Office of the Auditor General
Performance Audit Report

Children's Protective Services Investigations

Michigan Department of Health and Human Services

September 2018

State of Michigan Auditor General
Doug A. Ringler, CPA, CIA

431-1285-16

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

Article IV, Section 53 of the Michigan Constitution

OAG
Office of the Auditor General

Report Summary

Performance Audit
Children's Protective Services (CPS) Investigations
Michigan Department of Health and Human Services (MDHHS)

Report Number:
431-1285-16

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Michigan's Child Protection Law (CPL) requires that MDHHS investigate allegations of child abuse and/or neglect (CA/N). MDHHS's CPS investigators are responsible for conducting CPS field investigations in compliance with CPL and MDHHS policy requirements and taking appropriate action(s) to ensure the child's safety. Investigators are compelled to follow these requirements to help ensure that (1) allegations of CA/N are promptly and appropriately addressed, (2) the current safety and future risk of harm to a child are properly assessed, (3) appropriate protective interventions are put in place, and (4) preponderance of evidence conclusions are supported by a systematic and objective examination of facts and evidence. CPS investigators completed approximately 206,000 investigations between May 1, 2014 and July 31, 2016, and determined that a preponderance of evidence of CA/N existed in 26% of investigations.

Audit Objective	Conclusion
Objective #1: To assess the sufficiency of MDHHS's efforts to ensure the appropriate and consistent application of selected CPS investigation requirements.	Not sufficient

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS did not appropriately commence 17% of reviewed investigations within the CPL-required 24-hour time frame. MDHHS cited differences in interpretation of the law with the OAG regarding the requirement and application of MDHHS policy for over one-third of the exceptions noted (Finding #1).	X		Partially agrees
MDHHS could not support that investigators conducted Central Registry clearances for all required individuals in over 70% of the investigations reviewed (Finding #2).	X		Partially agrees
Investigators did not complete required criminal history checks for over 50% of the investigations reviewed (Finding #3).	X		Agrees
MDHHS could not support that investigators had conducted a complete CPS history review for family and household members in approximately 40% of the investigations reviewed (Finding #4).	X		Agrees

Findings Related to This Audit Objective (*Continued*)	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS could not support that the required contact with mandated reporters had occurred in over 30% of reviewed investigations. MDHHS also could not support that it provided the mandated reporter with written notification of MDHHS's disposition in nearly 70% of reviewed investigations (Finding #5).	X		Agrees
Investigators' face-to-face contact with alleged child victims was not within required time frames in 11% of reviewed investigations, averaging 6.4 days late (Finding #6).	X		Agrees
Investigators did not document required interviews of children, or the reason(s) why an interview was not conducted, in 7% of reviewed investigations. Investigators also did not document verification of the safety and whereabouts of all children in 13% of reviewed investigations (Finding #7).		X	Agrees
MDHHS could not support that initial safety planning had occurred or that it was not needed in 33% of reviewed investigations. Also, investigators' safety assessments were not complete or accurate for 7% of reviewed investigations and, on average, were not completed until 25 days after the initial contact with families (Finding #8).	X		Partially agrees
Required court petitions were not submitted by MDHHS in accordance with the CPL in 10% of reviewed investigations (Finding #9).	X		Agrees
MDHHS did not refer investigations to the county prosecuting attorney, as required, for 50% of reviewed investigations (Finding #10).	X		Agrees
Required sibling placement evaluations were not completed in 80% of the relevant investigations reviewed to document how a child remained safe in the perpetrator's care when another sibling(s) had been removed from the perpetrator's care (Finding #11).		X	Agrees
Required medical examinations of children were not obtained in over 15% of reviewed investigations, nor did MDHHS document the reasons why the medical examinations were not obtained (Finding #12).		X	Agrees
MDHHS did not accurately assess the risk of future harm to children in over 35% of reviewed investigations. These inaccuracies led to improper category classification and Central Registry omissions for 8 investigations in our sample (Finding #13).	X		Agrees
MDHHS did not conduct impact assessments for Michigan Statewide Automated Child Welfare Information System (MiSACWIS) risk assessment functionality changes. We identified over 6,000 previously completed investigations with incorrect risk levels and nearly 24,000 other investigations with potentially incorrect risk levels (Finding #14).	X		Agrees
Investigators did not complete required child and family needs and strengths assessments for nearly 20% of reviewed investigations (Finding #15).		X	Agrees

Findings Related to This Audit Objective (*Continued*)	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS did not complete nearly 30% of reviewed investigations within required time frames, ranging from 1 day to 8 months late and averaging 44 days late (Finding #16).	X		Agrees
Ineffective supervisory review of investigations significantly contributed to deficiencies reported in 15 findings, 11 of which are considered to be material conditions. Also, CPS supervisors did not review 18% of reviewed investigations within 14 calendar days and could not support that required case consultations occurred with investigators for 15% of reviewed investigations (Finding #17).	X		Agrees
MDHHS did not monitor families' participation in post-investigative services for nearly 22,000 investigations and therefore could not determine whether these families received and participated in the services intended to alleviate the child's risk level for CA/N (Finding #18).	X		Disagrees
Clarification of MDHHS policy and guidance provided to CPS investigators is needed for properly classifying investigations when MDHHS has filed a court petition and subsequent evidence does not support that CA/N occurred. Misclassification can impact Central Registry decisions, post-investigative service provision, and the accuracy of CPS history records (Finding #19).		X	Partially agrees
We identified 257 confirmed perpetrators of CA/N that MDHHS did not add to the Central Registry as required by the CPL (Finding #20).	X		Agrees
MDHHS could not support that it provided notification to perpetrators that their names had been added to the Central Registry for over 40% of reviewed investigations (Finding #21).	X		Agrees
Amendatory legislation is needed to add unlicensed Child Development and Care (CDC) Program child care providers to Section 8d(3) of the CPL to provide MDHHS with the statutory authority to include unlicensed CDC providers in the Central Registry when MDHHS identifies these individuals as perpetrators of CA/N in Category III CPS investigations (Finding #22).		X	Disagrees
CPS investigators were not required to complete an investigation checklist when conducting abbreviated CPS investigations, nor did MDHHS ensure that local county office directors always conducted a review of abbreviated investigations, when necessary, prior to closing the investigation (Finding #23).		X	Partially agrees

Observations Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
Our survey of CPS investigators indicated that a majority of the over 800 respondents had concerns regarding their physical safety while conducting CPS investigations (Observation #1).	Not applicable for observations.		
No statutory requirement exists for centralized oversight to ensure that an appropriate CA/N investigation protocol has been implemented in all Michigan counties (Observation #2).	Not applicable for observations.		
Standardizing commonly used policy terminology would increase MDHHS's assurance that CPS investigation requirements are carried out in a consistent, systematic, and objective manner (Observation #3).	Not applicable for observations.		

Audit Objective	Conclusion
Objective #2: To determine the effectiveness of MDHHS's efforts to accurately capture data used to report its compliance with selected CPS investigation timeliness requirements.	Moderately effective

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS did not capture complete, accurate, and/or valid investigation commencement data for 26% of reviewed investigations (Finding #24).	X		Agrees

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September 6, 2018

Mr. Nick Lyon, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Dear Mr. Lyon:

This is our performance audit report on Children's Protective Services Investigations, Michigan Department of Health and Human Services.

We organize our findings and observations by audit objective. Your agency provided preliminary responses to the recommendations at the end of our fieldwork. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and to submit it within 60 days of the date above to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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CHILDREN'S PROTECTIVE SERVICES INVESTIGATIONS

AUDIT OBJECTIVES, CONCLUSIONS, FINDINGS, AND OBSERVATIONS

APPROPRIATE AND CONSISTENT APPLICATION OF SELECTED CPS INVESTIGATION REQUIREMENTS

BACKGROUND

The care and safety of children* are basic responsibilities entrusted first and foremost to the children's parents according to the Child Welfare League of America* (CWLA) publication entitled *CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families*. The publication states that federal and state governments further protect children by legally mandating creation of a system to respond to allegations of harm to children and to protect children from abuse and neglect at the hands of those responsible for their care. In addition, keeping children safe from child abuse* and child neglect* is the foundation on which child protective services was established and is the first goal of any child protective services response.

The Michigan Department of Health and Human Services' (MDHHS's) Children's Protective Services (CPS) program is responsible for investigating allegations of child abuse and/or neglect (CA/N). Michigan's Child Protection Law* (CPL) and MDHHS policy provide the framework and requirements for the CPS program to carry out its field investigations. CPS investigators are compelled to follow these requirements to help ensure that (1) allegations of CA/N are promptly and appropriately addressed, (2) the current safety and future risk of harm to a child are properly assessed, (3) appropriate protective interventions are put in place, and (4) preponderance of evidence* conclusions are supported by a systematic and objective examination of facts and evidence.

During the CPS field investigation process, investigators are required to perform investigatory steps that include, but are not limited to:

- Commencing the investigation within 24 hours of complaint* receipt to assess the safety of the alleged child victim.
- Communicating with mandated reporters.
- Conducting face-to-face interviews with the alleged child victim(s), the alleged perpetrator(s), and other specified individuals.
- Viewing the home environment and verifying the safety and whereabouts of children.
- Reviewing criminal and CPS history of alleged perpetrators and other applicable adults.

** See glossary at end of report for definition.*

- Reviewing applicable and relevant documents, such as police reports, medical records, etc.

- Completing assessments of child safety and family needs and strengths.

- Referring required investigations to law enforcement and/or the county prosecuting attorney.

- Completing the investigation within 30 days.

Upon completion of a CPS investigation, the CPL requires MDHHS to determine if there is a preponderance of evidence that CA/N occurred, to assess the future risk of harm to the child, to classify the investigation into one of five specified categories, and to take any necessary required action(s) as follows:

- Category I - There ***is a preponderance of evidence*** of child abuse or neglect and a ***court petition is needed or required***. MDHHS shall open a protective services case to provide necessary services to the family and list the perpetrator(s) on the Central Registry*.

- Category II - There ***is a preponderance of evidence*** of child abuse or neglect and the risk assessment* indicates a ***high or intensive risk*** of future harm to the child. MDHHS shall open a protective services case to provide necessary services to the family and list the perpetrator(s) on the Central Registry.

- Category III - There ***is a preponderance of evidence*** of child abuse or neglect and the risk assessment indicates a ***low or moderate risk*** of future harm to the child. MDHHS shall assist the family in receiving community-based services.

- Category IV - There ***is not a preponderance of evidence*** of child abuse or neglect but the risk assessment indicates that there is future risk of harm to the child. MDHHS shall assist the child's family in voluntarily participating in community-based services.

- Category V - There is ***no evidence*** of child abuse or neglect.

All CPS investigators are directly overseen by a CPS supervisor. The supervisor is responsible for reviewing and approving the investigation and indicating agreement with the thoroughness, completeness, and accuracy of the investigation; the disposition of the investigation; the assessment of risk and safety of the children; the assessment of the family and/or child's needs and strengths; and the services provided to the family.

** See glossary at end of report for definition.*

The Michigan Statewide Automated Child Welfare Information System (MiSACWIS) is integral to the CPS investigation process. MDHHS utilizes MiSACWIS to assign and track CPS investigations, to document investigation activities and conclusions, to complete risk and safety assessments, and to add perpetrators to the Central Registry, when required. In addition to electronic MiSACWIS case records, MDHHS also maintains some hard-copy CPS case records. MDHHS's hard-copy CPS case records typically contain documentation of previously completed CPS investigations for the family, criminal history results, medical reports, MDHHS's interactions with the court and law enforcement, photographs, and other information pertinent to the investigation and resulting decisions.

MDHHS's CPS investigators completed approximately 206,000 CPS investigations between May 1, 2014 and July 31, 2016.

AUDIT OBJECTIVE

To assess the sufficiency of MDHHS's efforts to ensure the appropriate and consistent application of selected CPS investigation requirements.

CONCLUSION

Not sufficient.

FACTORS IMPACTING CONCLUSION

- The material conditions* related to deficiencies in:
    - Commencing CPS investigations within required time frames (Finding #1).
    - Documenting the performance of required Central Registry clearances (Finding #2).
    - Completing required criminal history checks (Finding #3).
    - Documenting complete reviews of CPS history for family and household members (Finding #4).
    - Documenting required communications with mandated reporters (Finding #5).
    - Completing face-to-face contact with alleged child victims within required time frames (Finding #6).
    - Documenting safety planning and completing accurate and timely safety assessments (Finding #8).
    - Filing required court petitions (Finding #9).
    - Referring investigations to the applicable county prosecuting attorney, when required (Finding #10).

** See glossary at end of report for definition.*

- Accurately assessing the risk of future harm to children (Finding #13).
- Performing impact assessments for MiSACWIS risk assessment functionality changes (Finding #14).
- Completing investigations within required time frames (Finding #16).
- Performing supervisory review of investigations (Finding #17).
- Monitoring families' participation in post-investigative services for Category III investigations (Finding #18).
- Adding confirmed perpetrators to the Central Registry (Finding #20).
- Notifying individuals who were added to the Central Registry (Finding #21).

- The reportable conditions* related to:
  - Documenting interviews of children or the reason(s) why interviews were not conducted and documenting verification of the safety and whereabouts of children (Finding #7).
  - Completing sibling placement evaluations (Finding #11).
  - Obtaining required medical examinations of children (Finding #12).
  - Completing child and family needs and strengths assessments (Finding #15).
  - Providing clarification and guidance for classifying investigations when a court petition is filed and the investigation evidence subsequently does not support that CA/N occurred (Finding #19).
  - Seeking amendatory legislation to add unlicensed Child Development and Care (CDC) Program child care providers to the CPL (Finding #22).
  - Completing the investigation checklist for abbreviated investigations (Finding #23).
- MDHHS ensured that investigators conducted the required face-to-face interviews with alleged perpetrators of CA/N for 94% of the investigations reviewed.
- MDHHS ensured that the required home visit(s) were performed for 97% of the investigations reviewed.

** See glossary at end of report for definition.*

FINDING #1

A MATERIAL CONDITION

Improvement needed to ensure that investigations are commenced in a timely manner.

