J Public Health. 2014 Nov;104 (11):e54-61. doi: 10.2105/AJPH.2014.302191. Epub 2014 Sep 11. PMID: 25211747; PMCID: PMC4202982.

5 Physiological Consequences of Strangulation Seconds to Minute Timeline

6 Glass N, Laughon K, Campbell J, Block CR, Hanson G, Sharps PW, Taliaferro E. Non-fatal strangulation is an important risk factor for homicide of women. J Emerg Med. 2008 Oct;35(3):329-35. doi: 10.1016/j.jemermed.2007.02.065. Epub 2007 Oct 25. PMID: 17961956; PMCID: PMC2573025.

7 Sharman LS, Fitzgerald R, Douglas H Medical evidence assisting non-fatal strangulation prosecution: a scoping review BMJ Open 2023;13:e072077. doi: 10.1136/bmjopen-2023-072077

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2023-0379

[redacted] [redacted]

Response received from MDHHS: July 22, 2025

Findings	Responses
The child advocate emphasizes that all instances of strangulation carry the potential to be life-threatening.	**MDHHS Response to Finding 1: MDHHS acknowledges review of this statement.**
The child advocate finds all reports of strangulation to a child by an adult should be considered alleged child abuse, regardless of the presence of visible injuries.	**MDHHS Response to Finding 2: MDHHS agrees in part. To screen in a referral involving allegations of strangulation, the department must consider whether the adult alleged to have strangled the child is considered a person responsible.** **The Structured Decision Making (SDM) Centralized Intake Assessment utilized by Centralized Intake (CI) staff at the point of intake does not require an injury be visible to select, and assign for, physical injury. If there are allegations of strangulation and no visible injuries, Centralized Intake will assess the elements captured in the following sub-item for physical injury: Dangerous behavior or excessive action toward the child AND current behavior could cause serious physical injury, including unsafe use of physical restraint.** **If the adult alleged to have strangled the child is considered a person responsible and allegations meet the criteria for physical injury, whether an injury is visible or not, the referral should be screened in for investigation assuming the allegations have not been, or are not currently being, investigated.**
The child advocate finds the only way to determine the extent of an injury from strangulation is for a full, thorough, and complete investigation to be conducted by CPS and law enforcement.	**MDHHS Response to Finding 3: MDHHS agrees in part. To screen in a referral involving allegations of strangulation, the department must consider whether the adult alleged to have strangled the child is considered a person responsible. If the adult alleged to have strangled the child is considered a person responsible and the allegations meet the criteria for physical injury, whether an injury is visible or not, the referral should be screened in for investigation. At that point, a full, thorough, and complete investigation should be conducted by CPS and law enforcement.**
The child advocate finds that when a child has allegedly been strangled, that child should be evaluated by a medical professional who has training on strangulation, its seriousness and lethality. The medical evaluation completed should include a neurological examination.	**MDHHS Response to Finding 4: MDHHS agrees in part. In instances where strangulation is alleged and a medical exam is obtained, CPS relies on the medical provider to assess the needs of, and any injury to, the child, and what additional evaluation, testing, and/or referrals may be needed.** **To determine the feasibility that every child who has allegedly been strangled can be evaluated by a medical professional who has training on strangulation, its seriousness, and lethality, including a neurological examination, MDHHS will discuss this finding with the Children's Services Administration's (CSA) Medical Advisory Committee (MAC). The MAC is comprised of child abuse pediatricians and other medical experts from across the state who help inform the department's policy and procedures from a medical perspective. The MAC will also have additional insight into access, especially in rural areas, and how timely neurological examinations can be completed.**

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2023-0379

[redacted] [redacted]

