STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR
OFFICE OF CHILDREN'S OMBUDSMAN
LANSING
RYAN SPEIDEL
CHILDREN'S OMBUDSMAN

Findings and Recommendations

Under state law a record of the Office of Children's Ombudsman's is confidential, is not subject to court subpoena, and is not discoverable in a legal proceeding. Additionally, a record of the Office of Children's Ombudsman's is exempt from disclosure under the Freedom of Information Act.

Date: August 23, 2023

Case No.: 2022-0263

Child: [redacted]

DOB: September 9, 2017

DOD: March 10, 2022 (4 years old)

Introduction:

The Office of Children's Ombudsman (OCO) 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 Children's Ombudsman Act, Public Act 204 of 1994, also requires the OCO ensure laws, rules, and policies pertaining to children's protective services, foster care, and adoption are being followed. The OCO is an autonomous entity, separate from the MDHHS.

The OCO review included reading confidential records and information in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), service reports, medical records, social work contacts, court documents, and law enforcement reports. The OCO also interviewed MDHHS staff, medical professionals, hospital staff, and law enforcement personnel. Due to the confidentiality of OCO investigations, the OCO 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 child protective services (CPS) investigations involving [redacted] were handled by Oakland and Wayne County CPS, and the involvement of MDHHS staff, court personnel, physicians, and law enforcement. This review reinforces that the safety and well-being of a child is the shared responsibility of the family, community, law enforcement and medical personnel 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 to advocate for changes within it on behalf of similarly situated children.

[redacted] was four years old when he died on March 10, 2022. Pursuant to MCL 722.627k, MDHHS notified the OCO of the child fatality. On March 15, 2022, the OCO opened an investigation

into the administrative actions of CPS regarding [redacted]'s death. The following report summarizes the information and evidence found during the OCO investigation.

Background and History:

[redacted] is the birth mother of [redacted] (DOB: 09/09/2017) and [redacted] (DOB: 06/18/2021). [redacted]'s father, [redacted] passed away in 2018. [redacted]'s father is [redacted]. [redacted], and [redacted] lived together during the timeframe of the CPS cases the OCO reviewed. After [redacted]'s death [redacted]'s parental rights to [redacted] were terminated.

Relevant to the OCO's findings and recommendations it is important to note that [redacted] has two additional biological children with a woman named [redacted]. Those children are [redacted] (DOB: 08/21/2012) and [redacted] (DOB: 08/18/2017). [redacted] and [redacted] both reside with their mother. As of the writing of this report, [redacted] maintains his parental rights to both biological children he shares with [redacted].

In October of 2021 [redacted] ([redacted]'s mother) was investigated by CPS for physical abuse of [redacted]. That investigation resulted in a Category IV, which is a finding of no child abuse or neglect. [redacted] was residing in the home during this investigation but was not identified as an alleged perpetrator.

Review of CPS Investigation Prior to [redacted]'s Death:

The central part of the OCO's investigation starts in October 2021 when [redacted] suffered a near fatal injury requiring emergency surgery. This CPS investigation opened on October 2, 2021, and closed on December 8, 2021. This investigation occurred just five months before [redacted] died. The OCO review of this investigation found several deficiencies and missed opportunities when MDHHS CPS attempted to determine what caused [redacted]'s severe injuries. The facts presented to the OCO during its investigation of the October 2021 investigation are complex in nature. In summary the OCO found:

- [redacted]'s live in boyfriend ([redacted]) was not identified properly by CPS and thus was not considered relevant to the CPS investigation.
- CPS did not complete a CPS or criminal background on [redacted].
- Had CPS properly identified [redacted] and conducted a background review they would have found that [redacted] has:
    - A criminal history involving serious violence.
    - Prior history with CPS in which he was substantiated for medical neglect of his biological child.
- The required law enforcement notification (LEN) was not submitted to a law enforcement agency for 10 days, well outside of the legally mandated 24 hours when severe child abuse is being investigated.
- Two law enforcement agencies were sent a LEN, the Detroit Police Department (DPD) and the Wixom Police Department (PD).
    - It is unknown if DPD received the LEN.
    - The delay in the LEN sent to Wixom PD caused a 27-day delay in having the Wixom police department open a child abuse investigation.
- There was little communication and no joint investigation completed by the parties who should be participating as a multidisciplinary team, if best practices are used.
- Wixom police investigators assigned to this case were unaware of Michigan's model child abuse protocol.

- A significant statement made by [redacted] during his hospital stay, in which [redacted] asked if [redacted] was going to hit him, was not included in the CPS investigation.
- A physician, Dr. Norat, specializing in non-accidental trauma and child abuse injuries was consulted, however his statements were not used correctly.
- The assigned CPS investigator in Oakland County did not speak directly with Dr. Norat.
- The CPS investigator appears to have disregarded statements from the medical practitioners who agreed that [redacted]'s injuries were inconsistent with the explanation of those injuries given by [redacted]'s mother.
- Dr. Norat attempted to explain the force necessary to cause [redacted]'s injury as a hypothetical cause.
    - The CPS investigator used the hypothetical example provided by Dr. Norat as the actual cause of [redacted]'s injuries.
    - These examples were not provided as a cause for [redacted]'s injuries by his caregivers.
- CPS was aware that [redacted] had a broken arm during his forensic interview but did not document the injury. [redacted] [redacted] was the only adult with [redacted] when [redacted] sustained his broken arm.
- The OCO investigation shows that [redacted]'s severe injuries sustained in October of 2021 were the direct result of physical child abuse.
- CPS closed the October 2021 child abuse investigation by finding no child abuse occurred.

Summary of Investigation:

On October 1, 2021, [redacted]'s mother brought him to the emergency room (ER) at Children's Hospital at Detroit Medical Center due to abdominal pain. It was discovered [redacted] needed emergency surgery as he had two holes in his small bowel. [redacted] did not have any bruising or visual injuries to his abdominal area.