MDHHS did not appropriately commence 17% of selected investigations within 24 hours of complaint receipt.

MDHHS did not always commence CPS investigations of suspected CA/N within required time frames. Timely commencement is essential because the primary and most immediate concern upon assignment of an investigation is to assess whether an alleged child victim is safe, pending face-to-face contact with the child.

MDHHS did not appropriately commence 27 (17%) of 160 selected CPS investigations within 24 hours after receiving reports of CA/N. The 27 investigations included 50 alleged child victims:

- MDHHS did not complete any commencement action or make face-to-face contact with 1 of the alleged victims.
- MDHHS's completion of commencement activity was an average of 31 hours (1.3 days) late for the remaining 49 alleged victims.

In addition, we reviewed another complaint that came to our attention ancillary to our selected investigations. We noted that MDHHS did not take any commencement action(s) or make face-to-face contact with the 2 alleged victims. MDHHS also did not conduct an investigation of the alleged CA/N of the children. MDHHS was unable to provide an explanation of why these actions did not occur.

MDHHS concurred with our conclusion for 16 of the 27 selected investigations. However, MDHHS disagreed with the conclusion for the other 11 because of interpretation differences with the Office of the Auditor General (OAG) related to the need for MDHHS to obtain information to assess the safety of alleged child victim(s) and when commencement occurs for complaints with multiple alleged victims.

The OAG used the following criteria to evaluate MDHHS's commencement of investigations:

- Section 8(1) of the CPL states: "Within 24 hours after receiving a report made under this act, the department . . . shall ***commence*** an investigation of ***the*** child suspected of being abused or neglected." [Emphasis added.]
- The Implementation, Sustainability, and Exit Plan* (ISEP) required MDHHS to commence all investigations of reported child abuse or neglect within the time frames required by State law.
- MDHHS policy in effect during the audit period ***defined commencement*** as contact with someone other than the reporting person within 24 hours of the receipt of the complaint ***to assess the safety*** of ***the*** alleged child victim.

** See glossary at end of report for definition.*

Policy also stated that an acceptable contact is an individual with ***direct knowledge that is relevant to the issues in the complaint*** and the information can be used to assess ***the*** alleged child victim's ***safety***.

MDHHS informed us that its interpretation of the CPL commencement requirement does not require investigators to:

- Garner information to assess the safety of the alleged victim(s).
- Carry out commencement activities for ***all*** of the alleged victims on a complaint within 24 hours.

Therefore, MDHHS contends that the exception rate in the 160 selected investigations was 10% rather than 17%.

In its interpretation of the CPL requirement to commence an investigation of "**the**" child suspected of being abused or neglected, MDHHS believes that it is not required to carry out commencement activities for **all** of the alleged victims on a complaint within 24 hours. MDHHS also believes that it has fulfilled the requirement upon completion of a single commencement activity within 24 hours. MDHHS maintains this belief even in situations when the complaint includes multiple alleged victims and the completed commencement activity does not extend to or impact all of the alleged child victims.

We contend that MDHHS's interpretation of the CPL commencement requirement likely does not reflect the law's intent with regard to commencing investigations of ***all*** children within 24 hours who are reported to MDHHS as suspected of being abused or neglected. In addition, MDHHS's stated position regarding the need for it to obtain information to assess the safety of alleged victims as a part of commencement directly contradicts its policy that was in effect during our audit period.

The table below provides an illustrative example to demonstrate the effect of applying the differing interpretations to ascertain MDHHS's compliance with the CPL 24-hour commencement requirement:

Illustrative Example
In one investigation, the allegations indicated that a child and his belongings consistently smelled of animal urine and feces because of unsanitary conditions in the child's home. ► This child and 3 additional siblings were identified in the complaint as suspected victims of physical neglect. ► MDHHS's single commencement activity within 24 hours of receiving the complaint was contact with the school counselor regarding 1 of the siblings. The counselor did not discuss the other 3 siblings who attended other schools. ► After contacting the counselor, MDHHS contacted the teacher of 1 of the 3 siblings within 24 hours; however, there was no discussion regarding the other 2 siblings. ► MDHHS's only other successful contact within 24 hours of receiving this complaint was with the reporting source.

MDHHS's Interpretation of the CPL Requirement and MDHHS Policy	The OAG's Interpretation of the CPL Requirement and MDHHS Policy
MDHHS considered this investigation to be appropriately commenced and in compliance with the CPL 24-hour requirement upon the investigator's contact with the school counselor, even though the contact provided no information to MDHHS regarding the 3 siblings who were also suspected of being physically neglected.	The OAG considered this investigation to not be in compliance with the CPL 24-hour requirement for commencement because MDHHS did not make a contact(s) within 24 hours of receiving the complaint to assess the safety of 2 of the siblings suspected of being physically neglected.
See Exhibit #4, Investigation Example Case #5, for additional details related to this investigation.	

The application of the differing interpretations to assess MDHHS's compliance with the CPL 24-hour requirement resulted in some of the exceptions noted in this finding. For the remaining exceptions, CPS investigators typically did not document explanations for untimely commencement contacts within the investigation files that we reviewed. However, our survey of over 750 CPS investigators found that 63% of the respondents felt as though their CPS caseload negatively impacted their ability to conduct investigations in compliance with MDHHS policy, and 55% responded that this happened at least half of the time (see Exhibit #3, Questions #21 and #22).

We consider this finding to be a material condition because of the importance of timely commencement in assessing an alleged child victim's safety, pending face-to-face contact with the child, and the exception rate range of 10% to 17% noted in our selected investigations.

RECOMMENDATIONS

We recommend that MDHHS commence CPS investigations of suspected CA/N within required time frames.

We also recommend that MDHHS seek legislative clarification to validate its interpretation of, and compliance with, the Section 8(1) CPL commencement requirement.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS partially agrees.

MDHHS agrees that 16 investigations did not begin within 24 hours as required and that beginning an investigation timely is important. However, MDHHS does not agree that a legislative clarification of the term commencement is needed. In practice,

commence has consistently meant "to begin" or "to start" an investigation within 24 hours. Oftentimes, an investigation involves multiple household children and the investigation must begin within 24 hours of receiving the complaint. During an investigation, CPS will complete a thorough assessment of each child by seeing and interviewing each child, speaking to all caregivers, gathering and examining evidence pertinent to each child, etc. MDHHS policy provides greater guidance to staff outlining the steps that must be taken to thoroughly assess the safety and wellbeing of each child over the course of the roughly 30-day investigation. In addition, MDHHS recently updated policy to ensure that it reflects current practice. Since January 2016, MDHHS has exceeded 90% statewide compliance with the requirement that CPS investigations start within 24 hours.

MSA 8	*1/1/15 - 6/30/15*	*85%*
ISEP 9	*7/1/15 -12/31/15*	*85.6%*
ISEP 10	*1/1/16 -6/30/16*	*92%*
ISEP 11	*7/1/16 -12/31/16*	*92.3%*

FINDING #2

A MATERIAL CONDITION

Considerable improvement needed in MDHHS's documentation of Central Registry clearances.

MDHHS did not always document its performance of a Central Registry clearance for all required individuals associated with a CPS investigation. Conducting Central Registry clearances helps investigators determine whether an alleged child victim is in a potentially unsafe situation with an individual(s) that has previously been confirmed to be a perpetrator of CA/N.

MDHHS policy requires CPS investigators to conduct a Central Registry clearance of parents or persons responsible and all persons listed on the complaint who are 18 years of age or older. Policy also requires Central Registry clearances of nonparent adults known to spend significant time with the family and who have substantial and regular contact with the child.

Investigators did not document performance of all required Central Registry clearances for over 70% of the investigations reviewed.

We reviewed 156 selected CPS investigations that required Central Registry clearances and noted that investigators did not document performance of a required Central Registry clearance for 262 individuals associated with 112 (72%) of the investigations. The 262 individuals included:

- 63 alleged perpetrators.
- 105 other adults residing in the home or spending a significant amount of time with the alleged victim(s).
- 89 alleged victims' parents.
- 5 alleged victims' parents' significant others that lived in the home.

During our review, we conducted a Central Registry clearance for 236 of these individuals and determined that 25 (11%) were named in the Central Registry as a confirmed perpetrator of CA/N. We further noted that 13 of the 25 individuals were listed in the Central Registry as a confirmed perpetrator for two or more previous CPS investigations. MDHHS's CPS investigation documentation did not contain sufficient detail for the 26 remaining individuals, such as full name and date of birth, to allow us to perform a Central Registry clearance and, therefore, it is undeterminable whether these 26 individuals were listed in the Central Registry.

Investigators relied on Centralized Intake and their own CPS history checks. However, 80% of the individuals lacking a Central Registry clearance were not known to Centralized Intake staff, and investigators' CPS history checks were deficient in approximately 40% of the investigations reviewed (see Finding #4).

CPS investigators often relied on MDHHS's Centralized Intake to perform Central Registry clearances at the time that Centralized Intake received a CPS complaint. However, Centralized Intake often did not have complete information regarding all investigation participants at the time of the complaint and CPS investigators often identified additional individuals during the investigation process after the complaint was received. We determined that only 20% of the 262 noted individuals were known to Centralized Intake at the time of the complaint. MDHHS also informed us that investigators may have relied on information from a MiSACWIS CPS history records check rather than performing the required Central Registry clearances; however, our review of investigators' performance of MiSACWIS CPS history records checks noted

deficiencies in approximately 40% of the investigations we reviewed (see Finding #4). In addition, MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct these deficiencies (see Finding #17).

We consider this finding to be a material condition because of the:

- Significant exception rate.
- Potential impact on child safety when MDHHS fails to identify that persons with substantial and regular contact with a child are previously confirmed perpetrators of CA/N.
- Lack of documentation, which is significant because, without proof that clearances occurred, MDHHS may be unable to support its actions and decisions if subsequently questioned or challenged and, for auditing purposes, we must presume that the clearances did not occur.
- Frequency in which MDHHS lacked documentation of complete and thorough CPS history records checks, which would have served as a compensating control for missing Central Registry clearances (see Finding #4).

RECOMMENDATION

We recommend that MDHHS document its performance of a Central Registry clearance for all required individuals associated with a CPS investigation.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that improvements can be made to increase consistency in documenting clearance checks. MDHHS disagrees that a prominent relationship exists between documenting a Central Registry clearance and assessing a family's history and child safety. Lack of documentation of the clearance does not mean the clearances were not completed, or that CPS was not aware of relevant history. The accumulation of facts and evidence collected during an investigation direct the outcome of the investigation, the assessment of child safety and risk, and interventions provided.

In February 2018, the Children's Services Agency (CSA) sent a statewide Communication Issuance outlining implementation strategies to increase uniformity in documentation. The communication directs child welfare staff to document completion of a Central Registry clearance on all adult case members within the Child Welfare History and Trends section of MiSACWIS, and within a social work contact, who a Central Registry clearance was completed for and the results of that clearance. In April 2018, a system change request was made to re-format the CPS Investigation Report, to improve the readability and increase accuracy in worker documentation and supervisory review. A

specific request included the addition of fields within MiSACWIS in the Child Welfare History and Trends section for Central Registry Clearances and Results to guide workers further in their documentation.

FINDING #3

A MATERIAL CONDITION

Considerable improvement needed in completion of required criminal history checks.

MDHHS did not always complete a criminal history check for all required individuals when conducting investigations of CA/N. Obtaining criminal history information enables the investigator to evaluate both child safety and worker safety issues (see Observation #1).

We reviewed 102 CPS investigations that required a Law Enforcement Information Network* (LEIN) check to be completed for at least one individual. We determined that investigators did not conduct LEIN checks for all required individuals in 53 (52%) of the 102 investigations, pertaining to 143 individuals. These individuals included:

Investigators did not conduct LEIN checks for all required individuals in over 50% of selected investigations.

- 40 alleged perpetrators.
- 39 alleged victims' non-perpetrator parents.
- 6 parents' significant others that lived in the home.
- 58 other household members or persons responsible for the child's health and welfare*.

We obtained information from MDHHS's investigation documentation and matched it with MSP criminal history record information to assess the criminal histories of the 143 individuals:

Our review of MSP criminal history information indicated that 26% of the individuals for whom MDHHS did not conduct a LEIN check had a felony and/or a misdemeanor conviction recorded prior to the investigation.

- MSP criminal history record information indicated 54 felony and 119 misdemeanor convictions that occurred prior to the investigation for 37 (26%) of the individuals based on an exact match of name, date of birth, and social security number. These convictions included, but were not limited to, the following:
    - 1 felony child abuse conviction.
    - 5 felony and 1 misdemeanor criminal sexual conduct convictions.
    - 3 felony and 8 misdemeanor assault convictions.
    - 3 felony and 13 misdemeanor domestic violence convictions.
    - 6 felony and 1 misdemeanor weapons convictions.
    - 8 felony and 15 misdemeanor drug related convictions.
- MSP criminal history record information indicated no felony or misdemeanor convictions for 92 (64%) of the individuals.

** See glossary at end of report for definition.*

- MDHHS did not maintain sufficient identity information in its investigation records, such as the individual's full name and date of birth, to allow for a criminal history record check of the 14 (10%) remaining individuals.

MDHHS policy in place during the audit period required investigators to:

- Complete a criminal history check using the LEIN for "all parents, person(s) responsible for the health and welfare of the child, and all household members for all sexual abuse, physical abuse, suspected caretaker substance abuse, drug-exposed infant cases, methamphetamine production allegations, and cases where domestic violence may be present."

- Evaluate the information obtained for risk and decision-making regarding the safety of the children and to give particularly close attention to information which indicates that the parent(s) or adult(s) was involved in violent behavior, or convicted of crimes against persons (including children), or crimes against self, including substance abuse. In addition, sexual abuse, physical abuse, and domestic violence convictions must also be closely examined to determine risk.

- Complete a LEIN check prior to contact with a family in situations in which MDHHS has documented a risk that leads to reasonable apprehension regarding the safety of performing a home visit. Policy recommends that all LEIN checks be completed and evaluated by the investigating worker prior to making contact with a family to enable the worker to evaluate both child safety issues and worker safety issues.