Response received from MDHHS: July 22, 2025

Findings	Responses
The child advocate finds that CI staff members and law enforcement officials interviewed during this investigation were unaware of the difference between choking and strangulation.	**MDHHS Response to Finding 5: Agree in part. MDHHS agrees that Centralized Intake employees were not trained in the difference between choking versus strangulation at the time that OCA was collecting data for this report in 2023. MDHHS cannot speak to what law enforcement officials may have known regarding choking or strangulation.**
The child advocate finds CI staff are attempting to determine the excessiveness of a strangulation through discussions on the phone with reporting sources.	**MDHHS Response to Finding 6: MDHHS agrees in part. The goal of Centralized Intake is to focus on initial fact gathering and evaluation of information to determine not only the validity but the severity of the intake, whether it meets statutory criteria for investigation, and to assess the level of risk to the child. Evaluation of the referral information determines the nature and priority of the initial response.**
The child advocate finds CI staff are not assigning strangulation complaints for investigation by CPS unless the child loses consciousness, can't breathe, or has a visible injury.	**MDHHS Response to Finding 7: MDHHS disagrees. Centralized Intake staff are trained to determine if the allegations of abuse/neglect, which would include choking/strangulation allegations, meet assignment criteria under the Michigan Child Protection Law and MDHHS Children Protective Services intake policy.** **The Structured Decision Making (SDM) Centralized Intake Assessment, utilized by Centralized Intake staff at the point of intake, does not require an injury to be visible to select, and assign for, physical injury. If there are allegations of strangulation and no visible injuries, Centralized Intake will assess the elements captured in the sub-item for physical injury: Dangerous behavior or excessive action toward the child AND current behavior could cause serious physical injury, including unsafe use of physical restraint.**
The child advocate finds that strangulation can cause damage to a person's voice box or windpipe, the main arteries of the neck, psychological trauma, neurological injury, laryngeal fractures, upper airway edema, vocal cord immobility, short and long-term memory problems, traumatic brain injuries, and/or death.	**MDHHS Response to Finding 8: MDHHS acknowledges review of this statement.**
The child advocate finds only one of two CI offices were trained on strangulation, its seriousness and lethality.	**MDHHS Response to Finding 9: MDHHS disagrees. Centralized Intake staff located in both offices were provided with the hard-copy training materials. The training was further reviewed and discussed during staff meetings.**
The child advocate finds there is currently no plan to train the CI office who did not receive training on strangulation.	**MDHHS Response to Finding 10: MDHHS disagrees. While one office was provided with in-person training, all Centralized Intake staff were provided with the hard-copy training materials, and those materials were reviewed during staff meetings.**

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2023-0379

[redacted] [redacted]

Response received from MDHHS: July 22, 2025

Findings	Responses
The child advocate finds, per MCL 750.84, strangulation is a felony in Michigan which can, if found guilty, lead to up to ten years in prison, fines up to $5,000, or both.	**MDHHS Response to Finding 11: MDHHS acknowledges the review and accuracy of this statute.**

Recommendations	Responses
The child advocate recommends MDHHS engage the TISP, or similar entity regarding development of a medical and investigatory policy surrounding intake and investigation of strangulation complaints.	**MDHHS Response to Recommendation 1: MDHHS agrees to explore this recommendation further to determine whether enhancements are needed and will update policy accordingly.**
The child advocate recommends all new and current MDHHS staff, including the entirety of centralized intake staff who have not been trained, be trained regarding strangulation, the seriousness and lethality of it.	**MDHHS Response to Recommendation 2: MDHHS agrees in part. Training in choking and strangulation should be developed and trained by the Office of Workforce Development and Training. However, as mentioned previously, the structured decision-making tool assists in delineating whether an action by a person responsible was excessive, regardless of the presence of marks or bruises.**
The child advocate recommends centralized intake discontinue efforts to try to determine the "excessiveness" of a strangulation complaint based on whether the child lost consciousness, couldn't breathe, or had marks, bruises, or other injuries. The decision whether a child was strangled and injured from the incident should be determined by those investigating it.	**MDHHS Response to Recommendation 3: MDHHS agrees in part. It is Centralized Intake's function to focus on initial fact-gathering and evaluation of information to determine whether it meets statutory criteria for investigation and to assess the level of risk to the child. Evaluation of the referral information determines the nature and priority of the initial response. The decision whether a child was strangled and injured from the incident should be determined by those conducting the investigation.**
The child advocate recommends centralized intake assign all complaints about strangulation for investigation so child protection experts and specialists can determine what happened to the child, and whether they were harmed.	**MDHHS Response to Recommendation 4: MDHHS disagrees. To screen-in intakes regarding strangulation, Centralized Intake must consider if the perpetrator is a person responsible for the child's health and welfare.** **The intake must be vetted to determine the validity of the intake, to determine if it meets criteria outlined in the child protection law and identify the maltreatment types.** **MDHHS does agree to require more in-depth questioning at the intake level and to collaborate with external professionals to include suggested questions on the structured decision-making tool.**
The child advocate recommends MDHHS train mandated reporters on non-fatal strangulation. This can be placed in MDHHS developed mandated reporter training.	**MDHHS Response to Recommendation 5: MDHHS agrees to share this recommendation with the Michigan Public Health Institute (MPHI) for consideration in the development of enhanced mandated reporter training curriculum as part of an ongoing project.**