Evidence shows [redacted] told hospital staff [redacted] had been at his grandmother's home the entire week prior to being taken to the hospital. [redacted] denied any knowledge of trauma to [redacted]'s abdomen or any abuse. [redacted] also explained that when [redacted] returned home, he slept a lot and complained of pain. The day before [redacted] brought [redacted] to the hospital, [redacted]'s symptoms and pain worsened and his abdomen became distended. [redacted] also described [redacted] as lethargic with a poor appetite. According to statements provided to hospital staff, [redacted] said the morning of October 1, 2021, she felt [redacted]'s abdomen which was firm and looked concerning, that is why [redacted] brought [redacted] to the hospital. [redacted] provided a possible explanation to hospital staff for [redacted]'s injuries. [redacted] described another four-year-old child at her mother's home who is very rough, and that [redacted] informed her this child punched him in the stomach. Due to the severity of [redacted]'s injuries and the explanation given, the hospital staff had concerns for physical abuse and contacted MDHHS Centralized Intake on October 2, 2021.

Because the hospital is located in Wayne County, the CPS complaint was initially assigned to the Wayne County South Central MDHHS office. An on-call CPS specialist for Wayne County South Central responded to the hospital on October 2, 2021, and verified the well-being of [redacted]. Due to [redacted] being asleep, no interview was attempted at that time. CPS spoke with [redacted] who explained not knowing what happened to her son. Evidence indicates that [redacted] told the CPS specialist [redacted] had been with her mother, [redacted], for a week. [redacted] further described picking [redacted] up on Wednesday (September 29, 2021) and [redacted] was complaining his stomach hurt. She thought he was constipated as he did not complain about it again and seemed normal. On Friday (October 1, 2021), [redacted] noticed [redacted] would not stand up and his stomach was hard. She decided to bring [redacted] to the hospital. Once at the hospital it was discovered [redacted] had a fever and two holes in his small bowel. [redacted] informed the CPS on call specialist that she ([redacted]) was told by "doctors" that [redacted]'s injuries were caused from blunt force trauma to the abdomen or

something [redacted] ate. [redacted] explained that she was informed [redacted] had been hit by another four-year-old child while at her mother's house. No safety plans were made during this visit regarding [redacted] or his sibling, [redacted].

The next social work contact entered into MiSACWIS is dated October 6, 2021. This contact was with hospital staff to inform CPS that [redacted] would be released from the hospital. After contact with the hospital, Wayne County CPS asked Oakland County CPS for what is known as a courtesy request. This particular courtesy request was made because [redacted] lived in Oakland County and the intent was to transfer the investigation to Oakland County.

After receiving the courtesy request Oakland County CPS spoke with [redacted]'s maternal grandmother, [redacted], via phone. [redacted] informed CPS she cares for [redacted] four days to a week at a time, due to [redacted] working. [redacted] confirmed she had [redacted] for the entire week prior to his hospitalization and denied knowing what caused [redacted]'s stomach pain. [redacted] informed CPS that she has custody of her four-year-old nephew, who often plays rough with [redacted], and she constantly must separate them.

An Oakland County CPS supervisor responded to the courtesy request with some follow up questions for Wayne County CPS. The supervisor asked Wayne County CPS if a LEN had been sent and if a criminal history request had been completed. The OCO could not determine who the criminal history request was for as this is not documented. The Oakland County supervisor also asked the Wayne County specialist to follow up with medical professionals regarding their opinion of [redacted]'s injury and to conduct a home visit to [redacted]'s home which is in Wayne County. The same Wayne County CPS specialist was asked to interview all household members at [redacted]'s home.

At the direction of the Oakland County CPS supervisor, the Wayne County CPS specialist contacted Children's Hospital and spoke with the hospital's social worker. According to CPS records the Children's Hospital social worker informed Wayne County CPS that [redacted] had two perforations in his intestine which had to be corrected through emergency surgery. The Children's Hospital social worker also explained that the only way [redacted] could have sustained this injury was through trauma to the abdomen. In addition to the injury to his intestines, the Children's Hospital social worker also explained [redacted] had a bruised liver.

The Wayne County CPS specialist visited [redacted] at the hospital on October 8, 2021, and documented doing what the specialist referred to as a forensic interview. During this interview the TV in [redacted]'s hospital room was turned on, and the CPS specialist documented [redacted] not understanding some of the questions he was asked. [redacted] said Anton hit him and Anton is a kid. [redacted] said this happened when he was at his grandmother's home.

It is documented the CPS specialist then spoke with Dr. Norat, one of [redacted]'s treating physicians. Dr. Norat explained that [redacted] had two small holes in his bowel and a bruise on his liver resulting from "nonspecific trauma." In his attempt to explain to the case worker the force necessary to cause such an injury, Dr. Norat provided an example of a child riding a bike down a hill and hitting the handlebars of the bike, or from a child who was involved in a car accident. Dr. Norat told the Wayne County CPS specialist that [redacted]'s intestine needed surgical intervention and the injury could have been caused by non-accidental trauma.

The courtesy request for a home visit was conducted by Oakland County on October 8, 2021. [redacted] provided the same version of events to the CPS specialist that she had relayed to hospital staff and the Wayne County Specialist. According to [redacted], while at the hospital [redacted] was examined by "a doctor" who informed [redacted] that [redacted]'s injury could have been a result of being hit, riding a bike, jumping off of bunk beds onto an object, or rough playing. This is the first time the OCO noticed a conflict in [redacted]'s statements about the possible cause of [redacted]'s injuries.

Previous statements made by [redacted] to CPS indicated the doctor explained blunt force trauma or something [redacted] ate.

[redacted] told the CPS specialist she asked [redacted] "what happened". According to [redacted]'s statement, [redacted] told his mother that his cousin hit him. [redacted] stated that [redacted]'s cousin has hit her, adding the cousin has "a heavy hand", and does hit hard. [redacted] informed CPS that her mother and her boyfriend, [redacted], watch the children while she works. The CPS specialist documented [redacted]'s name wrong and recorded it as [redacted] and [redacted]. The OCO could not find evidence to show CPS conducted any type of background check on [redacted]. [redacted]'s background was not reviewed until [redacted]'s death investigation.

Michigan law requires that MDHHS submit a report to the local law enforcement agency and the prosecuting attorney within 24 hours of becoming aware that a child sustained a severe injury from suspected child abuse or neglect[1]. This report is referred to as the law enforcement notification, or LEN. Evidence obtained by the OCO shows that MDHHS CPS waited ten days, until October 12, 2021, to submit a LEN. At this time [redacted], [redacted], and [redacted] lived in the City of Wixom in Oakland County, so a LEN was sent to the Wixom Police Department. Additional LENs were sent to the Detroit Police Department and the Wayne County Prosecutor's office as information provided by [redacted] stated that the injuries possibly occurred at [redacted]s house in the City of Detroit.