MDHHS informed us that CPS investigators may not have always had a thorough understanding of MDHHS's policy for conducting criminal history checks for investigations. In addition, MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct the deficiencies (see Finding #17).

We consider this finding to be a material condition because of the considerable exception rate and the impact on the investigator's ability to identify and evaluate criminal history that could pose significant risks to the safety of the alleged child victim and/or the investigator.

RECOMMENDATION

We recommend that MDHHS complete a criminal history check for all required individuals when conducting investigations of CA/N.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that criminal history checks should be completed and validated against another source for all applicable individuals directly associated with an investigation. It is important to note that a prior criminal conviction is one piece of information used when investigating the complaint allegations and is insufficient alone to reach a conclusion concerning parental capacity to provide a safe home and adequate food, clothing, shelter, and medical care.

MDHHS has addressed the identified errors with the involved field staff and the LEIN coordinator to determine what factors prevented compliance and the strategies that can be implemented to effectively increase compliance with policy.

Recent changes to policy and children's services resources are expected to result in improved compliance with LEIN access. In December of 2015, CPS Program Office hired a full-time LEIN coordinator whose full-time responsibility is to provide guidance and training to staff about access to and the use of LEIN. Policy was also amended in 2017 (finalized in 2018) to identify LEIN requirements more prominently, to ensure caseworkers are able to easily identify the requirements.

FINDING #4

A MATERIAL CONDITION

Documentation of a complete review of CPS history for family and household members needed.

MDHHS could not provide documentation to support that CPS investigators had conducted a complete review of CPS history for family and household members in approximately 40% of the investigations reviewed. Without these reviews, MDHHS cannot ensure that investigators are consistently assessing previous CPS investigation information for current relevance when determining the risks of harm to the child(ren).

MDHHS policy requires CPS investigators to conduct and document a thorough inquiry of family background, including a review of previous MDHHS case records on the family and household members (such as CPS records, foster care records, etc.). In addition, the *CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families* states that all child or family history of involvement with CPS or law enforcement should be reviewed and assessed for current relevance.

We examined MDHHS's investigation documentation and pertinent MiSACWIS CPS history records for 160 selected investigations. We noted:

MDHHS could not provide documentation of a complete review of CPS history for family and household members in approximately 40% of reviewed investigations.

a. In 65 (41%) investigations, investigators did not document a review of CPS history records for all family and household members. In these instances, documentation was missing to support a CPS history review for at least one of the family and/or household members.

b. In 58 (36%) investigations, investigators did not document a review of all previous CPS involvement for the family and household members. In these instances, the documentation indicated that the investigator had reviewed some of the pertinent CPS history but had not reviewed all previous CPS involvements for one or more family and/or household members.

c. In 38 (24%) of the investigations, both of the conditions in parts a. and b. existed and the documentation simultaneously lacked support for a review of MDHHS's CPS history for at least one family and/or household member and previous CPS involvement for at least one other family and/or household member.

MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to ensure that investigators had conducted a complete review of CPS history for family and household members (see Finding #17).

We consider this finding to be a material condition because of the:

- Significant exception rates.
- Importance of CPS history in evaluating the current and future risk of harm to the child and determining appropriate protecting interventions.

- Lack of documentation, which is significant because, without proof that the reviews occurred, MDHHS may be unable to support its actions and decisions if subsequently questioned or challenged and, for auditing purposes, we must presume that the reviews did not occur.

- Over 70% exception rate noted in MDHHS's documentation of required Central Registry clearances, which would have helped investigators identify some CPS history for those individuals that had been previously confirmed as a perpetrator (see Finding #2).

RECOMMENDATION

We recommend that MDHHS maintain documentation to support that CPS investigators conducted a complete review of CPS history for family and household members.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that investigators must consistently document the steps they took to review and summarize the family's history.

Consistent documentation in MiSACWIS was discussed with county administration. Local administrators and managers will determine strategies to increase consistent compliance with documentation requirements.

The department is developing changes to the electronic investigation report format that will likely increase compliance with documentation requirements. By modifying the CPS history and trends fields, the reports will become more readable and potentially increase the likelihood that supervisors will detect documentation omissions during their review. The changes intend to provide a more comprehensive understanding of a family's CPS history, prior service provision and progress, and safety and risk concerns.

In November 2017, a system change request was made to improve person search/case history search functionality within the application to improve the field's ability to navigate and document a family or child's child welfare history. This enhancement will improve the user's ability to view child welfare history and provide an at-a-glance comprehensive view of history. A project charter and requirements document for person search/case history enhancement has been completed and approved. Design sessions began in August 2018, with changes made incrementally over the subsequent several months.

FINDING #5

A MATERIAL CONDITION

Significant improvement needed in MDHHS's documentation of communication with mandated reporters.

MDHHS did not always document that it had contacted mandated reporters to obtain additional information and to clarify and verify the information that MDHHS received in the reporters' CA/N complaints. Also, MDHHS did not consistently document that it provided the mandated reporters with written notification of its disposition of the investigation that resulted from the reporters' complaints.

The MDHHS *Mandated Reporters' Resource Guide* states that mandated reporters are an essential part of the child protection system because they have an enhanced capacity, through their expertise and direct contact with children, to identify suspected CA/N. The Guide also states that CA/N reports made by mandated reporters are confirmed at nearly double the rate of those made by non-mandated reporters. Therefore, MDHHS's further contact with the mandated reporter is important to ensure that the CPS investigator collects all relevant evidence.

The CPL mandates that certain professionals report information to MDHHS if they suspect CA/N. These professionals include, but are not limited to, physicians, dentists, nurses, family therapists, teachers, social workers, and law enforcement officers. When a mandated reporter has reasonable cause to suspect CA/N, the CPL requires that these individuals immediately make an oral report to MDHHS.

We reviewed 119 CPS investigations initiated by mandated reporters' complaints during our audit period. These 119 investigations included 4 abbreviated investigations that did not require the CPS investigator to contact the mandated reporter other than providing the reporter with a notification of the disposition of the investigation. We noted:

Mandated reporters were not contacted for additional information in over 30% of reviewed investigations.

a. The CPS investigator did not document successful contact with the mandated reporter for additional information in 38 (33%) of the 115 CPS investigations. In 25 of these instances, the investigators did not document that they had made any attempts to contact the mandated reporter. Investigators documented only 1 unsuccessful attempt in 11 instances and multiple unsuccessful attempts in 2 instances.

   MDHHS policy requires that when a complaint is received from a mandated reporter, the assigned CPS investigator must make contact with the reporter for additional information or for clarification/verification of information received in the complaint.

   The CPS investigation process included controls intended to identify CPS investigation deficiencies. These included the use of the CPS investigation checklist, as required by the CPL, and supervisory oversight. However, neither of these controls prevented, detected, or corrected the CPS investigators' lack of documented contact with the mandated reporters for these investigations. See

Finding #17 related to deficiencies in MDHHS supervisory oversight intended to ensure compliance with investigation requirements.

Investigators did not document that written notification of the investigation disposition was provided to the mandated reporter for nearly 70% of reviewed investigations.

b. The CPS investigator did not document that written notification of the disposition of the CPS investigation was provided to the mandated reporter for 82 (69%) of 119 investigations reviewed.

   The CPL requires MDHHS to inform the mandated reporter in writing of its disposition of the CPS investigation that results from the reporter's complaint. This communication is important because a mandated reporter may have an established and ongoing relationship with the child victim and could potentially serve as a safety net once CPS is no longer involved with the family.

   MDHHS's CPS investigation checklist did not include an item for a disposition notification to a mandated reporter, and MDHHS policy did not clearly require CPS investigators to maintain documentation in the casefile to support that the CPS investigator sent the mandated reporter a notification of the investigation disposition. In addition, MDHHS's MiSACWIS application did not retain a log or a copy of the disposition notification letter when generated.

We consider this finding to be a material condition because of the:

- Significant exception rates.
- Noncompliance with CPL requirements.
- Essential part that mandated reporters play in the child protection system, considering that mandated reporter complaints are confirmed at a rate that is nearly double that of non-mandated reporters.
- Lack of documentation, which is significant because, without proof that the communications occurred, MDHHS may be unable to support its actions and decisions if subsequently questioned or challenged and, for auditing purposes, we must presume that the communications did not occur.

RECOMMENDATIONS

We recommend that MDHHS document that it has contacted mandated reporters to obtain additional information and to clarify and verify the information that MDHHS receives in the reporters' CA/N complaints.

We also recommend that MDHHS consistently document that it provided the mandated reporters with written notification of its disposition of the investigation that resulted from the reporters' complaints.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that it should document its contact with mandated reports and consistently document that it provided mandated reporters written notification of disposition.

In February 2018, CSA sent a statewide Communication Issuance outlining implementation strategies to increase uniformity in documentation. This communication directs child welfare staff to document in a social work contact, a summary of the discussion with the mandated reporting source to gather additional information/clarification. The communication directs staff to, at the submission of disposition, print the DHS-1224 (Complaint Source Notification Letter) and document within a social work contact that the notification was sent via mail. Efforts are underway to amend policy to clarify these requirements.

FINDING #6

A MATERIAL CONDITION

Improvement needed in completing timely face-to-face contact with alleged child victims.

In 11% of reviewed investigations, investigators did not make face-to-face contact with alleged child victims within the required time frames.

MDHHS did not consistently make face-to-face contact with alleged child victims within the required time frames. Timely face-to-face contact helps MDHHS determine the immediate safety of alleged victims of CA/N and ensure that prompt protective interventions are provided when needed.

MDHHS policy requires that the CPS investigator make face-to-face contact with all alleged child victims within 24- or 72-hour time frames, depending on the risk to the child, to ensure the immediate safety of the child and initiate any necessary protecting interventions.

We reviewed 160 investigations representing 269 alleged child victims and noted that investigators did not make face-to-face contact with 25 alleged child victims within the required time frames for 18 (11%) of the investigations:

- Face-to-face contact was not made with 2 of the alleged child victims.
- Face-to-face contact with the alleged child victim was 128 days late in 1 instance and averaged 6.4 days late for the remaining 22 alleged victims.

Illustrative Example
In one investigation, the complaint alleged that a mother had locked her teenaged child out of the home because of behavioral issues and would not allow the child back into the home. This complaint required the CPS investigator to make face-to-face contact with the alleged child victim within 24 hours because of MDHHS's initial assessment of posing immediate danger of harm to the child. The CPS investigator attempted to verify the safety of the child through an unannounced home visit 16 hours after the complaint was received and was informed that the mother had taken the child to a local hospital to seek treatment. The CPS investigator's next attempted contact with this child was at the hospital 4 days after the home visit.

CPS investigators did not typically document explanations for untimely face-to-face contacts within the files we reviewed. However, our survey of over 750 CPS investigators found that 63% of respondents felt as though their CPS caseload negatively impacted their ability to conduct investigations in compliance with MDHHS policy, and 55% responded that this happened at least half of the time (see Exhibit #3, Questions #21 and #22).

We consider this finding to be a material condition because of the critical role that timely face-to-face contact has in determining the immediate safety of an alleged victim of CA/N and the frequency and substantial average number of days late of untimely face-to-face contact with alleged victims.

RECOMMENDATION

We recommend that MDHHS consistently make face-to-face contact with all alleged child victims within required time frames.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that face-to-face contact did not occur timely in 18 cases. Making timely face-to-face contact with involved children is consistently an area of strength for the department and the cases reviewed by the OAG confirmed an 89% compliance rate with this requirement.

Face-to-face contact standards are closely monitored by Child Welfare Administration, Business Service Center (BSC) Directors and Staff, County Directors, District and Program Managers, First Line Supervisors and CPS Investigators through use of MDHHS's Data Warehouse tools, including Business Objects and Book of Business, as well as the Monthly Management Report which consistently shows steady improvement and recent performance above 90%.

Statewide compliance with face-to-face contact standards for CPS investigations (approximately 90,000 – 93,000 per year) has improved over the past three years as illustrated below.

	Statewide compliance with CPS investigation face-to-face standard of promptness
2015	*81%*
2016	*89%*
2017	*92%*

For the 18 cases identified by the OAG, each instance was addressed with the applicable local office staff and management to identify factor(s) that may have contributed to each delay and ways to overcome those factors in the future. Based upon feedback received from field and policy staff, strategies to improve practice will include: a more targeted focus on local office culture, increased access to quality supervision and supports, and local continuous quality improvement efforts.

FINDING #7

A REPORTABLE CONDITION

Improved documentation of investigators' efforts to interview and verify the safety and whereabouts of all children is needed.

MDHHS should improve its documentation of CPS investigators' efforts to interview all children in the home during a CPS investigation, including the reason(s) why the investigator did not interview all children. MDHHS should also improve its documentation to support that CPS investigators consistently verified the safety and whereabouts of all children, including those children who resided in another location.

MDHHS policy states that CPS investigators must interview all children in the home following the Forensic Interviewing Protocol and document the content of the interview(s) or document the reasons why an interview was not conducted in the investigation report. The State of Michigan Governor's Task Force on Child Abuse and Neglect and MDHHS's Forensic Interviewing Protocol explains that the goal of an interview with a child is to obtain a statement from the child that will support accurate and fair decision-making. In addition, MDHHS policy requires investigators to verify the safety and whereabouts of all children, including children who reside in another location.

We reviewed MDHHS's documentation of interviews and verifications of the safety and whereabouts of children for 156 selected investigations. We noted:

Investigators did not document interviews or verification of safety and whereabouts for all children in 7% and 13% of reviewed investigations, respectively.

a. CPS investigators did not document an interview, or the reason(s) why an interview was not conducted, for 17 children in the home associated with 11 (7%) of the 156 CPS investigations.

b. CPS investigators did not document their verification of the safety and whereabouts of 35 children associated with 20 (13%) of 156 CPS investigations.