Office of the Child Advocate

[redacted]

Case Number: 2023-0379

Investigation Start: August 23, 2023

Recommendation Issued: April 28, 2025

OCA Background

The Office of the Child Advocate (OCA) is tasked with making recommendations to positively effect change in policy, procedure, and legislation by investigating and reviewing actions of the Michigan Department of Health and Human Services (MDHHS), child placing agencies, or child caring institutions. The Child Advocate's Act, Public Act 204 of 1994, also requires the OCA to ensure laws, rules, and policies pertaining to Children's Protective Services (CPS), Foster Care, Adoption, and Juvenile Justice are being followed. The OCA is an autonomous entity, separate from MDHHS.

The OCA investigator's review included reading confidential records and case documentation located in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), the MDHHS Centralized Intake (CI) Portal, police reports, peer reviewed published research articles, brochures, diagrams, power points, handouts, and other educational documents related to strangulation and child abuse. The OCA also conducted interviews with CI staff and subject matter experts regarding strangulation and child abuse. The subject matter experts are employed at the Training Institute on Strangulation Prevention (TISP), C.S. Mott Children's Hospital, Children's Hospital of Michigan, and the Michigan Commission on Law Enforcement Standards (MCOLES). In total, sixteen different individuals were interviewed. Due to the confidentiality of OCA investigations, the OCA cannot disclose the identity of witnesses or complainants or sources of statements and evidence.

The objective of this review is to identify areas for improvement in the child welfare system by looking at how CPS complaints involving the strangulation of [redacted] were handled by CI and CPS staff, 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, MDHHS, 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 complaints about strangulation; 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.

The investigation and review aim to give a voice to the child, or children involved. The OCA has undertaken a comprehensive review of various cases where MDHHS has successfully implemented child welfare programs, demonstrating the dedication of professionals who support families in maintaining their resilience and unity during difficult periods. While the OCA's analysis centers on specific cases, the insights presented in this document highlight common areas for improvement that have been consistently observed. The OCA respectfully suggests that by addressing these recurring issues, MDHHS could significantly contribute to preventing potential harm in the future.

[redacted] was fourteen years old when the first complaint about her adoptive father, [redacted] strangling her was made to CI on May 12, 2023. On August 23, 2023, the OCA opened an investigation into the administrative actions of MDHHS concerning eight different CPS complaints made about [redacted] strangling [redacted] The following report summarizes the information and evidence found during the OCA's investigation.

Family History and Background

[redacted] is the biological mother of [redacted] (14 at time of investigation) and [redacted] (10 at time of investigation). [redacted] is the biological father of [redacted] and the adoptive father of [redacted] and [redacted] are married. [redacted] biological father's identity is unknown. According to CPS records, his parental rights were voluntarily terminated to [redacted] and [redacted] live together in a home in Clinton County.

Summary of the complaints made, and the CPS investigation completed regarding [redacted] strangling [redacted]

On May 12, 2023, a mandated reporter made a complaint to CI stating [redacted] hit [redacted] in the back of her head during a disagreement and later "choked" her. According to the complaint [redacted] did not have marks, bruises, or injuries from this incident. CI staff didn't assign this complaint for a CPS investigation. CI staff documented the complaint didn't meet the definition of child abuse or neglect because there was no indication [redacted] was injured.

On May 25, 2023, a mandated reporter made a complaint to CI stating when [redacted] picked up [redacted] from school today [redacted] confronted [redacted] about a vape device she found in [redacted] room. Because of this, [redacted] told [redacted] she would have to walk fifteen miles home from school. [redacted] then left the school. [redacted] grandfather showed up while [redacted] was walking home, and he took her to his home. Several weeks prior to this, [redacted] "choked" [redacted] and slapped her on the top of her head. No marks or bruises were reported, but [redacted] was afraid of [redacted] CI staff didn't assign this complaint for a CPS investigation. CI staff documented the complaint didn't meet the definition of child abuse or neglect because there was "[n]o indication of harm."

Case Number: 2023-0379

[redacted] [redacted]

Summary of the complaints made, and the CPS investigation completed regarding [redacted] strangling [redacted] continued:

On May 26, 2023, five complaints were made to CI regarding [redacted] being "choked" by [redacted] The first complaint was made at 11:32 am. This complaint stated on May 25, 2023; [redacted] parents made her walk home from school. [redacted] was one mile into the walk and her grandfather showed up and took her to his home. A week prior to this, [redacted] put his hands around [redacted] neck and hit her on the back of the head. CI staff documented the referral source didn't say that [redacted] had any marks, bruises, or injuries, but the relative was concerned about the safety and well-being of [redacted] CI didn't assign this complaint for a CPS investigation. CI staff documented the complaint didn't meet the definition of child abuse or neglect because [redacted] didn't have any marks, bruises, or injuries.