In reviewing evidence and conducting interviews the OCO found that CPS was not sure where the incident causing [redacted]'s intestine and liver injuries occurred.

CPS created a safety plan on October 12, 2021, 11 days into the investigation. [redacted] agreed to have her sister, [redacted], stay at [redacted]'s home and care for [redacted] until CPS completed their investigation. The OCO discovered that the only criminal history obtained for this investigation was on [redacted]. No other criminal histories were reviewed.

The Wayne County CPS specialist spoke with Dr. Norat again on October 12, 2021. It is documented Dr. Norat stated the injury could be non-accidental or accidental. Dr. Norat expressed concern because he had no history or explanation of what caused the injuries to [redacted]. Dr. Norat told the CPS specialist the type of injury [redacted] sustained would have been caused by a large amount of force applied to [redacted]'s abdomen. Records show Dr. Norat again explained that because he (Dr. Norat) did not have a plausible explanation for [redacted]'s injuries he was concerned the injuries were the result of child abuse. Dr. Norat had been provided with an explanation of another four-year-old hitting [redacted] which possibly caused the injury. Dr. Norat refuted that explanation and informed the CPS specialist "the only way a four-year-old could have hurt another four-year-old is if he [the four-year-old] pushed him [[redacted]] out of a window and he [[redacted]] fell on a tree." Dr. Norat stated this injury would be feasible if the four-year-old hit [redacted] in the stomach with a bat.

Dr. Norat informed CPS he spoke with [redacted]'s surgeon. The medical background Dr. Norat received from [redacted]'s surgeon indicated that [redacted]'s injury did not appear to have occurred the day [redacted] was brought into the ER, that it had happened "days ago". Dr. Norat further explained to CPS that [redacted] had a "liver injury due to a forceable injury to the stomach and a perforated intestine. It would have to be a force great enough to push the intestine to the spine, that type of force does not happen every day." Treating physicians at the hospital also noted [redacted] had scratches on his shoulder and scalp. [redacted]'s scalp was also bruised. Dr. Norat added there are no hard surfaces on the belly, and just because [redacted] did not have bruising on his belly does not mean "nothing [sic]" happened to him.

[1] MCL 722.628(1)

On or about October 20, 2021, Wayne County CPS called DPD to inquire about the LENs. DPD informed CPS that the case had not yet been assigned. On October 28, 2021, Oakland County CPS contacted Wixom PD who informed CPS they did not receive the LEN. A second LEN was submitted to Wixom PD. Wixom PD sent an email explaining that an officer will take an initial report then a detective will be assigned for further investigation.

On October 21, 2021, Wayne County transferred the CPS investigation to Oakland County. At this point, Wayne County CPS involvement with the case ended.

A forensic interview of [redacted] was scheduled at Care House, Oakland County's Children's Advocacy Center (CAC), for November 9, 2021, but had to be rescheduled to November 17, 2021. During the interview [redacted] provided no information to the forensic interviewer identifying who caused his injury.

During the OCO's investigation, it was discovered that [redacted] had a broken arm when he arrived at the CAC to be forensically interviewed. There is no record or documentation of [redacted]'s broken arm in the CPS investigation. Through interviews, the OCO learned the explanation for [redacted]'s broken arm was he fell down the apartment complex stairs, while in the care of [redacted]. All the evidence combined showed that when [redacted] sustained the fractured arm, the safety plan agreed to by [redacted] was still in place, and [redacted] was only to be cared for by [redacted]'s sister. The safety plan did not include [redacted] as the caretaker for [redacted] was not in compliance with the agreed-upon safety plan. CPS did not follow up on the noncompliance with the safety plan.

On December 2, 2021, with knowledge of [redacted]'s broken arm, CPS conducted a home visit at [redacted]'s residence. [redacted]'s boyfriend, was present and agreed to be interviewed. [redacted] was asked by CPS and denied using physical discipline with [redacted] told CPS he has watched [redacted]'s cousin playing rough with [redacted] on multiple occasions. [redacted] informed CPS that [redacted] has told [redacted] that his ([redacted]'s) cousin has hit him and is strong for his age. The OCO determined the 'cousin' [redacted] was referring to, was the four-year-old child who lived with [redacted]

Throughout the CPS investigation CPS did not identify the four-year-old child who [redacted] and [redacted] accused of causing [redacted]'s injury. CPS records refer to this child as Anton, Amir, Ahman, and Ahmad.

Oakland County CPS completed a safety assessment, and one immediate harm factor was identified. This immediate harm factor was "Caretaker(s) explanation of any injury to a child is unconvincing and the nature of the injury suggests that the child's safety may be of immediate concern". The immediate harm factor identified by CPS aligns with Dr. Norat's statement of non-accidental trauma but does not align with the disposition of this investigation as a category IV.

CPS concluded this investigation finding no child abuse had occurred. In the case closure disposition CPS partially summarized Dr. Norat's statements. CPS used the injury being sustained by a bike handlebar or from a car accident as the reason for the injury. None of Dr. Norat's other statements were cited in the disposition as supporting evidence. CPS also noted that due to no disclosures being made at the Care House interview, there was no preponderance of evidence found supporting improper supervision or physical abuse by [redacted] The risk level was low, and the case was closed.

The OCO reviewed medical records from [redacted]'s hospital stay at Children's Hospital from October 1, 2021, to October 12, 2021. The records confirmed [redacted] had two areas of perforation in his bowel, one posteriorly about 1.5cm and one smaller anterior perforation about a half a centimeter. Records show

[redacted] also had a contusion, about 1 centimeter by 3 centimeters on his liver. Due to these injuries' surgery had to be performed to repair the perforations. It is documented that in the professional opinion of nurse practitioner, [redacted], the injuries were concerning for non-accidental trauma as no significant abdominal trauma for [redacted] had been provided. Dr. Norat, Medical Director of the Child at Risk Evaluation (CARE) Team, agreed with the finding of non-accidental trauma.