Illustrative Example
In one investigation, the complaint alleged that an infant was present during a domestic violence incident between the child's mother and father. Early in the investigation, the CPS investigator determined that the mother was previously confirmed as a perpetrator of CA/N and had her parental rights terminated for 5 other children because of chronic homelessness and that she was currently out-of-state with the infant following the domestic violence incident. The investigator made phone contact with the mother and she stated that she and the child were now living in California with family members and that the child was doing well. Phone contact with the mother was the CPS investigator's only documented contact to verify the safety and the whereabouts of the child. The CPS investigator did not document any other successful collateral contacts with anyone with firsthand knowledge to verify the child's safety and whereabouts, or indicate that the investigator requested assistance from California CPS or other California authorities to verify the safety and/or whereabouts of the child.
See Exhibit #4, Investigation Example Case #1, for additional details related to this investigation.

MDHHS's lack of documentation is significant because, without proof that these events occurred, MDHHS may be unable to support its actions and decisions if subsequently questioned or challenged and, for auditing purposes, we must presume that the events did not occur.

MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct the deficiencies in the investigator's documentation of interviews and verification of the safety and whereabouts of all applicable children (see Finding #17).

RECOMMENDATIONS

We recommend that MDHHS improve its documentation of CPS investigators' efforts to interview all children in the home during a CPS investigation, including the reason(s) why the investigator did not interview all children.

We also recommend that MDHHS improve its documentation to support that CPS investigators consistently verify the safety and whereabouts of all children, including those children who reside in another location.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that documentation of actions taken during an investigation is important to create an accurate and thorough CPS record.

In each case identified, CSA program office staff met with affected county directors and program managers to discuss this finding. Local staff agreed to review factors that may have resulted in lack of documentation and implement steps to mitigate those factors.

The department has addressed the importance of documentation with all county offices statewide and the role of the supervisor in assuring it occurs, including issuing a statewide communication in February 2018 emphasizing the requirements and offering strategies to improve documentation. County offices will review their local practices and oversight processes to assure they support policy compliance and timely correction when missteps are detected.

FINDING #8

A MATERIAL CONDITION

Documentation of safety planning at initial contact with family and completion, accuracy, and timeliness of safety assessments need improvement.

CPS investigators did not consistently document that a safety plan had been established during the ***initial contact*** with families under investigation of CA/N or document why one was not needed. Also, CPS investigators need to improve the completion, accuracy, and timeliness of safety assessments.

Although safety planning is a continuous process throughout the entire investigation, initiating and documenting an appropriate plan ***at the onset*** of each investigation helps immediately eliminate or mitigate threats to a child's safety using the least intrusive means possible. In addition, accurate and timely completion of safety assessments helps facilitate the evaluation of the child's safety against all relevant safety factors and determine whether appropriate protective interventions are in place to protect the child.

MDHHS has identified child safety assessment and planning as a priority for all child welfare staff.

MDHHS identified child safety assessment and planning as a priority for all child welfare staff to ensure safety within all placement settings. To address this priority, MDHHS training indicates that appropriate safety assessment and planning are the heart of the investigators' work and that investigators fail to meet their charge as children's service workers if they do not first, and always, assess the immediate safety needs of the children and families they are trained to protect.

In addition, *Child Protective Services: A Guide for Caseworkers*, issued by the Administration for Children and Families, U.S. Department of Health and Human Services, indicates that CPS records should factually document what CPS does in terms of assessment and intervention, including clear documentation of ***initial*** decisions with respect to risk assessment and safety evaluation and reasons for continued agency involvement or for terminating services.

We reviewed MDHHS's documentation of safety planning established during ***initial contact*** with families under investigation and the safety assessment(s) for 156 selected CPS investigations and noted:

MDHHS lacked documentation of immediate safety planning during the ***initial contact*** with the family for 33% of reviewed investigations.

a. Investigators did not document an ***immediate*** safety plan during the ***initial contact*** with the family, or document why the plan was not necessary, for 52 (33%) of the investigations reviewed.

   MDHHS's mandatory training instructs CPS investigators that safety planning must be documented within the investigation report and should be documented when face-to-face contact occurs with the family. MDHHS's training explains that safety planning addresses immediate concerns and is a plan of specific actions that family members are willing and prepared to take in order to prevent or respond to foreseeable safety or risk issues.

Illustrative Example
In one investigation, the allegation indicated that the mother of a newborn was mentally unstable, was verbally abusive, and did not have stable housing. During the investigator's initial face-to-face contact with the mother, she verified that she had untreated mental health issues and unstable housing. However, the documented investigation evidence does not support that an immediate safety plan was established to address these safety risks for the child. Seven days after the initial face-to-face interview with the mother, the CPS investigator filed a petition for removal of the child and the mother was court-ordered not to be alone with the newborn.

MDHHS had not established policy that reinforced the training it provided to CPS investigators regarding their responsibility for the development and documentation of safety plans to address the immediate safety needs of children. The *CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families* states that a child protection agency should have policies, procedures, and assessment tools to assist CPS staff that have ***initial*** contact with the child and family with determining if the child is safe.

Safety assessments were not always complete or accurate.

b. Safety assessments were not always completed or accurate according to documented evidence within the case for 11 (7%) of the investigations:

   (1) There were no completed safety assessments documented for 3 of the investigations.

   (2) Investigators improperly included or excluded one or more safety factors according to the investigation casefile information for 8 investigations. Consequently, these 8 assessments indicated an incorrect level of safety for the child and 7 did not appropriately document current or planned protecting interventions to keep the child safe with regard to missing safety factors.

Illustrative Example
In one investigation, the CPS investigator selected no safety factors and concluded that the child was safe with no protecting interventions. However, the documented investigation evidence indicated that one of the child's caretakers suffered from substance abuse that seriously affected the caretaker's ability to supervise, protect, and care for the child. This required selection of a safety factor on the safety assessment, documentation of at least one protecting intervention in place, and explaining how the intervention protected the child.

MDHHS policy requires CPS investigators to:

- Assess 15 specified safety-related factors and to use the safety factor assessments, protecting interventions, and any other information known about the case to determine one of the three following safety assessment decisions:
    - Safe - No safety factors exist; child is safe.
    - Safe with services - At least one safety factor is indicated, and at least one protecting intervention has been put into place.
    - Unsafe - At least one safety factor is indicated, and the only possible protecting intervention is the removal of the child from the family.
- Describe the protecting intervention(s) that have been put in place or are immediately planned for any identified safety factors and to explain how each intervention protects (or protected) each child.

MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct these deficiencies (see Finding #17).

c. Investigators took an average of 25 days after the initial face-to-face contact with a family to complete a safety assessment for the 156 investigations. Completion of the assessments ranged from less than 1 day to 211 days.

On average, safety assessments were completed 25 days after the initial contact with a family.

MDHHS policy requires CPS investigators to complete a safety assessment as early as possible following the initial face-to-face contact but no later than the initial disposition of the investigation or when submitting a request for an extension of the 30-day investigation time frame.

We noted that MDHHS's policy for completion of safety assessments is somewhat contradictory regarding timeliness requirements. The policy instructed investigators to complete a safety assessment as early as possible following the initial face-to-face contact with the family while simultaneously allowing until the initial disposition or upon requesting an extension, which should typically occur around day 30 of the investigation, to do so.

We consider this finding to be a material condition because of the significant exception rate pertaining to safety planning and the possible negative impacts on child safety when appropriate safety

plans are not immediately put in place at the onset of an investigation. In addition, MDHHS's lack of documentation to support that safety planning occurred during the initial contact with the family is significant because, without proof that it occurred, MDHHS may be unable to support its actions and decisions if subsequently questioned or challenged and, for auditing purposes, we must presume that initial safety planning did not occur.

RECOMMENDATIONS

We recommend that CPS investigators consistently document that a safety plan has been established during the initial contact with families under investigation of CA/N or document why an immediate safety plan is not needed.

We also recommend that CPS investigators improve their completion, accuracy, and timeliness of safety assessments.

We further recommend that MDHHS establish a safety planning policy and clarify its policy for safety assessment timeliness requirements.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS partially agrees with the finding. While MDHHS consistently strives to improve to 100% in this critical area, assessing safety and timely completion of the safety assessment tool was an area of practice in which the department demonstrated strong compliance (93%).

Safety Planning

MDHHS disagrees with the OAG conclusion that safety planning did not occur in 37 of the cases identified. In many cases, no safety issues exist. In other cases, safety factors may not be apparent during the initial CPS contact but become evident during the course of the 30-day investigation. MDHHS reviewed each of the 52 cases and verified that in 37 cases safety planning occurred and was noted throughout the case, or the facts and circumstances of the case did not indicate safety planning was needed. In 15 cases, MDHHS agrees that documentation of safety planning or the fact it was not warranted was insufficient.

Assessing safety and safety planning are fundamental elements of every CPS investigation. Child welfare staff are trained to continuously assess, adjust, and document safety planning throughout an investigation, when facts and investigative evidence suggest that safety planning is warranted. To consistently improve and sustain good practice in this area, MDHHS implemented Safety by Design training and skill development in 2016 for all new hired staff, which focuses on safety planning. The training is also available to existing staff.

MDHHS policies 713-01 and 713-10 address continuous assessment of safety and safety planning. Policy will be

amended to provide clearer direction concerning continuous safety planning.

Safety Assessment Tool

MDHHS disagrees with the OAG concerns regarding timeliness of Tool completion. Policy allows for the tool to be completed any time prior to case disposition and the ability to accurately complete the tool depends on having and considering all relevant facts and evidence, which typically occurs closer to investigation completion. Policy will be clarified to reflect this approach.

Accurate completion of the Safety Assessment Tool during an investigation is an area of practice strength for the department, which is consistent with the 93% accuracy rate in the sample cases reviewed by the OAG. Because of the Tool's significance in directing case decisions, the Tool is presently being revalidated by the National Council on Crime and Delinquency. Further, the department is in the final stages of developing a peer to peer process by which a team of supervisors reviews investigations and Tool completion and provides feedback to improve practice.

FINDING #9

A MATERIAL CONDITION

Improvements needed to ensure compliance with CPL court petition filing requirements.

MDHHS did not always file court petitions when required by the CPL.

MDHHS, through its CPS investigations, draws conclusions regarding whether a child has been abused or neglected and is required to file petitions with the court in instances of severe CA/N. Filing petitions, as required, ensures that the court is provided its opportunity to determine the appropriate legal remedy to best ensure the child's safety, which may include removal of the child from the home, in-home jurisdiction, termination of parental rights, or removal of the perpetrator from the home.

The CPL requires MDHHS to submit a petition to the court in specified circumstances, such as, but not limited to, when MDHHS determines that a child victim was severely physically injured, sexually abused, or allowed to be exposed to or have contact with methamphetamine production and when the parent failed to protect the child from the abuse or exposure.

MDHHS did not comply with CPL court petition filing requirements for 10% of the investigations reviewed.

Of the 160 CPS investigations we reviewed, 20 investigations necessitated a petition to the court. However, MDHHS did not submit a petition in accordance with the CPL for 2 (10%) of these investigations.

In both investigations, the CPS investigator concluded that there was evidence that a male caretaker had perpetrated sexual abuse against the child, and the child's mother failed to protect the child from the sexual abuse. The CPL requires MDHHS to submit a petition pertaining to the mother's failure to protect in these circumstances; however, MDHHS did not file the petition for either investigation. In addition, we noted that MDHHS did not add two perpetrators to the Central Registry as required for one of these investigations because the investigation was not appropriately classified (see Finding #20 and Exhibit #4, Investigation Example Case #2, for additional details related to one of these investigations).

MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct these deficiencies (see Finding #17).

We consider this finding to be a material condition because of the importance of seeking the legal intervention of the court in instances of severe CA/N, as required by the CPL.

RECOMMENDATION

We recommend that MDHHS file court petitions when required by the CPL.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that court petitions need to be filed when required. In both cases identified, the Department notified law enforcement and assessed and verified child safety.

MDHHS consulted with the local office staff, supervisors and pertinent management staff to identify the factors that may have influenced practice. In both of the impacted counties, policy and law were reviewed with staff during local office meetings.

FINDING #10

A MATERIAL CONDITION

Significant improvements needed to ensure compliance with CPL-required referrals to county prosecuting attorneys.

In 50% of reviewed investigations, MDHHS did not appropriately make the referral to the county prosecuting attorney.

MDHHS did not always refer CPS Central Registry cases* to the applicable county prosecuting attorney when it determined that there was evidence of a child's death, serious physical injury, or sexual abuse or exploitation, as required by the CPL.

In our review of 160 CPS investigations, 6 Central Registry cases required referral to the county prosecuting attorney. In 3 (50%) instances, the CPS investigation concluded that a child had been sexually abused and MDHHS contacted law enforcement; however, MDHHS did not refer the cases to the applicable county prosecuting attorney. We noted that MDHHS did not appropriately classify one of these investigations as a Central Registry case. As a result, the case was neither properly referred to the prosecuting attorney nor was the perpetrator added to the Central Registry (see Finding #20).

The CPL requires that MDHHS refer all Central Registry cases involving a child's death, serious physical injury of a child, or sexual abuse or exploitation of a child to the county prosecuting attorney.

MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct these deficiencies (see Finding #17).

We consider this finding to be a material condition because of the significant exception rate and the potential safety impact to the child if appropriate legal action(s) is not pursued.

RECOMMENDATION

We recommend that MDHHS refer all CPS Central Registry cases to the applicable prosecuting attorney when it determines that there is evidence of a child's death, serious physical injury, or sexual abuse or exploitation.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that in 3 instances, documentation did not demonstrate whether MDHHS also sent a separate notice to the prosecuting attorney's office.

At the time each case was handled, the local MDHHS referred each case to law enforcement to determine whether a criminal investigation or additional action was appropriate. Most often, law enforcement makes those decisions in consultation with their prosecuting attorney's office.

To improve awareness and documentation of this requirement, CSA sent a statewide Communication Issuance in February 2018 to child welfare staff. Child welfare staff were directed to print and send the DHS-2164, Law Enforcement Complaint, to the

** See glossary at end of report for definition.*

Prosecuting Attorney in all applicable cases and to document that the form was sent. Further, staff were directed to provide a redacted copy of the completed CPS Investigation Report to the Prosecuting Attorney's Office to ensure compliance with the CPL requirement, and to document that action.

FINDING #11

A REPORTABLE CONDITION

Consistent completion of required sibling placement evaluations needs improvement.

