Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2024-0139 [redacted] [redacted]

Investigation Start: April 24, 2024

Recommendation Issued: April 22, 2025

Case Background

[redacted] case was identified in MiSACWIS as a Category I[1] ongoing services case with no documented petition or documented temporary voluntary arrangement (TVA). Investigations categorized as a category I require the filing of a petition under Michigan law. Additionally, if the department requests a parent enter into a TVA, the TVA is required to be formally documented with signatures from the parents and case manager showing their agreement to the TVA. The TVA is required to be uploaded to the electronic case management system. Additionally, PEI staff could not locate evidence [redacted] was visiting with his mother. A full investigation was opened on April 24, 2024, to determine the reason for the extended TVA, why there was a delay in filing a petition, if [redacted] was visiting with his mother, and if family services were offered to [redacted] and his mother.

Case Objective

The objective of this review is to identify areas for improvement in the child welfare system by looking at how the case involving [redacted] was handled by Wayne County MDHHS. This report is not intended to place blame, but to highlight areas of concern regarding the case, 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

[1] The Child Protection Law, MCL 722.628d defines categories which are assigned to each CPS investigation at the conclusion based on the absence or presence of child abuse or child neglect, and the results of safety and risk assessments completed by CPS. A Category I means the department determined there is evidence of child abuse or child neglect and one or more of the following is true: a petition is required under the Child Protection Law (MCL 722.628d, 722.637, and 722.638, the child is not safe and a petition for removal is needed, the case was previously classified as a category II and the child's family did not voluntarily participate in services, or there is a violation, involving the child, of a crime listed or described in section 8a(1)(b), (c), (d), or (f), of child abuse in the first or second degree as prescribed by section 136b of the Michigan penal code, 1931 PA 328, MCL 750.136b.

[2] The Child Protection Law, MCL 722.628d, defines a Category III case as the department determined there is a preponderance of child abuse or child neglect, and the risk assessment tool indicated low or moderate risk of future harm to the child. The department must assist the child's family in receiving community-based services relevant to the needs of the family and risk to the child. If the family does not voluntarily participate in services or fails to make progress to reduce the risk level, the department must consider reclassifying the case as a category II. PSM-1, Post Investigative Services, provides direction to case managers that if the child(ren) are determined to be safe and ongoing services and monitoring is not warranted, the case manager can utilize the open/close option in the electronic case record in the investigation, refer the family to voluntary, community-based services and complete a Family Team Meeting.

Response received from MDHHS: July 22, 2025

Findings

The Child Advocate finds MDHHS placed [redacted] in a TVA with his great-grandmother for eight months.

a. During this time, although not directly restricted by MDHHS, [redacted] was unable to visit with [redacted]

b. There was no signed copy of the TVA uploaded into the MiSACWIS casefile.

Responses

MDHHS Response to Finding 1: Agrees.

Findings and Recommendation Report Summary

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Case Number: 2024-0139

[redacted] [redacted]

Response received from MDHHS: July 22, 2025

Findings	Responses
The Child Advocate finds MDHHS drafted the first petition and sent it to the Attorney General's office for review on April 10, 2024, eight months after the incident occurred. a. Due to the amount of time that had passed, the lack of current risk, and the lack of services provided to the family, the petition was not supported by the Attorney General's office and was not filed with the court.	**MDHHS Response to Finding 2: Agrees.**
The Child Advocate finds MDHHS did not adhere to child protection law when placing [redacted] without a court order to do so.	**MDHHS Response to Finding 3: Agrees.**
The Child Advocate finds MDHHS is currently experiencing a staffing shortage crisis which was a factor in not having timely outcomes for [redacted] and [redacted]	**MDHHS Response to Finding 4: Agrees.**
The Child Advocate finds in May of 2024 after [redacted] surrendered [redacted] at the MDHHS office, MDHHS wrote a petition for removal. There was a 15-day delay between the date a petition was drafted by MDHHS until the petition was approved to move forward by an assistant AG.	**MDHHS Response to Finding 5: Agrees.**