The OCO also discovered a note was entered into [redacted]'s hospital records on October 10, 2021, nine days post-surgery. The note states that a hospital social worker overheard a conversation between [redacted] and [redacted]. The conversation was about [redacted] accidentally urinating in the hospital bed overnight. In this conversation [redacted] was heard by the hospital social worker asking [redacted] "does this mean you're going to hit me?". Hospital staff attempted to contact the assigned CPS specialist to provide this information, however the specialist was unavailable. The medical chart indicates a voicemail was left for the CPS specialist however the OCO could not determine if this information was ever provided by hospital staff to CPS. It is unknown if the CPS specialist was ever made aware of [redacted]'s comments to [redacted].

The OCO interviewed a hospital staff member who was involved with [redacted] and familiar with the circumstances of his surgery and hospital stay at Children's Hospital. The hospital staff member confirmed they had concerns for non-accidental trauma when [redacted] presented with the intestinal and liver injury. The hospital staff member explained during the interview that the type of injury [redacted] sustained is not something typically seen in children and that it was from "forceful trauma to the abdomen."

During the OCO's interview with the hospital staff member the OCO learned that the hospital staff member believed [redacted] was the individual who caused the injuries to [redacted] This staff member had the impression [redacted] was safety planned out of the home after [redacted] sustained the intestine and liver injuries. The hospital staff member confirmed [redacted] was the individual in [redacted]'s hospital room when [redacted] was overheard saying "does this mean you're going to hit me?". The hospital staff member provided insight into [redacted]s broken arm, stating the type of fracture [redacted] sustained was common in children and would not be concerning on its own, however given the suspicious nature of [redacted]'s abdominal injuries the broken arm was highly concerning for abuse. The hospital staff member informed the OCO that prior to [redacted]'s death, no law enforcement agency contacted hospital staff regarding [redacted]'s abdominal injuries from October of 2021. The hospital staff member interviewed by the OCO believed that no law enforcement agency was not involved. The OCO determined that there were no multi-disciplinary team meetings held where medical staff were invited to participate.

The OCO gathered evidence confirming Dr. Norat had concern for non-accidental trauma causing [redacted]'s injuries. The evidence also confirmed that Dr. Norat's medical opinion was a four-year old could not have caused the injuries [redacted] sustained by merely punching [redacted] The OCO did not find any version of events where anyone with knowledge of [redacted]'s injuries explained that his injuries were caused by the handlebar of a bike. No one provided CPS or Dr. Norat with this explanation. The OCO confirmed with Dr. Norat that a bike accident did not cause [redacted]s injuries.

The OCO obtained evidence supporting a breakdown of the multidisciplinary team in this case. Evidence obtained shows a LEN was not sent to any law enforcement agency until after 10 days following the start of the CPS investigation. When the LEN was sent, it was submitted by facsimile. Weeks went by before Wixom PD became involved which occurred after [redacted] had been discharged from the hospital. Wixom PD, once involved, requested a forensic interview of [redacted] at Care House. Due to the delayed LEN submission, [redacted] was not interviewed at the Care House until 48 days after the start of the CPS investigation. Documentation shows law enforcement did not have any contact with medical staff and concerns relayed from the medical staff to CPS, were never relayed to law

enforcement. Law enforcement was also unaware of [redacted]'s involvement with the family or that he was a household member.

Interviews conducted with mandated reporters from both law enforcement and medical professionals, showed there was very little communication between all parties regarding this case. The State of Michigan's Model Child Abuse Protocol, which instructs Multi-Disciplinary Teams on how to cooperate and conduct joint investigations, was not utilized.

Interviews with law enforcement investigators revealed they did not know about the state's model child abuse protocol. The interviews confirmed that law enforcement investigators had very limited communication with CPS concerning [redacted] and his injuries. Interviews revealed the investigating law enforcement agency was unaware of Dr. Norat's concerns for non-accidental trauma causing [redacted]'s injuries. They were also unaware [redacted] had a broken arm during the investigation. The investigating law enforcement agency closed their case citing a lack of disclosure indicating child abuse during [redacted]'s forensic interview and there was an impression that DPD was investigating the incident that caused [redacted]'s injuries. The OCO investigation shows that DPD was not involved in [redacted]'s case.

The OCO was informed that had law enforcement been aware of [redacted]'s involvement in the home, a criminal background check would have been completed. The criminal background check would have shown [redacted]'s extensive violent history, and likely would have led to more questioning surrounding this incident. [redacted]'s public criminal history included Felony Assault with a Dangerous Weapon (2019), Felony Criminal Sexual Conduct (2019) Felony Unlawful Imprisonment (2019), Felony Assault with Intent to do Great Bodily Harm Less than Murder by Strangulation (2019), Misdemeanor Domestic Violence and/or Knowingly Assaulting a Pregnant Individual (2019) and Felony Torture (2019).

During this investigation professionals from both law enforcement and CPS informed the OCO the process for notifying law enforcement through a LEN is ineffective. Currently, a LEN is sent via email or fax to the law enforcement agency with perceived jurisdiction. When the jurisdiction is unknown, the LEN is sent to multiple agencies, which is what occurred in this case. A LEN was sent to both Wixom PD and DPD. It is documented in MiSACWIS that a LEN was faxed to DPD, however there is no physical evidence DPD received the LEN for this case. It was determined through the OCO's investigation that MDHHS employees are unaware that a LEN can be sent to the Michigan State Police (MSP) when the jurisdiction is unknown. In addition, mandated reporters from all teams, stated direct contact with the law enforcement agency receiving the LEN would assist with more appropriate response times. The OCO found that in many cases the faxed LEN is lost, and emailed LENs are overlooked. The result is a delayed response from a law enforcement agency.

In addition to the lack of communication between the multi-disciplinary team, there was also a lack of communication between Wayne County CPS and Oakland County CPS. No one from Oakland County CPS spoke with Dr. Norat to gain clarity regarding his medical assessment. The result was an inaccurate representation of Dr. Norat's comments to the Wayne County CPS specialist being found in the Oakland County investigation.

Death of [redacted] - CPS Case Summary:

[redacted] died in March 2022 as the result of child abuse. [redacted] was found to be the abuser who caused [redacted]'s death. Below is a summary of the death investigation and evidence found by the OCO during its review.