A sibling placement evaluation was not completed for 8 (80%) of the 10 investigations reviewed.

MDHHS did not always complete the sibling placement evaluation, required by MDHHS policy, to document how a child remained safe in the perpetrator's care when another sibling(s) had been removed from the perpetrator's care. Without documentation, MDHHS may not adequately demonstrate that risk and safety concerns that have resulted in court actions for CA/N have been addressed in relation to the other siblings remaining in the home.

We reviewed 10 CPS investigations requiring the evaluation and noted that it was not completed for 8 (80%) of the investigations.

Illustrative Example
In one investigation, the investigator concluded that there was a preponderance of evidence that the parents had perpetrated improper supervision and classified the investigation as a Category II upon closure. Although one of the parents had two children previously removed from the parent's care in another state because of neglect, the CPS investigator did not complete a sibling placement evaluation to explain how the three children who were currently in this home were safe in relation to the specific issues that had led to the previous removal of the other siblings from this same parent.

MDHHS policy requires completion of the sibling placement evaluation form to explain how the remaining child is safe in the perpetrator's care when a child remains in the home and a sibling(s) has been removed.

MDHHS's lack of documentation is significant because, without proof that an evaluation occurred, MDHHS may be unable to support its actions and decisions if subsequently questioned or challenged and, for auditing purposes, we must presume that the evaluation did not occur.

The CPS investigation process included controls intended to identify CPS investigation deficiencies. These included the use of the CPS investigation checklist, as required by the CPL, and supervisory oversight. However, neither of these controls prevented, identified, or corrected the exceptions we noted for these investigations. See Finding #17 related to deficiencies in MDHHS supervisory oversight intended to ensure compliance with investigation requirements.

RECOMMENDATION

We recommend that MDHHS complete the required sibling placement evaluation to document how a child remains safe in the perpetrator's care when another sibling(s) has been removed from the perpetrator's care.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that it is required to document its determination when one child is removed from the home and others remain. Although the form was not used in the identified cases, MDHHS reviewed each case and verified that the assigned workers verified the safety and wellbeing of each child involved, with the exception of one, in which the parents took the child to California four days into the investigation.

MDHHS will assess the needs and practices of field staff to determine the utility of the form and whether alternative methods for documentation are more effective.

FINDING #12

A REPORTABLE CONDITION

Improvement needed in obtaining medical examinations for children or documenting why a medical examination was not obtained.

Investigators did not obtain required medical examinations for 18% of reviewed investigations, nor did they document why the medical examinations were not obtained.

MDHHS needs to improve its efforts to ensure that CPS investigators consistently obtain medical examinations for children when certain circumstances exist or document why a required medical examination was not obtained. Without a medical examination, investigators could be unaware of injuries that may not be apparent or obvious or of treatment needs when a child is too young, incapable, or too frightened to effectively communicate information about potential injuries to investigators.

We reviewed 160 CPS investigations that included 17 with circumstances that required medical examinations of children residing in the household. CPS investigators did not obtain medical examinations in 3 (18%) of the 17 investigations for 5 children nor did they document why the examinations were not obtained.

Illustrative Example
In one investigation, the complaint alleged that a child, who was less than 2 years old, was very thin and small for his age. There were two other siblings under the age of 8 living in the household. MDHHS policy requires a medical examination of the alleged victim and all other children in the household when there are allegations of malnourishment. However, the CPS investigator did not obtain medical examinations of any of the children associated with this investigation or document why.
See Exhibit #4, Investigation Example Case #4, for additional details related to this investigation.

MDHHS policy requires investigators to:

- Obtain a medical examination of alleged victims and any other children residing in the household when certain situations exist, for example:
    - Suspected child sexual abuse.
    - Signs of malnourishment or otherwise in need of medical treatment.
    - When a child has been exposed to or had contact with methamphetamine production.
    - When an infant who is not mobile has marks or bruises.
    - For children under the age of six or physically or developmentally disabled children with suspicious bruises, marks, or physical or medical needs that may not be met by the parents.
- Document why a medical examination was not completed if one is required.

The CPS investigation process included controls intended to identify CPS investigation deficiencies. These included the use of

the CPS investigation checklist, as required by the CPL, and supervisory oversight. However, neither of these controls prevented, identified, or corrected the weaknesses we noted for these investigations. See Finding #17 related to deficiencies in MDHHS supervisory oversight intended to ensure compliance with investigation requirements.

RECOMMENDATION

We recommend that MDHHS improve its efforts to ensure that CPS investigators consistently obtain medical examinations for children when certain circumstances exist or document why a required medical examination was not obtained.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that it needs to improve documentation when it determines that a medical examination is not needed and/or improve its consistency in requesting parents take their child for a medical examination when required. MDHHS reviewed the three investigations with the assigned investigators, supervisors and pertinent management staff in the applicable counties to identify the factors that led to the lack of documentation.

In February 2018, CSA sent a statewide Communication Issuance outlining implementation strategies to increase uniformity in documentation. This communication outlines specific actions for coordination of exams, records requests and documentation. In May 2018, Medical Examination and Assessment policy was updated, which further clarifies when to seek a medical examination and for which child(ren).

FINDING #13

A MATERIAL CONDITION

Significant improvement needed to ensure accurate assessment of the risk of future harm to children.

MDHHS did not always accurately assess the risk of future harm to children for CPS investigations. This assessment is pivotal because it directs key investigation decisions pertaining to post-investigative monitoring, including protecting interventions needed, service levels, and contact standards; the CPL classification of the investigation; and whether MDHHS must add a confirmed perpetrator of CA/N to the Central Registry.

The CPL requires MDHHS to use a structured decision-making (SDM) tool* (commonly referred to as the risk assessment tool) to measure the risk of future harm to a child and to classify each completed investigation as a Category I, II, III, IV, or V based on its investigation conclusions. MDHHS's SDM tool contains 22 questions. Investigators must respond to 15 questions based on gathered evidence, and MiSACWIS provides automatic responses for 7 questions based on the family's data entered into MiSACWIS. Investigator-provided responses address topics such as the caretaker's mental health, current abuse of substances, domestic violence history, and CA/N experienced as a child. MiSACWIS automatically populates responses for questions related to prior household and family member CPS involvement, the number of children in the household, and the age of the youngest child in the home. Based on the accumulated responses to the 22 questions, a numeric score is calculated and the risk level (intensive, high, moderate, or low) of future harm to the children is assessed. This assessed level and the investigator's conclusion of whether a preponderance of evidence of CA/N exists dictate the investigation category classification. The CPL requires MDHHS to add confirmed perpetrators of CA/N to the Central Registry in all investigations classified as Category I and II and certain Category III investigations.

An accurate assessment of the risk of future harm to a child is pivotal because it dictates several key investigation decisions and MDHHS's corresponding actions.

We reviewed the completed risk assessment tool for 156 investigations, in conjunction with other investigation documentation. We noted that the risk assessment tool was inaccurately completed because, in some instances, MiSACWIS incorrectly populated certain responses and the investigator did not make the necessary corrections and, in other instances, the investigator incorrectly responded to questions contrary to collected evidence. This resulted in improper risk-level assessments for 57 (37%) of the investigations as follows:

Investigators did not accurately complete the risk assessment tool for 57 (37%) investigations, resulting in improper risk-level assessments.

- For 46 investigations, the inaccuracies resulted in assessed risk levels that were too low. When the risk of future harm to a child is assessed too low, families may not receive adequate post-investigative monitoring and/or services to sufficiently address all relevant CA/N risk factors to reduce the risk. In addition, inappropriately low assessments can lead MDHHS to assign an improper category classification to the investigation which, in certain circumstances, can result in MDHHS not adding confirmed perpetrators of CA/N to the Central Registry when required by the CPL.

** See glossary at end of report for definition.*

- For 11 investigations, the inaccuracies in the risk assessment tool resulted in assessed risk levels that were too high. When the risk of future harm to a child is assessed too high, families may be subject to higher-than-needed levels of monitoring, such as additional face-to-face contacts with MDHHS, and receive services that are not warranted for the circumstances. Also, when a preponderance of evidence of CA/N is found in the investigation and the risk is assessed too high, there is a risk that MDHHS may assign a higher category classification to the investigation and inappropriately add the perpetrator to the Central Registry.

In 8 (14%) of the 57 investigations, improper risk levels led to the omission of the confirmed CA/N perpetrators from the Central Registry (see Finding #20).

The resulting improper risk levels led to an improper category classification for 8 (14%) of the 57 investigations. In these instances, MDHHS's moderate-risk level conclusion led MDHHS to assign a Category III classification to the investigation, thereby allowing for some, or no, monitoring and likely lesser service provision. However, our review determined that the associated investigation documentation supported a high-risk level, thus requiring a Category II classification for the investigations, post-investigative monitoring of the family, and the addition of 10 confirmed CA/N perpetrators to the Central Registry (see Finding #20).

We determined that underlying system coding caused MiSACWIS to often provide an inaccurate response for 6 of the 7 automatically generated responses and investigators did not always make the appropriate corrections. In addition, MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct the inaccurately assessed risk levels (see Finding #17).

We consider this finding to be a material condition because of the significant exception rate and the potential for negative implications on child safety resulting from inaccurate CPS investigation conclusions related to post-investigative monitoring and services, investigation category classification, and proper placement of known perpetrators on the Central Registry.

RECOMMENDATION

We recommend that MDHHS accurately assess the risk of future harm to children for CPS investigations.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees with the need for CPS to accurately assess risk of future harm to children during CPS investigations. To that end, MDHHS determined that errors in completion of the Risk Assessment Tool were chiefly the result of user error in scoring the tool.

The following has been implemented to address efforts to improve accuracy in Risk Assessment Tool completion and scoring:

In the July 2017 release, MiSACWIS stopped prefilling questions in the risk assessment which helps ensure that the worker accurately completes the assessment rather than relying on the system to score the items. To improve supervisory overview of tool completion and increase the likelihood that user misapplication of the tool will be identified and corrected, the department has requested a MiSACWIS enhancement that will result in all questions and responses for each risk factor to appear on the CPS Investigation Report. Supervisors reviewing the Report will have more information upon which to verify tool accuracy.

Train Staff

Training on tool completion is provided to all new hires. In 2018, CSA will identify ways to enhance the training to improve practice application. Further, as part of its efforts to align practice with policy requirements, CPS program office staff will address accurate tool completion during its on-site outreach with local field staff. In 2018, MiSACWIS staff will include this topic in its Training Academy Workshops provided to field staff.

Peer to Peer Review

The department is in the final stages of developing a peer to peer process by which a team of supervisors reviews investigations and tool completion and provides feedback to improve practice.

Tool Revalidation

Revalidation of the tool by the National Council on Crime and Delinquency is presently underway and will be completed in 2019. Revalidation will assure that the Tool reliably predicts the likelihood of future risk of harm to a child.

FINDING #14

A MATERIAL CONDITION

Impact assessments needed to identify and evaluate the effect of MiSACWIS risk assessment functionality changes.

MDHHS made system changes and did not conduct impact assessments to identify and evaluate existing errors in previously completed CPS investigations.

At least 163 investigations with confirmed CA/N had incorrect low- or moderate-risk levels, resulting in improper category classification and the improper exclusion of over 200 confirmed perpetrators from the Central Registry.

MDHHS did not conduct impact assessments for MiSACWIS risk assessment functionality changes. We identified 6,200 previously completed investigations with incorrect risk levels and 23,900 other investigations with potentially incorrect risk levels.

During our review of case records for 156 investigations, we identified 9 MiSACWIS risk assessment functionality errors. MDHHS informed us that it had made system changes to prospectively correct nearly all of these errors; however, it did not conduct impact assessments to identify and evaluate potential risk assessment errors existing in completed investigations that were processed in MiSACWIS prior to the changes. Impact assessments would facilitate decision-making regarding identified errors.

Using data analytics, we identified 6,200 completed investigations with incorrect risk levels (intensive, high, moderate, or low) and an additional 23,900 investigations with risk levels that may have been potentially impacted as a result of the MiSACWIS risk assessment functionality errors. We applied limited procedures to some of the completed investigations to help identify the existence of potentially significant impacts. We determined that there were at least 163 completed investigations with confirmed CA/N that also had an inaccurate risk level of low or moderate assigned, rather than a correct risk level of high or intensive. MDHHS inappropriately classified these 163 investigations as Category III investigations because of the incorrect risk levels.

The CPL requires MDHHS to classify investigations with a high or intensive risk and confirmed CA/N as Category II investigations and to add the perpetrators to the Central Registry. However, because MDHHS had not completed an impact assessment, it had neither identified the inaccurate risk levels and category classifications for these 163 investigations nor added the 205 associated perpetrators to the Central Registry (see Finding #20) and may not have provided the appropriate level of post-investigative monitoring to the children and families associated with these investigations.

The chart below contains a description of one MiSACWIS functionality error, the number of completed investigations that were potentially impacted by the error, and an example of the unidentified and uncorrected impacts on a completed investigation:

Illustrative Example of a MiSACWIS Functionality Error and Its Impact
Description of Error
Prior to October 2016, MiSACWIS functionality allowed investigators to decrease the system calculated investigation risk by one level; however, this was not allowed by MDHHS policy.

Number of Completed Investigations Potentially Impacted
We identified 1,046 completed investigations in which investigators decreased the MiSACWIS calculated risk level. MDHHS identified and corrected this functionality error in October 2016 without assessing the impact on previously completed investigations.
Unidentified and Uncorrected Impacts on a Completed Investigation
In an investigation completed in September 2016, the investigator found a preponderance of evidence that a mother and stepfather had abused and neglected a child. The completed risk assessment resulted in a system-calculated high-risk level, requiring a Category II classification for the investigation, the addition of the 2 perpetrators to the Central Registry, and mandatory child protective services for the family. However, the MiSACWIS functionality error allowed the investigator to decrease the risk level to moderate for this investigation. This resulted in an improper Category III classification of the investigation, no addition of the perpetrators to the Central Registry, and referral of the family for community services rather than mandatory provision of child protective services.