Recommendations	Responses
The child advocate recommends MDHHS request allocations to hire additional support staff to assist case managers with obtaining records and service reports for investigations which would assist in providing some relief to case managers to attend to substantial matters involving their cases, such as filing petitions.	**MDHHS Response to Recommendation 1: MDHHS disagrees.** **With the implementation of CCWIS, the department anticipates that family history and records will be more readily available to case managers and subsequently reduce the amount of time necessary to gather this vital information, providing time for petition writing and other essential duties.** **The new teaming model, that started with the first cohort in April 2025, includes family resource specialists and other supportive roles whose duties will include operational support such as assessing historical trends and prior services.**
The child advocate recommends MDHHS request allocations to fund positions in larger counties at an analyst or specialist level for petition writing. The individuals hired should be experienced with court proceedings and petition writing or trained specifically for that purpose.	**MDHHS Response to Recommendation 2: MDHHS agrees in part.** **We recognize the importance of clear and concise petitions. However, the Department finds that allocating full-time positions solely for petition writing is not an effective use of funds.** **Improved petition quality can be achieved through alternative methods, including:** **• Providing hands-on training assistance.** **• Facilitating collaboration with local court liaisons for pre-filing reviews.** **• Establishing peer review processes within local offices.** **• Furthermore, with readily available writing application tools, case managers have access to valuable resources that can enhance their petition writing and general communication skills, negating the need to divert money to new positions.**

Findings and Recommendation Report Summary

Office of the Child Advocate

Case Number: 2024-0139

[redacted] [redacted]

Response received from MDHHS: July 22, 2025

Recommendations	Responses
The child advocate recommends MDHHS track all TVAs throughout the State of Michigan to ensure TVAs are consistently reviewed. Tracking of TVAs will allow MDHHS to follow up with staff when a TVA is nearing the end of the timeframe to determine if the TVA needs an extension if a TDM needs to be scheduled with the family.	**MDHHS Response to Recommendation 3: MDHHS agrees in part. In July 2024, the In Home Services Bureau assessed the number of TVAs in place at that point in time to determine the prevalence of TVAs across the state. At that time, there were approximately 132 TVAs in place across 27 counties. Tracking these from a statewide perspective would require a considerable amount of time and resources; however, MDHHS will explore what this could look like from a regional/Business Service Center (BSC) perspective and determine any next steps accordingly.**
The child advocate recommends each county identify an individual to approve extensions of a TVA.	**MDHHS Response to Recommendation 4: MDHHS agrees to discuss this recommendation with leadership across the state to assess the pros and cons of this approach and determine any next steps accordingly.**
The child advocate recommends MDHHS amend CPS policy 713-01 as it pertains to TVAs and provide a clear timeline for case managers regarding appropriate length of TVAs and when an extension is necessary, require management approval.	**MDHHS Response to Recommendation 5: MDHHS agrees and is actively working on enhancements to TVA policy, practice, and training to include that TVA's are to be short-term in nature and only used when essential.**
The OCA recommends MDHHS amend CPS policy 713-01 concerning TVAs to ensure parents are being afforded the opportunity to visit with their children while the TVA is in place. These visits should be documented within MiSACWIS to include when a parent has refused or is otherwise unable to visit their child(ren).	**MDHHS Response to Recommendation 6: MDHHS disagrees. Policy and training currently state that during a temporary voluntary arrangement, case managers and/or temporary caregivers may not restrict a parent's physical custody or access to their child(ren). Parents are free to visit their children at any time during a TVA; therefore, MDHHS should not be requiring or facilitating visits and subsequently documenting them in a social work contact. This is also reiterated on the MDHHS-5433, Temporary Voluntary Arrangement form.**
The OCA recommends MDHHS staff be required to complete training on TVAs and safety planning on a yearly basis.	**MDHHS Response to Recommendation 7: MDHHS agrees in part. In 2024, 18 TVA trainings were provided across the state. In September 2024, a brief overview of TVAs was provided during the statewide supervisor call and CSA all-staff meeting. To date in 2025, four TVA trainings have been provided. Additionally, a TVA micro-learning is available to all staff on the Prevention, Preservation, and Protection SharePoint site and has been shared across the state on several occasions. TVA training is always available on request and should continue to be at the discretion of the BSCs and/or local office leadership based on the unique needs of staff within their offices.** **In addition, MDHHS has developed several micro-learnings around safety planning that are available to staff at any time. These are also maintained on the Prevention, Preservation, and Protection SharePoint site.**

Office of the Child Advocate

[redacted]

Case Number: 2024-0139

Investigation Start: April 24, 2024

Recommendation Issued: April 22, 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, child caring institutions, or certain facilities offering Juvenile Justice services. 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 the MDHHS.