In reviewing the initial complaint dated March 5, 2022, called into MDHHS centralized intake from Providence Park Hospital, the complaint indicates [redacted] was found unresponsive by [redacted] The complaint also reported [redacted] had a rectal temperature of 85 degrees, roughly 13 degrees lower than the average normal temperature of a human being and was in cardiac arrest. Due to [redacted]'s injuries and critical condition, [redacted] was transferred to Mott Children's Hospital in Ann Arbor.

At Mott Children's Hospital several other injuries were observed which created suspicion of child abuse, so another complaint was made to MDHHS centralized intake detailing the injuries. The reported injuries were both new and old. New injuries noted were a "posterior skull fracture (acute), and a 4-millimeter subdural hematoma (brain bleed)". The old injuries identified were a "humeral fracture", and "4-5 old rib fractures". The rib fractures were documented as "healing" and did not appear to be due to chest compressions. The complaint stated [redacted]'s prognosis was unknown. An additional skeletal examination would be done to check for further injuries. [redacted] was intubated and unresponsive. The complaint to MDHHS centralized intake stated non-accidental trauma and child abuse was the suspected cause of [redacted]'s condition. The complaint stated the individual who caused [redacted]'s injuries was an "unknown boyfriend", and [redacted] was not at the home when [redacted] was found.

Mott Children's Hospital is located in Ann Arbor. Consequently, Washtenaw County CPS was assigned this investigation. Interviews that CPS conducted with hospital staff indicate [redacted]'s injuries appeared to be the result of blunt force trauma to the head. Hospital staff relayed to the CPS specialist statements that [redacted] gave to them when describing events at the home he shared with [redacted] told hospital staff [redacted] was brushing his teeth and he ([redacted] heard a thud, found [redacted] unresponsive and attempted to wake him up by placing him into cold water and tapping him on the face. [redacted] also relayed [redacted] urinated and defecated on himself. Hospital staff also shared statements made by responding law enforcement officers that [redacted] waited an hour to contact law enforcement after he found [redacted]

When interviewed [redacted] provided the following information to CPS. [redacted] stated that she was at work at the time of the incident and told CPS her children were left with [redacted] explained that she started having [redacted] watch the children more after [redacted]s bowel injury (October 2021 CPS investigation) as she believed those injuries happened at her mother's home. [redacted] denied knowing [redacted] had a broken arm or broken ribs and stated he never complained of pain near his ribs.

Due to the suspicion of child abuse being involved, CPS spoke to Mott Children's Hospital Child Protection Team (CPT) nurse practitioner [redacted] and CPT physician, Dr. Bethany Mohr. According to Dr. Mohr's statement, [redacted] gave her a version of events that conflicted from the version of events she had previously provided to CPS. Dr. Mohr stated [redacted]'s injury could not have occurred simply by falling on the tub, but the injuries were possible if [redacted]'s head was slammed on the side of the tub. Dr. Mohr expressed heightened concern due to [redacted]'s other injuries. The CPT believed that it was highly unlikely [redacted] would survive his injuries and added that he was hypothermic when he arrived at the hospital.

[redacted] died from his injuries on March 10, 2022.

Following his death, the CPS investigation transferred to Oakland County CPS as this is where [redacted]'s injuries occurred and where the family resided. A new CPS complaint was also made to centralized intake regarding [redacted]'s other biological children with [redacted]. [redacted] and her children with [redacted] reside in Macomb County. Due to this complaint Macomb County CPS interviewed [redacted] During this investigation Oakland County CPS was made

aware that [redacted] was previously in a relationship with [redacted] for twelve years, [redacted] was extremely violent during their relationship, and she was the victim in a criminal case of domestic violence and sexual assault in Wayne County. [redacted] identified [redacted] as the individual charged with these crimes. There was a no contact order in place, and [redacted] had not physically seen the children in several years, however she allowed phone contact at her discretion.

It is important to note that [redacted] was arrested on December 4, 2019, and incarcerated in the Wayne County Jail due to the domestic and sexual assault of [redacted] At the time of his arrest in December of 2019, he was on circuit court probation after pleading guilty to feloniously assaulting [redacted] in June of 2019. Due to the COVID-19 pandemic, [redacted] was released from jail in June of 2020 on a $5,000 personal bond with a GPS tether. The Wayne County Prosecutor argued against [redacted]'s release which was denied by the court[2]. After his release [redacted] became involved with [redacted] and [redacted] and fathered [redacted]

A home visit was conducted at [redacted]'s residence following [redacted]'s death. During this home visit CPS and [redacted] discussed the intestine injury from October 2021. [redacted] explained that she believed it came from her three-year-old cousin who was extremely rough. [redacted] was asked if a medical professional confirmed this narrative as a plausible explanation and she said no. She explained that a safety plan was in place during that investigation, and [redacted] had an interview at the Care House, where he denied physical abuse. She denied being aware of the outcome of this investigation. [redacted] and CPS also spoke about [redacted]'s broken arm in November of 2021. [redacted] explained that she was at work when [redacted] sustained his broken arm, adding that [redacted] was in the care of [redacted]

[redacted] was interviewed by CPS in jail. [redacted] and CPS discussed the October 2021 investigation. [redacted] informed CPS he and [redacted] noticed [redacted]'s stomach was swollen during a bath which led [redacted] to take [redacted] to the hospital "a few days later". During this interview [redacted] told CPS he took [redacted] to the Care House interview with [redacted] This is the first time it was made known that [redacted] accompanied [redacted] a child abuse victim, to the forensic interview at Care House. [redacted] and CPS also discussed [redacted]'s explanation for the cause of [redacted]'s broken arm in November 2021. [redacted] admitted to being the cause of [redacted] falling down the stairs (which caused [redacted]'s broken arm) but explained it was accidental. He denied intentionally pushing [redacted] believed that the other child's ([redacted]'s cousin) "continuous aggressive treatment of [redacted] led to [redacted]'s equilibrium being off and that this led to him constantly falling and hitting his head since September of 2021. [redacted] gave a version of events to describe how [redacted] sustained the injuries in March 2022 which eventually caused [redacted]'s death, explaining [redacted] fell and hit his head on the tub. He believed his fall was a result of [redacted] being in constant confusion due to "continuous beatings" by the other child at the grandmother's home. [redacted] did admit [redacted] only took [redacted] to his grandmother's house for care one more time after October 2021 and because of this [redacted] became the sole caretaker of [redacted] and [redacted] ([redacted]'s sister), while [redacted] was at work.