Another complaint was made to CI on May 26, 2023, at 6:00 pm. This complaint stated there were ongoing issues between [redacted] and [redacted] that has led to verbal arguments and physical altercations. The relative stated [redacted] and [redacted] will wrestle, and one time [redacted] hit [redacted] on the shoulder. The relative didn't know if [redacted] was injured.

At 6:12 pm on May 26, 2023, a mandated reporter contacted CI to make another complaint. They stated two weeks ago [redacted] put his hands around [redacted] neck and law enforcement was called. The mandated reporter said law enforcement was involved with the family again on May 26, 2023. They said on this date law enforcement was called to do a child welfare check on [redacted] When law enforcement completed the check, they didn't have any concerns. The mandated reporter also stated [redacted] parents drink alcohol and smoke marijuana in her presence. CI staff added the mandatory reporter and information they provided to the complaint made at 6:00 pm.

At 6:14 pm on May 26, 2023, a third relative made another complaint to CI. This complaint stated that two weeks ago [redacted] got upset with [redacted] and responded by putting his hands around her neck and she could not breathe. The relative didn't know how long this had occurred but [redacted] had red marks around her neck after the incident. The relative stated [redacted] was afraid of [redacted] and scared to be at home with him. [redacted] stayed the night with the relative on May 25, 2023, but on May 26, 2023, [redacted] picked her up. When [redacted] picked her up, [redacted] hid from him. This caused [redacted] to become "belligerent," and he made her leave with him. The relative also reported [redacted] parents made her walk home from school on May 25, 2023, but while she was walking home a relative picked her up. The relative making the complaint said [redacted] is threatening to make [redacted] sleep in a tent outside as a form of punishment.

The fifth and final complaint made on May 26, 2023, was made by one of the relatives who had made a complaint to CI earlier that day. Their new complaint was made at 6:26 pm and it stated [redacted] slapped [redacted] across the back of the head a few days ago and she had a headache for several days. They said [redacted] also "choked" [redacted] two weeks ago and this left bruises around her neck. They further stated [redacted] calls [redacted] names like "retard" and "bitch," and both parents lock [redacted] in her room at night. [redacted] said she would rather kill herself than live with her parents. The relative was concerned because [redacted] had access to her parents' guns.

Excluding the first complaint made on May 26, 2023, at 11:32 am, all the other complaints made to CI on May 26, 2023, were assigned to CPS for investigation as one complaint. CI staff documented they assigned this complaint because [redacted] sustained red marks on her neck, couldn't breathe due to being "choked" by [redacted] and [redacted] slapped [redacted] repeatedly on the back of her head, which resulted in [redacted] having a headache for several days. No preponderance of evidence of abuse or neglect was found by CPS staff during their investigation of the assigned May 26, 2023, complaint. CPS documented this decision was based on [redacted] telling them [redacted] never grabbed her around her neck and [redacted] telling Forest View Hospital staff she and her grandfather lied to police about [redacted] "choking" her.

On May 27, 2023, a complaint was made to CI. The complaint stated on May 24, 2023; [redacted] was threatening to make [redacted] sleep in a tent because she ([redacted] was no longer welcome in the home. The complaint also said [redacted] put [redacted] in a "chokehold," was threatening to put her head through a wall and smacks her on the back of the head all the time. The complaint also documented that [redacted] had to stop [redacted] from shaking [redacted] while he was "choking" her. The family friend didn't know if [redacted] had any type of injuries from these incidents. CI staff didn't assign this complaint for a CPS investigation. CI staff documented the complaint didn't meet the definition of child abuse or neglect because there were no known marks, bruises, or injuries.

Case Number: 2023-0379

[redacted] [redacted]

Interviews with medical and legal experts and research regarding strangulation:

In addition to investigating the complaints made to CI and the investigation completed by CPS staff regarding this family, the OCA investigator also completed interviews with subject matter experts regarding strangulation and child abuse and researched published peer reviewed articles and documents regarding strangulation.