The OAG used the following criteria:

- The CPL requires MDHHS to classify each completed investigation as a Category I, II, III, IV, or V based on its investigation conclusions, including the risk assessment. The category classification defines the required level of post-investigative monitoring and whether MDHHS must add the confirmed perpetrators' names to the Central Registry.

- Control Objectives for Information and Related Technology* (COBIT) indicates that managing changes mitigates the risk of negatively impacting the stability or integrity of the changed environment. Changes should be managed in a controlled manner, including evaluating impact assessments. COBIT also indicates that management should identify, evaluate, prioritize, and process solutions to known errors based on a cost-benefit business case and business impact and urgency.

We consider this finding to be a material condition because the risk assessment tool drives CPS investigation conclusions. Therefore, the absence of impact assessments prohibits MDHHS's ability to identify the magnitude of existing risk assessment tool errors and employ necessary corrective actions.

RECOMMENDATION

We recommend that MDHHS conduct impact assessments for MiSACWIS risk assessment functionality changes.

** See glossary at end of report for definition.*

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that it is necessary to assess the impact of the MiSACWIS risk assessment functionality changes.

MDHHS fixed each of the identified errors in MiSACWIS by December 2016 and is currently reviewing the impact of the MiSACWIS errors on investigations that were completed prior to the system fixes. As case file amendments and further actions are identified, MDHHS will work in coordination with the applicable county offices to make them.

FINDING #15

A REPORTABLE CONDITION

Completion of child and family needs and strengths assessments needs improvement.

Investigators did not complete the required child and family needs and strengths assessments for nearly 20% of the investigations reviewed.

CPS investigators need to improve their completion of child and family needs and strengths assessments because they incorporate the family's input to identify focus areas to reduce the risk of future CA/N. Specifically, the assessments help identify the services needed, gaps in resources, and strengths that may help the family provide a safer environment for the children.

Of 73 CPS investigations that required completion of the child and family needs and strengths assessments, they were not completed for 14 (19%) investigations and 29 children, which included 5 alleged victims and 24 other children.

MDHHS policy requires a completed child assessment of needs and strengths for each child victim and any other children residing in a household with a perpetrator of child abuse or neglect when a preponderance of evidence of CA/N is found to exist. In addition, policy indicates that a family assessment of needs and strengths must also be completed in most instances when an investigation finds that a preponderance of evidence of CA/N exists.

MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct the deficiencies noted in the completion of child and family needs and strengths assessments (see Finding #17).

RECOMMENDATION

We recommend that CPS investigators improve their completion of child and family needs and strengths assessments.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that it needs to improve its completion of the Child and Family Assessments of Needs and Strengths tool in MiSACWIS.

Discussions with affected staff and local management teams are planned to identify factors that may have contributed to the undocumented assessments, both at the worker and supervisor levels, and to identify steps that will be taken to increase the likelihood that the assessments will be documented in future cases. Based upon feedback already received from field and policy staff, potential strategies to improve practice may include: training enhancements and opportunities, policy changes, supervisory and/or management practices, and addressing other factors known to impact practice, like staff turnover, local office culture, quality supervision, and local continuous quality improvement efforts, among others.

FINDING #16

A MATERIAL CONDITION

Improvement needed in timely completion of investigations.

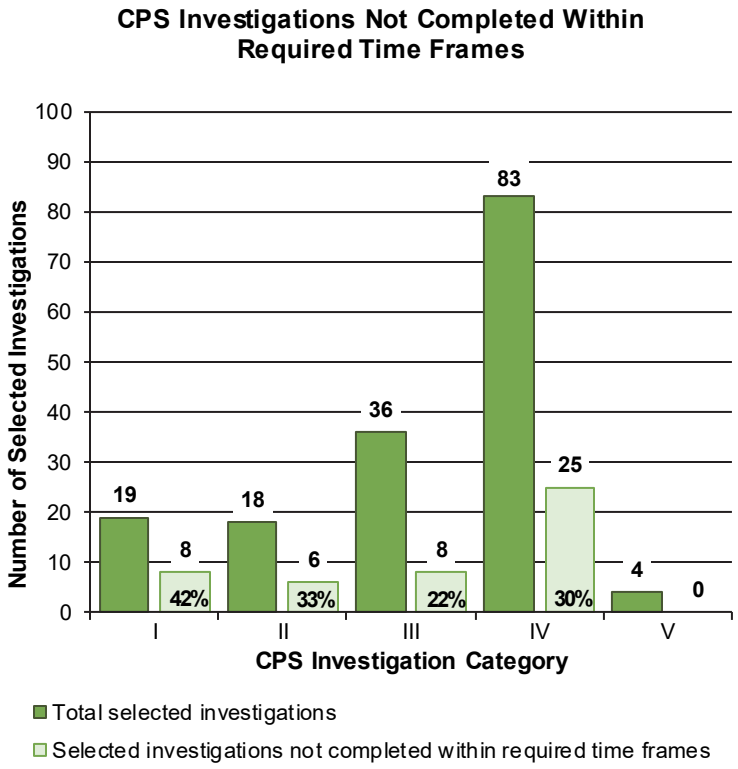
Almost 30% of reviewed investigations were not completed within required time frames and were, on average, 44 days late.

CPS investigators did not always complete CPS investigations within required time frames to ensure prompt evidence collection, conclusions, and actions in regard to the safety and well-being of children and families.

We reviewed 160 CPS investigations and noted that MDHHS did not complete 47 (29%) of the investigations within 30 days or within the time frame of an approved extension, when applicable. These 47 investigations ranged from 1 to 241 days late and were, on average, 44 days late. We also noted that 14 (30%) of these investigations required the addition of 24 perpetrator(s) to the Central Registry, and this action would have been delayed because of the late completion of the investigations.

MDHHS's policy and the Modified Settlement Agreement and Consent Order* and its successor, the ISEP, all set forth the standard of promptness for completing CPS investigations as 30 days from MDHHS's receipt of a CA/N complaint and allow supervisors to approve extensions in extenuating circumstances.

The graph below depicts a comparison of the total number of selected investigations with the number that were not completed within required time frames for each of the five CPS investigation categories, and the table shows the number of days that the 47 investigations were overdue in four ranges:



** See glossary at end of report for definition.*

Number of Days Selected Investigations Were Overdue

Number of Days Overdue	Number of Selected Investigations Determined to be Overdue	Percent of Selected Overdue Investigations
1 - 25	24	51%
26 - 50	9	19%
51 - 100	7	15%
100+	7	15%
Total	47	100%

Although investigators did not typically document explanations for the untimely completion of the investigations within the files that we reviewed, our observations and the responses that we received to our survey of over 750 CPS investigators suggested that CPS caseloads were the likely factor. For example, 499 (63%) of the CPS investigators who responded to our survey indicated that their CPS caseload had negatively impacted their ability to conduct investigations in compliance with MDHHS policy and 272 (55%) responded that this happened at least half of the time (see Exhibit #3, Questions #21 and #22).

We noted a similar condition in our performance audit* of the Statewide Electronic Central Registry, Department of Human Services (431-2100-08), issued in September 2010. The department agreed with the recommendation and indicated that in October 2010 it began monitoring the 30-day standard of promptness for investigation completion and would develop corrective action plans for staff when indicated.

We consider this finding to be a material condition because of the:

- Significant exception rate.
- Possible negative impact on child safety when investigators do not draw timely conclusions to allow MDHHS to take prompt and appropriate action(s) and evidence supports that CA/N occurred.
- Possible negative impact of lingering CPS involvement with families when investigators do not draw timely conclusions and evidence does not support that CA/N occurred.
- Resulting delay in performance of required supervisory review to identify any investigation deficiencies that may adversely impact a child's safety, such as insufficient protecting interventions.

** See glossary at end of report for definition.*

RECOMMENDATION

We recommend that CPS investigators complete CPS investigations within required time frames.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that investigations should be completed within 30 days whenever possible and prudent. This cannot always occur and investigators should never sacrifice thoroughness and accuracy for expediency. Completion of timely investigations is an area of practice strength in Michigan. The Implementation, Sustainability, and Exit Plan (ISEP) requires 90% of investigations to be completed by the worker within 30 days and approved by the supervisor within 14 days of worker completion. Compliance is measured by whether investigations were both completed by the worker and approved by the supervisor within 44 days. During ISEP 11 (July – Dec. 2016), compliance improved to 84.2%. Statewide performance has been validated by the federal monitors assigned by the court to assess the state's progress on the ISEP.

This is also an area closely monitored by Child Welfare Administration, BSC Directors and Staff, County Directors, District and Program Managers, First Line Supervisors and CPS Investigators through use of MDHHS's Data Warehouse tools, including Business Objects and Book of Business, as well as the Monthly Management Report.

Circumstances occur in which CPS investigations cannot be completed within 30 days. In October 2017, with approval of federal monitors, MDHHS expanded the acceptable reasons to extend the 30-day standard of promptness for completion of CPS investigations.

MDHHS understands the importance of completing timely CPS investigations balanced against realistic workload demands. A priority goal of CSA is to assure that CPS investigators receive adequate training, resources, and supervisory support to complete CPS investigations as expeditiously as possible without compromising adherence to policy requirements, thorough evidentiary collection and well-reasoned decision-making.

FINDING #17

A MATERIAL CONDITION

Significant improvement needed in the supervisory oversight of CPS investigations.

CPS supervisors need to improve the effectiveness and timeliness of CPS investigation reviews and the consistency of case consultations with investigators. Doing so would help MDHHS ensure that its CPS investigation activities and decisions intended to protect the safety and well-being of the children are carried out appropriately.

The OAG used the following criteria to evaluate supervisory review and case consultation:

- MDHHS policy requires supervisors to review and, after all needed corrections are made, approve investigation reports. Supervisor approval indicates the supervisor's agreement with the thoroughness, completeness, and accuracy of the investigation; disposition of the investigation; assessment of risk and safety of the children; assessment of the family and/or child's needs and strengths; and services provided to the family.

- MDHHS policy and the ISEP require that the CPS supervisor review and approve all CPS investigation reports within 14 calendar days of receipt of the report.

- MDHHS policy requires that the CPS supervisor meet with the investigator on every assigned complaint prior to case closure; the ISEP requires that CPS supervisors meet with investigators monthly to review the status and progress of each CPS investigation.

We reviewed CPS documentation for 160 investigations to assess compliance with numerous requirements. In addition, we reviewed the timeliness of the supervisor's review and approval of the investigation reports and documentation of case consultation meetings with investigators. We noted:

Ineffective supervisory review significantly contributed to the errors reported in 15 of the findings included in this report; 11 are considered to be material conditions.

a. CPS supervisors often did not identify and/or correct investigation deficiencies when reviewing investigations and commonly approved investigation reports with existing deficiencies. Ineffective supervisory review of investigations significantly contributed to the errors that we noted during our testing of the selected investigations and reported in Findings #2 through #5, #7 through #13, #15, #20, #21, and #24.

b. CPS supervisors did not review 28 (18%) of the 160 investigations within 14 days of their receipt of the investigation. On average, the supervisory review of these 28 investigations was 17 days late, with a range of 1 day to 6.9 months late. Timely supervisory review is imperative to help ensure that any investigation deficiencies impacting a child's safety will be promptly identified and addressed.

c. Documentation did not exist to support that supervisors met with the investigator for a case consultation prior to

the disposition for 24 (15%) of 156 investigations that required a case consultation. Collaboration between the investigator, who is the primary holder of the case information, and the supervisor, who is responsible for directing the investigator's activities, is essential to reach consensus on decisions regarding the safety and permanence of the children associated with the investigation.

Reasons for these deficiencies are likely due to the infrequent use of the CPS supervision checklist and because of supervisory workload demands. The checklist was designed to aid the supervisor during the review process in determining whether child safety needs and investigation requirements have been met; however, the checklist was not used in more than half of the investigations we reviewed. In addition, almost 40% of the CPS supervisors who responded to our survey indicated that the number of staff they are supervising negatively impacts their ability to thoroughly review and approve CPS investigations, and 35% of investigators who responded to our survey indicated that they had submitted an investigation for approval to meet the 30-day completion requirement knowing that a policy requirement was not met (see Exhibit #3, Questions #30 and #25).

Almost 40% of the CPS supervisors who responded to our survey indicated that the number of staff they are supervising negatively impacts their ability to thoroughly review and approve CPS investigations.

We consider this finding to be a material condition because supervisory oversight was MDHHS's primary control to detect and correct investigation deficiencies, yet frequent and pervasive errors persisted as evidenced by the numerous findings contained in this report.

RECOMMENDATION

We recommend that CPS supervisors improve the effectiveness and timeliness of CPS investigation reviews and the consistency of case consultations with investigators.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that supervisors play a critical role in supporting staff, reducing turnover, instilling confidence in staff, building skill and competencies, and providing oversight of decisions and actions. Given the difficulty, complexity, and challenges of being a CPS supervisor and the supervisor's relative significance in terms of staff performance and child and family outcomes, consistent efforts are needed to support supervisors in their role.

Timely approval of reports is closely monitored by Child Welfare Administration, BSC Directors and Staff, County Directors, District and Program Managers, First Line Supervisors and CPS Investigators through use of MDHHS's Data Warehouse tools, including Business Objects and Book of Business, as well as the Monthly Management Report. The Implementation, Sustainability, and Exit Plan (ISEP) requires 90% of investigations to be completed by the worker within 30 days and approved by the supervisor within 14 days of worker completion. Compliance is

measured by whether investigations were both completed by the worker and approved by the supervisor within 44 days. During ISEP 11 (July – Dec. 2016), compliance improved to 84.2%. Statewide performance has been validated by the federal monitors assigned by the court to assess the state's progress on the ISEP.

Recognizing the role of supervision in caseworker performance and retention, child welfare supervisory training was fully redesigned, and an enhanced New Supervisor Institute launched in January 2018. In addition to providing CPS supervisors with training on specific policies and procedures, supervisors receive instruction on leadership topics, creating positive office culture, coaching, and data driven decision making, among others. In partnership with state universities, MDHHS also regularly offers supplemental training sessions for supervisors on topics aimed at strengthening individual and group supervision. The department has made efforts and will continue to provide the necessary systems, tools and training to enhance supervisory oversight and timeframes.