Due to the results of the child abuse investigation CPS filed a petition for the removal and termination of parental rights of [redacted] from both [redacted] and [redacted]

CPS appropriately concluded [redacted]'s death investigation as a Category I. A preponderance of evidence was found supporting physical abuse of [redacted] by [redacted] failure to protect and improper supervision of [redacted] by [redacted] and improper supervision and threatened harm of [redacted] by

[2] "Releasing dangerous convicts due to COVID backlogs; new case getting new scrutiny" WXYZ Detroit News, March 14, 2022, https://www.wxyz.com/news/releasing-dangerous-convicts-due-to-covid-backlogs-new-case-getting-new-scrutiny

[redacted] and [redacted] Court records show [redacted] was arrested for homicide-felony murder and one count of felony child abuse in the 1st degree.

Law and Policy Research:

Research was conducted into states outside of Michigan and how the respective child welfare entities and law enforcement interact. The OCO located foundationally sound policies in Tennessee and New York.

The State of New York CPS manual[3] requires CPS to "immediately give telephone notice and forward a copy of the report to the appropriate local law enforcement agency when CPS receives a report that contains any of the following:

- Allegations of suspected physical injury by other than accidental means which causes or creates a substantial risk of death, serious or protracted disfigurement, protracted impairment of physical or emotional health, or protracted loss or impairment of the function of any bodily organ;
- Allegations of sexual abuse of a child; or
- Allegations of the death of a child".

This requirement is also codified in New York law; "If the local child protective services determines that local law enforcement shall be given notice, they shall give telephone notice and immediately forward a copy of the reports to local law enforcement"[4].

The State of Tennessee Department of Children's Services (DCS) administrative policies and procedures manual 14.6[5] states:

> "The Child Protective Investigation Team (CPIT) serves as the statutorily mandated Multi-Disciplinary Team (MDT) in Tennessee. DCS uses the MDT approach during investigations of severe child abuse to ensure completion of a strategic and thorough investigation, as well as providing child victims with the needed supports to ensure their safety."

The Tennessee DCS manual further states that each CPIT be composed of one staff member from DCS CPS, one representative from the Office of the District Attorney General, one juvenile court officer or investigator from a court of competent jurisdiction, one law enforcement officer with countywide jurisdiction, and the director of the children's advocacy center or designee. The CPIT is required to immediately convene per local protocols to discuss and develop a case strategy. The CPIT also determines investigative tasks and assigns responsibility to team members. Tennessee also provides the CPIT a form (cs-0561[6]) to aid in the coordination of the child abuse investigation.

In both the State of New York and the State of Tennessee the child abuse investigator with the state's respective CPS agency is required to physically speak with members of the MDT. In both states this requirement is specifically to speak with and develop investigative strategies with the investigating law enforcement agency.

MCL 722.628(3) requires MDHHS to seek the assistance of and cooperate with law enforcement officials within 24 hours after becoming aware of the following:

- Child abuse or child neglect is the suspected cause of a child's death.

[3] New York State Child Protective Services Manual: Chapter 6
[4] NY Soc Serv L § 424
[5] State of Tennessee DCS Policy and Procedure Manual 14.6
[6] Tennessee DCS cs-0561 form

- The child is the victim of suspected sexual abuse or sexual exploitation.
- Child abuse or child neglect resulting in serious physical harm to the child.
- Law enforcement intervention is necessary for the protection of the child, a department employee, or another person involved in the investigation.
- The alleged perpetrator of the child's injury is not a person responsible for the child's health or welfare.
- The child has been exposed to or had contact with methamphetamine production.

MCL 722.628(4) requires law enforcement officials to cooperate with the department when conducting these types of investigations. This subsection also states, "The department and law enforcement officials must conduct investigations in compliance with the protocols adopted and implemented as required by subsection (6).". MCL 722.628(6) requires the department and each county prosecutor to develop a protocol for involving law enforcement officials and CACs, as appropriate, in the above listed child welfare investigations.

MDHHS CPS policy manual, PSM 712-3 only requires the department to notify law enforcement officials. Additionally, the CPS policy manual states:

> "In addition to the situations requiring a referral to law enforcement and the prosecuting attorney in this policy item, the case manager must also seek assistance from law enforcement for any referral in which it is necessary for the protection of the child(ren), a department employee, or another person involved in the investigation; MCL 722.628(3).
>
> Case managers must make efforts to coordinate and communicate with law enforcement in mutually conducted investigations."

Although Michigan law requires the department and the county prosecutor to develop protocols for a coordinated investigation, the MDHHS CPS manual does not appear to require a coordinated investigation. The manual guides case managers to "…make efforts to coordinate and communicate…" with law enforcement officials.

Factual Findings:

Introduction:
The ombudsman shall prepare a report of the factual findings of an investigation and make recommendations to the department or the child placing agency if the ombudsman finds 1 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 ombudsman believes the findings should be further considered by the department, and additional actions by MDHHS and other child welfare partners are necessary.

Findings:

1. The OCO finds [redacted]'s perforated bowel and bruised liver, were the result of non-accidental trauma in October 2021.

2. The OCO finds MCL 722.628 requires the department to "…seek the assistance of and cooperate with law enforcement officials…" and must conduct investigations in coordination with law enforcement officials, as directed by the county child abuse and neglect protocol.

3. The OCO finds PSM 712-3, Coordination with prosecuting attorney and law Enforcement requires MDHHS CPS to notify law enforcement within 24 hours regarding complaints involving acts that constitute 1st, 2nd, 3rd, or 4th degree child abuse, severe physical injury, and allegations including sex crimes, methamphetamine production and abuse/neglect alleged by someone not responsible.

4. MDHHS Publication 794, A Model Child Abuse Protocol Utilizing a Multidisciplinary Team Approach, states CPS must coordinate investigative efforts with law enforcement and other MDT members by using a coordinated investigative team.

5. The OCO finds there was an overall breakdown of the multi-disciplinary team during the October 2021 CPS physical abuse investigation into [redacted]'s intestine and liver injuries.

   The OCO finds there has been a significant breakdown in the use of the multi-disciplinary teams across the State of Michigan. As a result, teams are not working together properly, and child abuse is being missed. [redacted]'s death is an example of a worst-case scenario when the required agencies do not work as a multi-disciplinary team.