From these interviews and research, the OCA investigator was able to determine there is a difference between choking and strangulation. According to published articles, choking is an event that occurs internally when an object, such as food, partially or completely obstructs the passage of air from the upper airway into the trachea.[1] When this happens, the air supply to your lungs gets cut off. Strangulation is when external forces, like someone's hands, are applied to the neck with enough pressure to restrict airflow to someone's lungs and/or blood flow to their brain.[2] Per MCL 750.84, strangulation is a felony in Michigan which can, if found guilty, lead to a maximum of ten years in prison, fines up to $5,000, or both.

There are no stages, levels, or degrees to strangulation. According to the experts interviewed, strangulation is just strangulation. Different kinds of injuries can occur depending on how much pressure is applied to someone's neck and for how long. The injuries caused by strangulation vary from person to person and the unique situations of each incident.

According to the experts interviewed, it is not appropriate for anyone to try to determine the excessiveness of a strangulation. The experts interviewed said strangulation of a child by an adult, in and of itself, is excessive regardless of injury. Experts weighed in informing the OCA what should be determined in such situations is whether the child was injured because of the strangulation, adding this can only be determined by performing an investigation. The same experts suggested that all complaints made to CI about the strangulation of a child should be assigned for a full investigation by CPS and law enforcement.

As part of the strangulation investigation, the experts said the child should be medically examined and forensically interviewed to determine whether the child was injured and what happened. They said younger children should be interviewed at a Child Advocacy Center (CAC). When interviewed, children should be asked specifically about someone putting something on or around their neck and applying pressure. The medical exam should include a neurological examination and be performed by a doctor who is trained and regularly does such exams. If signs and symptoms of strangulation are found during the medical exam, further medical testing, such as CT imaging, may be done.

The experts also said if the strangulation occurred recently, photographs should be taken of the child to track the progression of any external injuries that develop. A strangulation tool or checklist should also be used to track signs, symptoms, and visible injuries resulting from the strangulation. The experts further stated that any witnesses and the perpetrator should be interviewed, and any items used during the strangulation (i.e. cords, ropes, etc.) should be observed, collected if possible, and photographed.

According to the expert interviewed at the Training Institute on Strangulation Prevention (TISP), the research regarding children being strangled is in its "infancy." Most of the available research primarily focuses on adult victims. That research indicates in fifty percent of strangulation cases there are no visible injuries and in another thirty-five percent of cases the visible injuries are so slight that they cannot be photographed.[3] This means only fifteen percent of strangulation cases exhibit visible injuries on the victim that can be documented via photographs. Strangulation, like domestic violence in general, is "highly underreported."[4]

According to the TISP's website, strangulation is extremely dangerous and is one of the most lethal types of domestic and family violence.[5] The website informs readers once pressure is applied to someone's neck it only takes 6.8 seconds on average for that person to be rendered unconscious. The website also states that it only takes eleven to seventeen seconds of being strangled for someone to have an anoxic seizure and only fifteen seconds for someone to lose bladder control. Loss of bowel control can occur in thirty seconds, and someone's respiration can begin to cease after sixty-two seconds of being strangled. After being strangled for one hundred- and fifty-seven-seconds respiration stops.

The website goes on to state that temporary or permanent brain damage can occur in as little as thirty seconds. It only takes four to five minutes of being strangled to cause brain death. Non-lethal strangulation can cause damage to a person's voice box or windpipe, the main arteries of the neck, psychological trauma, neurological injury, laryngeal fractures, upper airway edema, vocal cord immobility, short and long-term memory problems, and traumatic brain injuries.

Finally, according to the experts interviewed, if there is not some sort of professional intervention when strangulation, child abuse, or domestic violence occurs, it's highly probable that such occurrences will continue and are likely to increase in severity. When issues are reported, it is crucial that they are thoroughly investigated, as failing to do so can pose significant dangers. Nonfatal strangulation "is a significant predictor for future lethal violence."[6] This means if the perpetrator of a strangulation doesn't kill the victim the first time they strangle them, they are likely to continue to do it until they eventually do.

Case Number: 2023-0379 [redacted] [redacted]

Interviews with medical and legal experts and research regarding strangulation:

According to a peer reviewed research article written by Sharman LS, Fitgerald R, and Douglas H. entitled "Medical evidence assisting non-fatal strangulation prosecution: a scoping review," once someone is strangled, they are 7.48 times more likely to be a victim of homicide or other serious future harm.[7]

Interviews with CI staff and law enforcement:

The OCA investigator interviewed eight CI staff and three police officers who were familiar with the strangulation incident between [redacted] and [redacted] All the individuals interviewed stated strangulation is commonly referred to by the general public as choking. Due to this, the individuals interviewed said when strangulation gets reported they document it as choking. Only one of the individuals interviewed knew the difference between choking and strangulation. The person who knew the difference, however, wasn't certain they were correct. None of the individuals interviewed had training dedicated to specifically understanding strangulation, the seriousness or lethality of it, or how often observable or photographable injuries occur.