This OCA review included reading confidential records and information in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), service reports and social work contacts. The OCA also interviewed MDHHS staff, and reviewed law and policy surrounding temporary voluntary arrangements (TVA). 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 the case involving [redacted] was handled by Wayne County MDHHS. This report is not intended to place blame, but to highlight areas of concern regarding the case, 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.

This case came to the attention of the OCA after a complaint was received regarding [redacted] being kept in a TVA for approximately eight months. During this time, it was alleged that [redacted] and his mother did not have services in place, and [redacted] mother was being denied the ability to visit with [redacted]

Prior to opening a full investigation on this case, a preliminary investigation was completed by OCA Public Education and Intake (PEI) Unit staff. At the time of the preliminary investigation, [redacted] case was identified in MiSACWIS as a Category I[1] ongoing services case with no documented petition or documented TVA. Investigations categorized as a category I require the filing of a petition under Michigan law. Additionally, if the department requests a parent enter into a TVA, the TVA is required to be formally documented with signatures from the parents and case manager showing their agreement to the TVA. The TVA is required to be uploaded to the electronic case management system. Additionally, PEI staff could not locate evidence [redacted] was visiting with his mother. A full investigation was opened on April 24, 2024, to determine the reason for the extended TVA, why there was a delay in filing a petition, if [redacted] was visiting with his mother, and if family services were offered to [redacted] and his mother.

Family History and Background

[redacted] is [redacted] biological mother, [redacted] is [redacted] putative father, and [redacted] is [redacted] maternal great-grandmother.

The focus of the OCA investigation was the August 2023 Category I CPS investigation which closed on October 16, 2023. [redacted] mother, has prior CPS history from 2022 that includes a finding of child abuse or neglect. That case was dispositioned as a Category III Open/Close[2]. In the 2022 case [redacted] was found responsible for improper supervision of [redacted]

CPS Policy Review:

MDHHS' Protective Services Manual (PSM) 713-01 describes the parameters of Temporary Voluntary Arrangements. This policy states:

> "As part of a safety plan during CPS involvement, a parent or a legal guardian may decide to allow their child(ren) to temporarily stay with the other parent, a relative, or a friend, as the parent determines appropriate and/or as part of the parent's safety plan.
>
> In such circumstances, discussions of a temporary voluntary arrangement must be led by a parent or legal guardian; and the decision to change, extend, or stop the arrangement rests with the parent. During a temporary voluntary arrangement, case managers and/or temporary caregivers may not restrict a parent's physical custody or access to their child(ren). Temporary voluntary arrangements are meant to be short-term and should not be used in lieu of court involvement or removal.

Case Number: 2024-0139

[redacted]

CPS Policy Review Continued:

A parent's right to care and custody of their children must not be restricted without the parent's consent or court involvement. Restricting these parental rights would be a violation of that parent's 14th Amendment rights. Restricting a parents' clearly established right to the companionship and care of their children without arbitrary government interference is a violation of the Due Process Clause of the Fourteenth Amendment.

When safety concerns exist that do not necessitate court involvement, and the parent secures a temporary voluntary arrangement for their child(ren), the case manager must ask the parent to sign the MDHHS-5433, Temporary Voluntary Arrangement, and upload the form into the documents section within the electronic case management system. Like any other safety plan established during CPS involvement, case managers must continuously monitor the effectiveness of the safety plan, verify the child(ren)'s continued safety, and assist the family with any additional services and supports needed. When there is no longer a need for the temporary voluntary arrangement, the case manager must notify the family, and document this in a social work contact. If there is a need to extend the timeframe of the temporary voluntary arrangement, a Family Team Meeting (FTM) must be held to determine next steps".