6. The OCO found the CPS investigation into the cause of [redacted]'s October 2021 injuries was insufficient.

7. The OCO finds law and/or policy in other states requires CPS to inform law enforcement officials through verbal communication in cases involving severe physical injury, child death, physical abuse, and sexual abuse related complaints.

   a. MCL 722.628, PSM 712-3, and the State of Michigan's Model Child Abuse Protocol does not mandate law enforcement as a member of the Multi-Disciplinary Team.

   b. MCL 722.628, PSM 712-3, and the State of Michigan's Model Child Abuse Protocol does not mandate verbal communication between CPS and the investigating law enforcement entity or individuals.

8. The OCO finds that in cases where it is unknown what jurisdiction the incident occurred in, PSM 712-3 provides no guidance to case specialists on what agency or agencies should receive the LEN.

9. The OCO finds [redacted]'s parental rights of his biological children remain intact because those children are not related to [redacted]'s parental rights remain intact despite his involvement in [redacted]'s abuse and subsequent death.

   MCL 722.638, mandates a petition for termination of parental rights (TPR) in cases of severe physical abuse, murder, abandonment, torture, and sexual abuse, of the abused child or siblings of the abused child, however the law does not contemplate biological children of the abuser when those children are not related to the child victim.

Recommendations:

The children's ombudsman recently made similar findings and recommendations concerning the breakdown of the MDT and policy surrounding medical assessments through OCO investigation 2020-0440 and the 2022 Office of Children's Ombudsman annual report.

1. The OCO recommends county prosecuting attorneys, or their designee, conduct regular MDT meetings to increase communication among members. The OCO has seen positive outcomes when the MDT is actively involved in case-by-case decision-making to facilitate and support the work of its members. The MDT should include members of law enforcement, medical personnel, mental health personnel, and Child Advocacy Centers.

    a. The OCO recommends the Michigan Legislature amend Child Protection Law, MCL 722.628(6), to require that, as the lead criminal investigators, law enforcement be added to the MDT, along with the prosecuting attorney and the department.

    b. The OCO recommends the Michigan Legislature provide funding for MDHHS to hire individuals who serve as liaisons to the MDT for each county MDHHS office. Liaison duties could include but are not limited to, serving as a bridge between MDT members, assisting the MDT leader in facilitating monthly MDT case review meetings, collaboration with MDHHS central office on policy changes, and actively participate in the investigation as an advisor to the MDT when the child presents with abnormal or suspicious bruising or injury, severe injury, sexual assault, or death.

2. The OCO recommends MDHHS require local county directors develop processes in coordination with the local MDT.

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

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

    c. Invite medical practitioners involved in child abuse and neglect cases to MDT meetings and case reviews.

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

3. The Children's Ombudsman recommends the Legislature amend MCL 722.628 to require, in addition to sending a LEN, in person or phone contact with law enforcement officials within the same 24 hours currently required for LEN submission. The purpose of the in person or phone contact will be to discuss the circumstances that required the LEN.

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

5. The Children's Ombudsman recommends the legislature amend MCL 722.638 to require a petition for termination of parental rights when an individual is found responsible for, abandonment of a young child, criminal sexual conduct involving penetration, attempted penetration, or assault with intent to penetrate, battering, torture, or other serious physical

harm, loss or serious impairment of an organ or limb, life threatening injury, and/or murder or attempted murder when the person responsible has rights to other children who are not the victim child or a sibling of the victim child.

Conclusion:

Under authority pursuant to The Children's Ombudsman Act, MCL 722.903, the OCO respectfully submits this findings and recommendations report.

It is important that the matters addressed in this report be further considered by MDHHS, the Michigan Legislature, prosecuting attorneys, and the Governor. 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 respond to this report. The published report will include any statement of reasonable length made to the OCO by MDHHS in defense or mitigation of the action.

Ryan Speidel
Children's Ombudsman
Office of Children's Ombudsman
111 S. Capitol Avenue
Lansing, Michigan 48933

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

November 2, 2023

Ryan Speidel, Director
Office of Children's Ombudsman
401 S. Washington Square
Lansing, MI 48933

Dear Mr. Speidel:

The following is the Michigan Department of Health and Human Services (MDHHS) response to the findings and recommendations from the Office of Children's Ombudsman (OCO) Report of Findings and Recommendations regarding [redacted] [redacted]

This report contains confidential information from a Children's Protective Services file. The Michigan Child Protection Law [MCL 722.627, section 7(3)] prohibits the release of this information to any individual/entity not authorized under Section 7(2) of the law. Pursuant to Section 13(3), release of this confidential information to an unauthorized individual/entity may subject you to criminal and/or civil penalties.

Findings:

1. The OCO finds [redacted]'s perforated bowel and bruised liver, were the result of non-accidental trauma in October 2021.

MDHHS Response to Finding 1: Agree.

2. The OCO finds MCL 722.628 requires the department to "…seek the assistance of and cooperate with law enforcement officials…" and must conduct investigations in coordination with law enforcement officials, as directed by the county child abuse and neglect protocol.

MDHHS Response to Finding 2: Agree.

3. The OCO finds PSM 712-3, Coordination with prosecuting attorney and law enforcement requires MDHHS CPS to notify law enforcement within 24 hours regarding complaints involving acts that constitute 1st, 2nd, 3rd, or 4th degree child abuse, severe physical injury, and allegations including sex crimes,

methamphetamine production and abuse/neglect alleged by someone not responsible.

MDHHS Response to Finding 3: Agree.

4. The OCO MDHHS Publication 794, A Model Child Abuse Protocol Utilizing a Multidisciplinary Team (MDT) Approach, states CPS must coordinate investigative efforts with law enforcement and other MDT members by using a coordinated investigative team.

MDHHS Response to Finding 4: Michigan Department of Health and Human Services (MDHHS) agrees that coordination with law enforcement is best practice, though MDHHS Publication 794, A Model Child Abuse Protocol Utilizing a Multidisciplinary Team Approach, Section VI-C, Utilizing a Multidisciplinary Team Approach does not mandate it.

5. The OCO finds there was an overall breakdown of the multi-disciplinary team during the October 2021 CPS physical abuse investigation into [redacted]'s intestine and liver injuries.