CI staff told the OCA investigator when a complaint is received about strangulation, the accepted practice is for them to try to decide if the strangulation was excessive. They said this is determined by whether the child loses consciousness, can breathe, or has marks, bruises, or other injuries. They said if a child remains conscious, can breathe, and doesn't have marks, bruises, or other injuries from the strangulation, then the complaint typically doesn't get assigned for investigation.

CI staff said this practice isn't something that is in a manual, policy, or any other location. They said this information is learned on the job from other experienced CI staff, supervisors, and management. CI staff also said if the person making the complaint is unaware of the details regarding if loss of consciousness, breathing issues, or other injuries occurred, and CI staff cannot obtain it from other sources, the complaint typically won't be assigned for investigation.

Specifically related to the strangulation incident between [redacted] and [redacted] CI staff said the one complaint about this incident that was assigned for investigation was only assigned because the reporting person said [redacted] had red marks on her neck, couldn't breathe from the strangulation, and had a headache for several days after being hit by [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 the findings should be further considered by the department, an administrative act should be corrected, and additional actions by MDHHS and other child welfare partners are necessary to help detect and prevent child abuse.

Findings

1. The child advocate emphasizes that all instances of strangulation carry the potential to be life-threatening.

2. The child advocate finds all reports of strangulation to a child by an adult should be considered alleged child abuse, regardless of the presence of visible injuries.

3. The child advocate finds the only way to determine the extent of an injury from strangulation is for a full, thorough, and complete investigation to be conducted by CPS and law enforcement.

Case Number: 2023-0379 [redacted]

Findings

4. The child advocate finds that when a child has allegedly been strangled, that child should be evaluated by a medical professional who has training on strangulation, its seriousness and lethality. The medical evaluation completed should include a neurological examination.

5. The child advocate finds CI staff members and law enforcement officials interviewed during this investigation were unaware of the difference between choking and strangulation.

6. The child advocate finds CI staff are attempting to determine the excessiveness of a strangulation through discussions on the phone with reporting sources.

7. The child advocate finds CI staff are not assigning strangulation complaints for investigation by CPS unless the child loses consciousness, can't breathe, or has a visible injury.

8. The child advocate finds in fifty percent of cases of strangulation there are no visible injuries and in another thirty-five percent of cases the visible injuries are so slight they cannot be photographed.

9. The child advocate finds that visible injuries, which can be captured through photographs, are present in only fifteen percent of strangulation cases.

10. The child advocate finds that strangulation can cause damage to a person's voice box or windpipe, the main arteries of the neck, psychological trauma, neurological injury, laryngeal fractures, upper airway edema, vocal cord immobility, short and long-term memory problems, traumatic brain injuries, and/or death.

11. The child advocate finds only one of two CI offices were trained on strangulation, its seriousness and lethality.

12. The child advocate finds there is currently no plan to train the CI office who did not receive training on strangulation.

13. The child advocate finds, per MCL 750.84, strangulation is a felony in Michigan which can, if found guilty, lead to up to ten years in prison, fines up to $5,000, or both.

Recommendations

1. The child advocate recommends MDHHS engage the TISP, or similar entity regarding development of a medical and investigatory policy surrounding intake and investigation of strangulation complaints.

2. The child advocate recommends all new and current MDHHS staff, including the entirety of centralized intake staff who have not been trained, be trained regarding strangulation, the seriousness and lethality of it, and how often strangulation results in observable or photographable injuries.

3. The child advocate recommends centralized intake discontinue efforts to try to determine the "excessiveness" of a strangulation complaint based on whether the child lost consciousness, couldn't breathe, or had marks, bruises, or other injuries. The decision whether a child was strangled and injured from the incident should be determined by those investigating it.

4. The child advocate recommends centralized intake assign all complaints about strangulation for investigation so child protection experts and specialists can determine what happened to the child, and whether they were harmed.

5. The child advocate recommends MDHHS train mandated reporters on non-fatal strangulation. This can be placed in MDHHS developed mandated reporter training.

Case Number: 2023-0379 [redacted]

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.

Ryan Speidel, Michigan's Child Advocate
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