Review of August 2023 CPS Investigation:

On August 10, 2023, CPS Centralized Intake received a complaint concerning improper supervision and physical neglect of [redacted] (age two at time of complaint) by his mother, [redacted] The complainant expressed concerns [redacted] was left in the apartment alone for over an hour on August 8, 2023, and again for fifteen minutes on August 10, 2023, there was no furniture or food in the home, and [redacted] mental health was possibly affecting her parenting ability. According to the complaint [redacted] had been hyperverbal and paranoid and was transported to Henry Ford Main Hospital for a mental health evaluation. This complaint was accepted and assigned to Wayne County CPS for investigation.

[redacted] was in Oakland County with his maternal great-grandmother, [redacted] when this CPS investigation began. CPS requested an Oakland County MDHHS staff member see [redacted] in [redacted] home and verify his well-being. Oakland County CPS saw [redacted] on August 11, 2023. CPS implemented a safety plan with [redacted] that upon [redacted] release from the hospital, [redacted] could contact the case manager with any concerns. An additional safety plan was put into place with [redacted] via phone on August 15, 2023. This safety plan included [redacted] caring for [redacted] while [redacted] was hospitalized and until it was confirmed [redacted] was compliant with her medication and/or well enough to care for [redacted]

CPS interviewed [redacted] at Kingswood Hospital on August 17, 2023. [redacted] advised CPS she left [redacted] at the apartment because her blood sugar was severely low, and she needed juice. She told CPS she ran across the street to get some juice and did not want to take [redacted] with her because she was worried she would pass out and leave him somewhere unsafe. [redacted] admitted to having limited furniture but denied the concerns surrounding her mental health. She advised CPS her current landlord was out to get her, and she was trying to find new housing. The CPS investigation report documents the case manager advised [redacted] that [redacted] was currently staying with [redacted]

On August 18, 2023, CPS spoke with a social worker at Kingswood Hospital and was told [redacted] was being released early. CPS was informed [redacted] was compliant with her medication, was no longer hyperverbal, her mood had stabilized, and [redacted] was doing well overall. The social worker had no concern at the time for [redacted] caring for herself or [redacted]

Following her release, [redacted] contacted CPS requesting to see [redacted] and informed the case manager she was released early. CPS told her [redacted] should stay in the safety plan with [redacted] until further notice. Case records show CPS suggested [redacted] take the weekend to get readjusted and obtain groceries for the home. [redacted] stated she understood. CPS contacted [redacted] to ensure she understood the safety plan. [redacted] agreed to not give [redacted] back to [redacted] until CPS advised her to do so.

On August 21, 2023, CPS visited [redacted] home. Records show the home had adequate food, working utilities, appropriate sleeping arrangements and was free of any safety hazards. CPS documented they were uncomfortable sending [redacted] home at the time due to hospital notes stating [redacted] was suicidal. [redacted] also had not yet picked up her medication after being released from the hospital.

CPS held a Team Decision Making Meeting (TDM) on September 7, 2023. During the TDM, [redacted] was advised a temporary custody petition would be filed due to improper supervision, physical neglect, and [redacted] mental health. Records show CPS was going to refer [redacted] to the MDHHS Kinship Unit to be assessed for placement of [redacted] At this point in time [redacted] had been caring for [redacted] for approximately 30 days.

CPS closed the investigation as a Category I with a high-risk assessment, stating a petition was necessary and would be filed. The investigation closed on October 16, 2023, and a subsequent ongoing services case was opened. Though required by Michigan law, a petition was not filed in this matter.

Case Number: 2024-0139

[redacted]

Additional OCA Evidence:

During its investigation the OCA located a social work contact which documented interactions with CPS and an assistant attorney general (AAG). This social work contact documented a petition was emailed to the AAG for review on April 10, 2024, nearly seven months after the CPS investigation started. An additional social work contact dated April 10, 2024, documented a case conference was held between the AAG, the CPS case manager, the CPS supervisor, and a MDHHS section manager. The AAG raised concern with the length of time the case had passed with [redacted] being in a safety plan, no services being provided to the mother during this time period, and no new instances of abuse or neglect had occurred. Documentation shows a plan was agreed upon for [redacted] to go home to his mother with services in place. CPS would need to have a meeting with [redacted] to discuss what services would be referred.