In April 2018, a request was made to re-format the existing CPS Investigation Report, to improve the readability to provide increased accuracy in worker documentation and supervisory review. Other imperative items will be incorporated into the structure of the new report to help ensure worker compliance with policy and law requirements, improve supervisory oversight of compliance, and potentially remediate several of the CPS Audit related findings.

FINDING #18

A MATERIAL CONDITION

Monitoring of families' participation in post-investigative services needed for all Category III investigations.

MDHHS did not monitor families' participation in post-investigative services to determine whether the families are receiving and participating in the services intended to alleviate the child's risk level for abuse and/or neglect, when applicable. Without proper monitoring, the child victim(s) could remain in a potentially vulnerable situation and MDHHS cannot determine whether it must reclassify the investigation and add the perpetrator(s) to the Central Registry.

Section 8d of the CPL defines a Category III investigation as one where a preponderance of evidence of CA/N is found and requires that the department ***shall*** assist the child's family in receiving community-based services commensurate with the risk to the child. The CPL also states that if the family does not voluntarily participate, or if the family voluntarily participates but does not progress toward alleviating the child's risk level, the department ***shall*** consider reclassifying the case as a Category II investigation, therefore requiring MDHHS to add the names of the perpetrators to the Central Registry.

MDHHS closed 74% of Category III investigations without monitoring the families' participation in post-investigative services or considering whether the investigation should be reclassified to a Category II investigation.

We determined that MDHHS closed 21,911 (74%) of the 29,450 Category III classified CPS investigations during our 27-month audit period without monitoring the families' participation in post-investigative services or considering whether the investigation should be reclassified to a Category II CPS investigation.

Illustrative Example
In one investigation, the complaint alleged medical neglect because the parents repeatedly missed scheduled eye specialist appointments for the reevaluation of their young child's poor vision. The reporting source alleged that, if the child did not receive glasses and treatment, the child could become blind in one eye. There was no documentation in the CPS investigation casefile indicating that the child's vision had been reevaluated by a medical professional at any time during the investigation. Therefore, we concluded that MDHHS would have needed to monitor the family's participation in post-investigative services to determine whether the family was progressing toward alleviating the child's risk level and to determine whether it should reclassify this investigation to a Category II and add the parents to the Central Registry. However, the CPS investigator concluded that there was a preponderance of evidence that the parents had perpetrated medical neglect and closed the investigation classifying it as a Category III CPS investigation with no monitoring of post-investigative services.

MDHHS's policy allowed CPS investigators the option of closing Category III investigations after assisting the family in receiving community-based services; however, this option does not comply with Section 8d of the CPL.

MDHHS asserted that legal discretion existed and that the CPL did not intend nor require MDHHS to monitor all Category III CPS investigations. Correspondingly, MDHHS's policy allowed CPS investigators the option of closing Category III investigations after assisting the family in receiving community-based services commensurate with the risk of the child, with no further monitoring. However, in our

auditor judgment, legal discretion did not exist and this option did not comply with Section 8d of the CPL. The language in Section 8d, specifically infers that MDHHS must monitor the family's participation and progress in community services for Category III investigations in order to fulfill its statutory obligation to reconsider reclassification as a Category II investigation. MDHHS's required consideration of whether or not progress toward alleviating the child's risk had occurred could not have reasonably taken place without monitoring.

We consider this finding to be a material condition because MDHHS's policy does not correspond to CPL requirements. In addition, MDHHS closed 74% of all Category III investigations without monitoring to determine whether threats to the child's safety had been alleviated and/or escalation to Category II was required.

RECOMMENDATIONS

We recommend that MDHHS monitor families' participation in post-investigative services to determine whether the families are receiving and participating in the services intended to alleviate the child's risk level for abuse and/or neglect, when applicable.

We also recommend that MDHHS seek legislative clarification to validate its interpretation of, and compliance with, Section 8d(1)(c) of the CPL for Category III investigations.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees. The CPL does not require ongoing child protective services intervention in response to a Category III disposition.

When the 5 Category system was contemplated in 1998, the intent was to create multiple tracks for completed investigations based on the disposition of the complaint allegations, the risk level, and the safety decision. For investigations involving confirmed maltreatment, one of three possible category dispositions may be assigned, and the action taken in response, including whether a protective services case must be opened, are set forth in law by category:

- *Category I indicates a court petition is required.*
- *Category II indicates "Child Protective Services Required," which means the department is required to open a child protective services case and remain involved to reduce risk.*
- *Category III indicates "Community Services Needed," and means CPS will assist the family to voluntarily participate in community services. Typically this means that the worker will make a referral on behalf of the family to recommended services or provide the family with referral information based upon need. Unlike Category II, for which the law requires a*

child protective services case to be opened, the law does not require ongoing child protective services involvement for Category III.

Where legal discretion exists, decisions about whether to open a protective services case should be driven by the risk of future harm to the child, the safety of the child, and the needs of the family. Any change in statewide response to Category III investigations should be informed by data, specifically recurrence data showing the rate at which children in Category III investigations experience subsequent maltreatment within 6 or 12 months.

The CPS Program Office is exploring a change in policy requirements for service provision in Category III cases based on recurrence work with the University of Michigan, and MDHHS's Data Warehouse Team, including whether or not particular Category III cases should be opened based on specific risk factors i.e. age, vulnerability, etc. The goal is for the family to engage in effective services and supports to reduce the likelihood of recurrence.

FINDING #19

A REPORTABLE CONDITION

Clarification needed to ensure proper classification for investigations in which a court petition has been filed but subsequent investigation evidence does not support that CA/N occurred.

MDHHS needs to clarify its policy and the guidance it provides to CPS investigators for properly classifying investigations when MDHHS has filed a court petition and the evidence subsequently obtained during the investigation does not support that CA/N occurred. Misclassification can impact Central Registry decisions, post-investigative service provision, and the accuracy of CPS history records.

MDHHS policy is sometimes ambiguous related to Category I classifications for CPS investigations. The CPL states that the department shall determine in which single category (of 5 choices) to classify an allegation of CA/N based on the results of a completed field investigation and defines the 5 single categories. Section 8d(1)(e) of the CPL defines a Category I CPS investigation as an investigation in which a court petition is required, ***and*** the department determines that there is evidence of CA/N, ***and*** 1 or more of 4 specifically outlined situations are true. The CPL also requires that MDHHS list all perpetrators associated with a Category I investigation on the Central Registry.

While the majority of MDHHS's policy is directly reflective of these CPL requirements for a Category I classification, policy language related to CPS risk assessment and escalation of a CPS category both contain statements indicating that CPS investigators must assign a Category I classification to an investigation any time a court petition is filed without any additional commentary related to the other CPL requirements. Even though MDHHS intends for these statements to be applied only in situations where there is a preponderance of evidence that CA/N has occurred, our interviews with MDHHS investigation staff and management confirmed that confusion commonly exists when determining the appropriate classification for investigations when a court petition is filed and the evidence obtained during the investigation does not support that CA/N occurred. This confusion was also evidenced in our selected investigations.

Our interviews with MDHHS investigation staff and management confirmed that confusion commonly exists when determining the appropriate classification for investigations in these situations.

Illustrative Example
In one investigation, the complaint alleged that a father was sexually and physically abusing and improperly supervising his preteen daughter. After interviewing the alleged victim, the CPS investigator determined that the child needed to be outside of the father's care during the CPS investigation to ensure the child's safety. The father was unable to secure appropriate outside care for his child through family or friends so MDHHS sought and received a petition for an emergency removal order from the court. The child was removed from the home and later placed in licensed foster care. During the investigation, the child acknowledged to a trained forensic interviewer that the allegation of being sexually and physically abused was false and that the child was angry with her father. Based on this information, the court dismissed the earlier court petition for removal and MDHHS returned the child to her father's care. At the conclusion of the investigation, MDHHS had no evidence that CA/N occurred. However, because

MDHHS had filed a court petition for the case, the CPS investigator interpreted policy as requiring a Category I CPS investigation classification and added the father to the Central Registry as a perpetrator of CA/N. During our discussions with the CPS supervisor and MDHHS management regarding this investigation, MDHHS maintained that the Category I classification for this investigation was appropriate based on its interpretation of the CPL and made no changes to the classification. In contrast, MDHHS agreed that the father should not have been added to the Central Registry as a perpetrator of CA/N and subsequently removed him in January 2017, as a result of our review.
See Exhibit #4, Investigation Example Case #3, for additional details related to this investigation.

We were not able to conduct data analytics related to all CPS investigations in which a court petition was filed. Our intent was to determine the extent that CPS investigators misinterpreted and misapplied policy and the number and identity of individuals that MDHHS inappropriately added to the Central Registry. However, MDHHS did not capture CPS investigation data in a manner that would allow such analysis.

RECOMMENDATIONS

We recommend that MDHHS clarify its policy and the guidance it provides to CPS investigators for properly classifying investigations when MDHHS files a court petition and the evidence subsequently obtained during the investigation does not support that CA/N has occurred.

We also recommend that MDHHS identify misclassified Category I investigations, correct the investigation classification to reflect CPL requirements, and remove the names of any individuals that MDHHS has inappropriately added to the Central Registry as a result of the misclassifications.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees. Law, policy, and training are clear that a complaint investigation may only be classified as a Category I after child abuse or neglect is confirmed. The error that the OAG detected was the result of a MiSACWIS error that has since been rectified to reflect existing policy. Prior to April 2016, MiSACWIS defaulted to a Category I disposition when a court petition was filed which may have led to confusion amongst some field staff.

MDHHS agrees that any misidentification of a person's name on the Central Registry would be concerning and warrant prompt correction. MDHHS is in the process of determining if any other names may have been improperly listed on the Central Registry prior to the modification made to MiSACWIS.

FINDING #20

A MATERIAL CONDITION

Improvement needed to ensure that perpetrators are appropriately added to the Central Registry, as required by the CPL.

Central Registry information is widely used to help protect children from potentially vulnerable situations.

Our review identified 257 confirmed perpetrators of CA/N that MDHHS did not add to the Central Registry, as required.

MDHHS did not always ensure that it added confirmed perpetrators of CA/N to the Central Registry when required by the CPL. Doing so is important because the information is widely used to help protect children from potentially vulnerable situations. For example, CPS investigators in Michigan and other states use the Central Registry information when conducting investigations to help evaluate the CPS history of an alleged perpetrator and to determine risk of harm to a child victim. State licensing agencies and child placing agencies also utilize Central Registry information to help determine the suitability of child care providers, foster care providers, prospective adoptive parents, and volunteers and employees of certain organizations.

The CPL requires MDHHS to maintain a Statewide, electronic Central Registry to carry out the intent of the CPL and to add the perpetrators from all Category I and II investigations, and certain Category III investigations, to the Central Registry.

We reviewed the disposition and category classification documentation for 160 CPS investigations, applied analytical review procedures to the population of 206,000 completed CPS investigations, and analyzed risk assessment tool errors noted during our audit and identified 257 confirmed perpetrators that MDHHS did not add to the Central Registry, as required. We noted that:

- 205 perpetrators' names were not added because MDHHS did not evaluate the impact of known MiSACWIS risk assessment tool functionality errors and correct instances when the errors had led to inappropriate category classifications and the omission of perpetrators from the Central Registry (see Finding #14).

- 40 perpetrators' names were not added because MiSACWIS failed to generate a value for the investigation category classification field for 31 Category I and II investigations. Typically, MiSACWIS automatically generates a value for the investigation category classification field based on investigation information entered by the investigator and lists the confirmed perpetrators for all Category I and II investigations on the Central Registry. However, because there was no category classification value generated, the perpetrators from these Category I and II investigations were not added to the Central Registry.

- 12 perpetrators' names were not added because MDHHS assigned an incorrect category classification to 9 investigations as a result of a missed court petition for 1 investigation and improperly completed risk assessment tools for 8 investigations (see Findings #9 and #13).

During our fieldwork, we notified MDHHS of our testing results related to the 257 confirmed perpetrators. At the end of our fieldwork, MDHHS informed us that it had added 40 to the Central

Registry; however, it did not provide any additional information regarding the remaining 217.

MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct the deficiencies noted in this finding (see Finding #17).

We consider this finding to be a material condition because of the significant number of perpetrators that we identified who were not properly added to the Central Registry and the Central Registry's critical function in helping protect children from potentially vulnerable situations.

RECOMMENDATION

We recommend that MDHHS ensure that it adds confirmed perpetrators of CA/N to the Central Registry when required by the CPL.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that individuals, confirmed by CPS for child abuse or neglect, must be listed on the Central Registry as required by the CPL.

Each case identified in the audit is being thoroughly reviewed by respective county staff to identify the appropriate actions, which may include adding the individuals' names to the Central Registry. As part of this process MDHHS must notify each person and inform the person of their due process rights.

FINDING #21

A MATERIAL CONDITION

The notification process to inform individuals whose names MDHHS adds to the Central Registry needs significant improvement.

MDHHS needs to improve its process for notifying individuals that their names have been added to the Central Registry as perpetrators of CA/N. Without improvements, MDHHS cannot ensure that individuals are always made aware that they are named in the Central Registry as a perpetrator of CA/N, that they have been notified of their right to request that MDHHS expunge* their record from the Central Registry, and that they have a right to a hearing if MDHHS refuses the expungement request.

The CPL states that if MDHHS classifies a report of suspected C/AN as a Central Registry case, MDHHS shall notify in writing each person who is named in the record as a perpetrator of the CA/N within 30 days after the classification. The CPL also states that a perpetrator has up to 240 days from the date of service of notice to request a hearing for amendment or expunction. In addition, MDHHS policy requires formal, documented notification when CPS staff list an individual on the Central Registry.

MDHHS did not have documentation to support that it had notified perpetrators added to the Central Registry for over 40% of reviewed investigations.

Our review of 37 investigations that required MDHHS to add the perpetrator(s) to the Central Registry noted that MDHHS did not have documentation to support that it had appropriately provided written notification to 24 perpetrators associated with 16 (43%) of the investigations.