MDHHS Response to Finding 5: Agree, the local multidisciplinary team has recently reviewed and updated the Oakland County Child Abuse and Neglect Protocol and provides ongoing training to each of the multidisciplinary agency groups.

The OCO finds there has been a significant breakdown in the use of the multi-disciplinary teams across the State of Michigan. As a result, teams are not working together properly, and child abuse is being missed. [redacted]'s death is an example of a worst-case scenario when the required agencies do not work as a multi-disciplinary team.

MDHHS Response: Many multi-disciplinary teams across the State of Michigan are working collaboratively and effectively to identify and address child abuse and neglect. MDHHS recognizes the importance of timely and effective MDT collaboration and is actively working with local offices across the state to continue enhancing their MDT processes and partnerships.

6. The OCO found the CPS investigation into the cause of [redacted]'s October 2021 injuries was insufficient.

MDHHS Response to Finding 6: Agree, although CPS missed or delayed in certain investigative steps, the department followed through on critical actions

to ensure child safety. CPS made contact with the local child abuse expert at Children's Hospital to determine his assessment of the child's injuries, requested a second opinion, and coordinated with law enforcement to complete a forensic interview of the child at the local Child Advocacy Center. Doctors completed a thorough examination of the other child including a skeletal exam. Additionally, to maintain the safety of the sibling, CPS implemented a safety plan during the investigation by having a relative move into the mother's home to provide additional oversight and supervision. Since this investigation, DHHS has implemented a statewide Critical Case Review Process.

7. The OCO finds law and/or policy in other states requires CPS to inform law enforcement officials through verbal communication in cases involving severe physical injury, child death, physical abuse, and sexual abuse related complaints.

    a. MCL 722.628, PSM 712-3, and the State of Michigan's Model Child Abuse Protocol does not mandate law enforcement as a member of the Multi-Disciplinary Team.

    b. MCL 722.628, PSM 712-3, and the State of Michigan's Model Child Abuse Protocol does not mandate verbal communication between CPS and the investigating law enforcement entity or individuals.

MDHHS Response to Finding 7: Agree.

8. The OCO finds that in cases where it is unknown what jurisdiction the incident occurred in, PSM 712-3 provides no guidance to case specialists on what agency or agencies should receive the LEN.

MDHHS Response to Finding 8: Agree, MDHHS will update policy to provide guidance to case managers when it is unknown what jurisdiction an incident occurred in, and what agency/agencies should receive the LEN.

9. The OCO finds [redacted]'s parental rights of his biological children remain intact because those children are not related to [redacted] [redacted]'s parental rights remain intact despite his involvement in [redacted]'s abuse and subsequent death.

    MCL 722.638, mandates a petition for termination of parental rights (TPR) in cases of severe physical abuse, murder, abandonment, torture, and sexual abuse, of the abused child or siblings of the abused child, however the law does not contemplate biological children of the abuser when those children are not related to the child victim.

MDHHS Response to Finding 9: Agree.

Recommendations:

The children's ombudsman recently made similar findings and recommendations concerning the breakdown of the MDT and policy surrounding medical assessments through OCO investigation 2020-0440 and the 2022 Office of Children's Ombudsman annual report.

1. The OCO recommends county prosecuting attorneys, or their designee, conduct regular MDT meetings to increase communication among members. The OCO has seen positive outcomes when the MDT is actively involved in case-by-case decision-making to facilitate and support the work of its members. The MDT should include members of law enforcement, medical personnel, mental health personnel, and Child Advocacy Centers.

    a. The OCO recommends the Michigan Legislature amend Child Protection Law, MCL 722.628(6), to require that, as the lead criminal investigators, law enforcement be added to the MDT, along with the prosecuting attorney and the department.

    b. The OCO recommends the Michigan Legislature provide funding for MDHHS to hire individuals who serve as liaisons to the MDT for each county MDHHS office. Liaison duties could include but are not limited to, serving as a bridge between MDT members, assisting the MDT leader in facilitating monthly MDT case review meetings, collaboration with MDHHS central office on policy changes, and actively participate in the investigation as an advisor to the MDT when the child presents with abnormal or suspicious bruising or injury, severe injury, sexual assault, or death.

MDHHS Response to Recommendation 1a-b: MDHHS agrees and will always work with its law enforcement and legislative partners on any funding or policy that will improve child protection.

2. The OCO recommends MDHHS require local county directors develop processes in coordination with the local MDT

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

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

c. Invite medical practitioners involved in child abuse and neglect cases to MDT meetings and case reviews.

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

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

3. The Children's Ombudsman recommends the Legislature amend MCL 722.628 to require, in addition to sending a LEN, in person or phone contact with law enforcement officials within the same 24 hours currently required for LEN submission. The purpose of the in person or phone contact will be to discuss the circumstances that required the LEN.

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

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

MDHHS Response to Recommendation 4: PSM 712-3, Coordination with Prosecuting Attorney and Law Enforcement, outlines required collaboration between CPS and law enforcement, including efforts to coordinate and communicate with law enforcement in mutually conducted investigations, how

to handle delays in starting an investigation, and when to request law enforcement reports. Collaboration between CPS and law enforcement is clearly outlined in department policy and is sufficient for investigative purposes.

5. The Children's Ombudsman recommends the legislature amend MCL 722.638 to require a petition for termination of parental rights when an individual is found responsible for, abandonment of a young child, criminal sexual conduct involving penetration, attempted penetration, or assault with intent to penetrate, battering, torture, or other serious physical harm, loss or serious impairment of an organ or limb, life threatening injury, and/or murder or attempted murder when the person responsible has rights to other children who are not the victim child or a sibling of the victim child.

MDHHS Response to Recommendation 5: MDHHS will work with our legislative partners to ensure a legislative change of this nature falls under the purview of CPS and has no unintended consequences.

Conclusion:

Under authority pursuant to The Children's Ombudsman Act, MCL 722.903, the OCO respectfully submits this findings and recommendations report.

As the Children's Ombudsman, it is important that the matters addressed in this report be further considered by MDHHS, the Michigan Legislature, and the Governor. If implemented, these recommendations will effectuate positive change and improve the lives of similarly situated children involved in Michigan's child welfare system.

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

Thank you for the opportunity to respond to this Report of Findings and Recommendations. If you have questions or concerns, please feel free to contact me.

Sincerely,

Demetrius Starling, Senior Deputy Director
Children's Services Administration