Social work contacts indicate a TDM meeting was held the following day on April 11, 2024. Records show during the TDM [redacted] agreed to participate in Professional Outreach Counseling, Health Families Services, weekly mental health therapy, monthly psychiatric appointments, and counseling appointments for [redacted] also agreed to take her prescribed medications for her mental health and diabetes. [redacted] agreed to continue being a support for [redacted] and she would visit the home at least twice a week to assist in caring for [redacted]

During our investigation the OCA was provided evidence indicating a petition was no longer warranted due to the amount of time that had passed between when the CPS investigation first started and the April 2024 TDM took place. Additionally, all parties in the TDM believed [redacted] was safe and had been safe for some time. The OCA was informed that a petition was not timely filed because the county CPS staff were extremely short staffed, and [redacted] was safe with [redacted]

Several reasons were provided to the OCA to explain the extended TVA. The OCA was informed the original case manager abruptly left the department and there were multiple conversations with the AG's office regarding the petition. MDHHS advised they were ensuring [redacted] was seenconsistently and provided gift cards, food, and diapers to the grandmother to assist her with caring for him. MDHHS staff explained there was a delay in reassigning the CPS case to another case manager when the original case manager abruptly left employment with MDHHS. These reasons were also provided as the cause for a petition not being filed.

There is no signed TVA uploaded to the case file and the document could not be produced during this investigation. The only proof of one existing is the social work contacts describing the TVA in the case report. MDHHS staff denied withholding visitation from [redacted] with [redacted] and explained [redacted] was very compliant with MDHHS because she did not want to do anything to jeopardize [redacted] returning to her care. MDHHS staff was uncertain how many times [redacted] visited with [redacted] over the extended TVA timeline.

On Monday, April 29, 2024, 263 days after being placed in a TVA, [redacted] returned to [redacted] care. On Wednesday, May 1, 2024, [redacted] brought [redacted] back to the MDHHS office stating she did not have the means or ability to provide care for [redacted] [redacted] informed MDHHS staff she wanted to surrender [redacted] MDHHS again put a TVA in place with [redacted] A petition was drafted and sent to MDHHS supervision for approval on May 3, 2024. According to MDHHS staff, the petition was sent to the AG's office on May 6, 2024. There continued to be back and forth conversation on the petition language and whether or not a petition was needed. The petition was signed by the AAG and filed with the court on May 21, 2024. MDHHS was notified of the scheduled preliminary hearing on May 22, 2024. A preliminary hearing was held on June 6, 2024. [redacted] was made an in-home temporary court ward and returned to his mother's care. What occurred in April of 2024 followed the legal process for removal of a child from the parental home as this removal was court ordered and not extrajudicial.

During the course of this investigation the OCA was informed MDHHS started tracking TVAs to ensure policy is followed and that TVAs are not used in lieu of a petition for removal of a child from the parental home.

Additional Cases with Similar Issues:

The OCA has observed the misuse of safety plans and TVAs in additional cases. The TVAs were used in lieu of filing timely petitions.

- OCA preliminary investigation, 2024-0264, concerned the death of [redacted]. [redacted] died as a result of natural causes. Prior to [redacted] birth there was a CPS investigation (MDHHS investigation case #165933449) which addressed concerns for the mother's substance use causing neglect in the home. TVAs were implemented for [redacted] siblings, [redacted] and [redacted] [redacted] was placed in a TVA with his grandmother, while [redacted] was placed in a TVA with her legal father. These TVAs were initiated on April 5, 2024, and were documented to be in place until April 5, 2025.

Case Number: 2024-0139

[redacted] [redacted]

Additional Cases with Similar Issues Continued:

- OCA investigation 2024-0076 concerning [redacted] (MDHHS investigation case #156423373) came to the OCA's attention over concerns of a petition not being filed, no visitation between the mother and the children, the children missing school, and no signed TVA in place. By April 2024, when the OCA opened its full investigation, the children had been with a relative since December 20, 2023. When asked about the delay in filing a petition for this case, MDHHS staff advised being "slammed" with multiple cases that had "high needs", and the children were in safe placements at the time. The OCA was provided evidence to show [redacted] mom was not having visits with the children during the extended safety plan.

- OCA investigation 2024-0254 concerning the death of [redacted] (MDHHS investigation case #168803516) involved safety plans and TVAs being utilized in lieu of a petition being filed. On April 29, 2024, CPS responded to the home and found both parents were highly intoxicated. CPS was unable to create a safety plan with the parents due to their high level of intoxication. CPS contacted the police and had a family friend care for the children for the night. On April 30, 2024, CPS created a safety plan with the mother where she agreed to have a sober caretaker for her children. During this investigation, a new CPS investigation (MDHHS investigation case #176893476) was assigned after the mother was arrested for driving under the influence of alcohol with the minor children present in the vehicle. The mother was in jail, was not agreeable to a TVA and was hostile with CPS. The mother did sign the TVA form but vocalized not agreeing with the TVA. The original TVA was initiated on June 20, 2024. The children were to reside with their maternal grandmother in the mother's residence. The TVA was not readdressed until August 22, 2024, where it was noted, the TVA would be effective from August 9, 2024, to August 20, 2024. A court hearing was held on August 20, 2024, and the petition to remove the children was authorized by the court.

  During the investigation, the OCA observed the children's placement dates as June 20, 2024, two months prior to the court hearing. The OCA sought clarification from the Federal Compliance Division and was informed that because the TVA was not properly extended and was not agreed upon by the mother, the children were considered removed without a court order on June 20, 2024.

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 finds MDHHS placed [redacted] in a TVA with his great grandmother for eight months.
   a. During this time, although not directly restricted by MDHHS, [redacted] was unable to visit with [redacted]
   b. There was no signed copy of the TVA uploaded into the MiSACWIS case file.

2. The Child Advocate finds MDHHS drafted the first petition and sent it to the Attorney General's office for review on April 10, 2024, eight months after the incident occurred.
   a. Due to the amount of time that had passed, the lack of current risk, and the lack of services provided to the family, the petition was not supported by the Attorney General's office and was not filed with the court.

3. The Child Advocate finds MDHHS did not adhere to child protection law when placing [redacted] without a court order to do so.

4. The Child Advocate finds MDHHS is currently experiencing a staffing shortage crisis which was a factor in not having timely outcomes for [redacted] and [redacted]

5. The Child Advocate finds in May of 2024 after [redacted] surrendered [redacted] at the MDHHS office, MDHHS wrote a petition for removal. There was a 15-day delay between the date a petition was drafted by MDHHS until the petition was approved to move forward by an assistant AG.

Case Number: 2024-0139 [redacted] [redacted]

Recommendation(s):

1. The child advocate recommends MDHHS request allocations to hire additional support staff to assist case managers with obtaining records and service reports for investigations which would assist in providing some relief to case managers to attend to substantial matters involving their cases, such as filing petitions.

2. The child advocate recommends MDHHS request allocations to fund positions in larger counties at an analyst or specialist level for petition writing. The individuals hired should be experienced with court proceedings and petition writing or trained specifically for that purpose.

3. The child advocate recommends MDHHS track all TVAs throughout the State of Michigan to ensure TVAs are consistently reviewed. Tracking of TVAs will allow MDHHS to follow up with staff when a TVA is nearing the end of the timeframe to determine if the TVA needs an extension if a TDM needs to be scheduled with the family.

4. The child advocate recommends each county identify an individual to approve extensions of a TVA.

5. The child advocate recommends MDHHS amend CPS policy 713-01 as it pertains to TVAs and provide a clear timeline for case managers regarding appropriate length of TVAs and when an extension is necessary, require management approval.

6. The OCA recommends MDHHS amend CPS policy 713-01 concerning TVAs to ensure parents are being afforded the opportunity to visit with their children while the TVA is in place. These visits should be documented within MiSACWIS to include when a parent has refused or is otherwise unable to visit their child(ren).

7. The OCA recommends MDHHS staff be required to complete training on TVAs and safety planning on a yearly basis.

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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