CPS investigators provided us with differing responses to explain why documentation of written notification was absent. Responses included that a notice was not provided or documented, and some investigators provided no explanation. In addition, MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct instances when documentation of notifications was deficient (see Finding #17).

We consider this finding to be a material condition because of the significant exception rate and the impact on individuals being potentially unaware of their inclusion on the Central Registry and their legal right to request hearings for amendment or expunction. MDHHS's lack of documentation is significant because, without proof that notifications occurred, MDHHS may be unable to support its actions and decisions if subsequently questioned or challenged and, for auditing purposes, we must presume that the notifications did not occur.

RECOMMENDATION

We recommend that MDHHS improve its process for notifying individuals that their names have been added to the Central Registry as perpetrators of CA/N.

** See glossary at end of report for definition.*

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that documentation in MiSACWIS was not sufficient in some cases to subsequently demonstrate that notification occurred and that improvements with documentation consistency are needed. Lack of documented notice does not necessarily mean that notification was not provided to individuals listed on the Central Registry. Oftentimes, the CPS worker provides the written notification to the person during the initial Family Team Meeting. When that is not feasible, the worker is responsible for sending the notification letter registered or certified mail and documenting this in the electronic case file.

In February 2018, MDHHS sent a statewide Communication Issuance to child welfare staff outlining implementation strategies to increase uniformity in documentation. Staff were directed to print, sign and provide the DHS-847 (notification letter) via certified mail. The communication directs staff to document in MiSACWIS that the notice was sent via certified mail; and then, upon receipt of the certified mail receipt, document, scan, and upload a copy in MiSACWIS that proof of receipt was received.

FINDING #22

A REPORTABLE CONDITION

Amendatory legislation needed to add unlicensed child care providers to the CPL to allow Central Registry additions in Category III investigations.

Unlicensed child care providers have direct and regular contact with children in much the same manner as licensed and registered child care providers.

MDHHS needs to seek amendatory legislation to add unlicensed Child Development and Care (CDC) Program child care providers to the CPL. An amendment would provide MDHHS with the statutory authority to include unlicensed CDC Program child care providers in the Central Registry when MDHHS identifies these individuals as perpetrators of CA/N in Category III CPS investigations.

Unlicensed CDC Program providers are enrolled by the Michigan Department of Education to provide child care for up to six CDC Program children in the provider's home or the child's home. Licensed and registered child care homes and centers are regulated by the Department of Licensing and Regulatory Affairs and provide child care for CDC Program and/or non-CDC Program children, generally in a private home (one to 12 children) or a child care facility (more than one child).

Section 8d(3) of the CPL provides MDHHS with authority to include the perpetrators of CA/N from Category III CPS investigations who are owners, operators, volunteers, or employees of a licensed or registered child care organization* in the Central Registry. However, the CPL does not provide MDHHS similar authority for the perpetrators of CA/N who are unlicensed CDC Program child care providers.

The CPL needs to provide MDHHS with this statutory authority because unlicensed CDC Program child care providers have direct and regular contact with children in much the same manner as the other individuals specified in Section 8d(3) of the CPL. The September 2016 Michigan Department of Education Office of Great Start report entitled *Building a Better Child Care System* reported that of the approximately 30,000 children in Michigan receiving CDC Program subsidies, 26% are receiving care from unlicensed CDC Program child care providers.

We noted a similar condition in our performance audit of the Statewide Electronic Central Registry, Department of Human Services (431-2100-08), issued in September 2010. The department agreed with the recommendation and indicated that it would carefully consider placing unlicensed CDC providers (formerly known as enrolled child day-care providers) on the Central Registry when they were determined to be perpetrators of child abuse in Category III CPS investigations.

In November 2011, the department had completed an analysis and determined that legislative action was necessary for implementation of appropriate corrective action with an estimated completion date of June 2012. In June 2012, the department concluded that it no longer supported a statutory change because unlicensed CDC providers do not receive prescribed training in the same manner as the other individuals specified in the CPL and, therefore, should not be held to the same standards.

** See glossary at end of report for definition.*

Unlicensed CDC Program child care providers are required to complete a one-time basic training that includes the American Heart Association first aid and CPR certification course, nutrition, health and safety, shaken baby syndrome, safe sleep practices, and age-appropriate child development.

RECOMMENDATION

We again recommend that MDHHS seek amendatory legislation to add unlicensed CDC Program child care providers to the CPL.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS disagrees. The Central Registry was created over 25 years ago to provide a way for child welfare staff conducting CPS investigations or licensing studies across the state to identify individuals confirmed for maltreatment in other counties. With the maturity of electronic tracking and case management technology in the late 1990s, Central Registry is no longer the sole or most effective means for CPS and licensing staff to track, search, and access child welfare history and pertinent information needed to inform decisions. Since the department launched its MiSACWIS in 2014, child welfare investigators and caseworkers have the ability to access comprehensive family case histories and trends.

In addition, MDHHS believes there is insufficient basis to justify adding unlicensed child care providers to Central Registry and no basis for the assertion that it will safeguard children and believes it will not result in any additional or new information on which to assess child safety. As of July 1, 2018, the list of entries on Central Registry has grown to 460,552 and does not distinguish among seriousness of abuse/neglect committed nor classify the names of individuals listed by likelihood of risk to children.

The department intends to propose an amendment to state law to delink placement on Central Registry from the Risk Assessment outcome and instead link placement of names on the registry with egregious abuse/neglect. This change will result in more meaningful information upon which to determine a person's threat to children, without compromising the department's ability to perform essential CPS, foster care, and licensing responsibilities.

FINDING #23

A REPORTABLE CONDITION

Changes needed to comply with the CPL when conducting abbreviated CPS investigations.

MDHHS did not require CPS investigators to complete an investigation checklist when conducting abbreviated CPS investigations. In addition, MDHHS did not always ensure that local county office directors conducted a review of the abbreviated CPS investigations that did not have a completed investigation checklist prior to closing the investigation. The checklist and reviews would provide MDHHS increased assurance that CPS investigators conduct an abbreviated investigation in compliance with existing laws and policies and reduce the likelihood of improperly closing an investigation with unidentified risks of CA/N.

An abbreviated CPS investigation is a CA/N investigation in which the investigator determines that there is no evidence of CA/N. This results in a Category V classification and no services are required. MDHHS requires CPS investigators to conduct certain procedures during an abbreviated investigation, such as completing a field contact; evaluating prior family CPS history; evaluating the need for a follow-up contact with the reporting person; and completing all contacts mandated by the CPL, including referral to law enforcement and notification of the results of an investigation to the reporting person.

Public Act 511 of 2008 amended the CPL and required MDHHS to implement an investigation checklist for ***all*** CPS investigations and specified that MDHHS may close a CPS investigation only after a supervisory review shows that the investigation checklist is completed and the investigation has complied with certain State laws and department policy. If the supervisor determines that an investigation does not comply, the investigation shall not be closed until after the local county office director has reviewed the investigation. This legislation was enacted following a 2007 child death review in which the Office of Children's Ombudsman* found that the department had made errors during its CPS investigation that included noncompliance with existing law and policy.

MiSACWIS data indicated that MDHHS completed approximately 4,450 abbreviated investigations during the audit period.

Analysis of MiSACWIS data indicated that MDHHS completed approximately 4,450 abbreviated investigations during the audit period. It was undeterminable how many were closed without a completed checklist or a review by the local county office director.

Although Section 8e(1) of the CPL states that the department ***shall*** implement an investigation checklist to be used in each investigation of suspected abuse and neglect, MDHHS informed us that it does not consider abbreviated investigations to be a CPS investigation as referred to in Section 8e of the CPL. However, the language in Section 8d(1)(a) of the CPL and MDHHS policy sustain that an abbreviated investigation is a CPS investigation in that both require MDHHS to assign a Category V classification when the department concludes that no evidence of CA/N exists.

** See glossary at end of report for definition.*

RECOMMENDATIONS

We recommend that MDHHS require CPS investigators to complete an investigation checklist when conducting abbreviated CPS investigations.

We also recommend that MDHHS ensure that local county office directors conduct a review of the abbreviated CPS investigations that do not have a completed investigation checklist prior to closing the investigation.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS partially agrees. MDHHS updated policy effective July 1, 2016, to require county directors to review abbreviated investigations prior to case closure. MDHHS believes that use of the investigation checklist for an abbreviated investigation is not an effective approach as the majority of the checklist elements are not applicable to abbreviated investigations. The dual review process that is now required by the July 2016 policy update provides sufficient oversight and approval for abbreviated investigations, both at the decision point when the complaint is assigned and prior to case closure. These enhanced review requirements were also added to MiSACWIS.

OBSERVATION #1

Survey results indicate that CPS investigator safety is a significant concern.

Our survey of CPS investigators indicated that a majority of the over 800 respondents had concerns regarding their physical safety while conducting investigations (see Exhibit #3, Question-#5). Although audit standards preclude us from reporting an audit finding because sufficient criteria (the "should be" scenario) cannot be articulated, clearly this is an issue that demands further evaluation.

The *CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families* states that a sense of safety in the office and in the field will relieve stress and improve the ability of staff members to concentrate on supporting families. In addition, the U.S. Department of Health and Human Services publication, entitled *Supervising Child Protective Services Caseworkers,* states that the nature of CPS work involves evaluating the risks and needs of families, some of whom display hostility and violence. Sometimes parents or caregivers react with hostility when their behavior is challenged, but CPS investigators do not have the ability, training, and formal protection to protect themselves or respond in a manner similar to other professionals confronted with aggressive behavior, such as law enforcement officers.

25% of responding investigators indicated that they feared for their physical safety half the time or more when conducting CPS investigations.

In our survey of CPS investigators, 25% of responding investigators indicated that they feared for their physical safety half the time or more when conducting investigations, 61% indicated that the physical safety training provided by MDHHS does not adequately prepare them for unsafe situations, and 37% indicated that they have considered leaving their position as a CPS investigator because of physical safety concerns. We also surveyed CPS supervisors, and 51% of responding supervisors indicated that physical safety training provided to CPS investigators was not adequate to prepare investigators for unsafe situations and 37% indicated that they were aware of instances in which personal safety was a contributing factor to employee turnover (see Exhibit #3, Questions #5 through #17).

Effectively addressing this issue will require input from a variety of stakeholders, including MDHHS, the investigators, the Legislature, and others. We encourage relevant parties to begin those discussions.

OBSERVATION #2

Centralized oversight of county-level implementation of required CA/N investigation protocols could foster improvements.

No statutory provision exists for centralized oversight to ensure that counties have implemented an appropriate CA/N investigation protocol.

The CPL states that in each county, the prosecuting attorney and the department shall adopt and implement standard CA/N investigation protocols. However, no statutory provision exists for centralized oversight to ensure that counties have done so.

Use of these protocols helps ensure that MDHHS can meet the goal of the Governor's Task Force on Child Abuse and Neglect. The Task Force's goal is to improve cooperation among professionals and agencies that furthers the development of common goals and methodologies for better management of CA/N cases.

We reviewed CA/N investigation protocols for 21 judgmentally selected Michigan counties and noted:

- 4 (19%) of 21 counties had not implemented the protocol during the audit period. Two of the 4 counties implemented the protocol subsequent to our audit period.
- 1 (6%) of the 17 counties that had implemented a protocol during the audit period did not outline the responsibilities of the prosecuting attorney and law enforcement.
- 13 (76%) of the 17 counties that had implemented a protocol during the audit period did not address the involvement of all other recommended professionals in the implemented protocol. The Task Force's model protocol recommends that each county's protocol address involvement of other professionals, including child advocacy center personnel, medical personnel, mental health personnel, school personnel, and friend of the court personnel.

We believe that establishing centralized oversight of county CA/N investigation protocols could foster improvements in CPS activities.

OBSERVATION #3

Commonly used MDHHS policy terms should be standardized to provide clarity and help ensure consistency in carrying out investigations.

Inconsistent policy terminology may have contributed to some deficiencies noted during our review of 160 selected CPS investigations.

Standardizing commonly used policy terminology would increase MDHHS's assurance that CPS investigation requirements are carried out in a consistent, systematic, and objective manner.

The *CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families* states that the child protection agency should develop and maintain written policies and procedures that provide its staff and community members with important information about the agency's philosophy, mission, purpose, practice expectations, and organizational structure. The agency's policies and procedures should provide staff with a clear statement of their roles and responsibilities and should be written in a consistent format.

As an example, we noted that MDHHS used 11 different terms throughout CPS policies to describe adults associated with an investigation. These inconsistencies may have contributed to some of the deficiencies noted during our review of Central Registry clearances (Finding #2), criminal history checks (Finding #3), and CPS history checks (Finding #4):

Illustrative Example

MDHHS's CPS policy terminology used to describe adults for:

Central Registry Checks	Criminal History Checks	CPS History Checks
• Parents • Persons responsible • All persons listed on the complaint who are age 18 or older • Nonparent adult known to spend significant time with the family and who has substantial and regular contact with the child	• All parents • Person(s) responsible for the health and welfare of the child • All household members for select investigations • Other necessary individuals	• The family • Household members

Although this issue is not worthy of an audit finding in accordance with applicable auditing standards, it does represent an opportunity for MDHHS to clarify and improve its CPS policies.

ACCURATELY CAPTURING DATA TO REPORT COMPLIANCE WITH TIMELINESS REQUIREMENTS

BACKGROUND

The CPL and/or MDHHS policy establish investigation timeliness standards for several significant investigation requirements, including:

- Investigation commencement with someone other than the reporting person to assess the safety of the alleged child victim within 24 hours of receiving the complaint.
- Face-to-face contact with the alleged child victim within 24 or 72 hours, depending on the risk to the child victim.
- Investigation completion within 30 days of complaint receipt.

Accurate, complete, and valid data should be captured in accordance with established standards for each investigation to ensure that aggregate reports are fair representations of actual departmental compliance.

MDHHS requires CPS investigators to enter information in MiSACWIS for each investigation to reflect the investigator's efforts toward meeting timeliness requirements. MDHHS summarizes the data entered in MiSACWIS to aggregately report department-wide compliance with established timeliness requirements for investigation commencement, face-to-face contact with alleged victims, and investigation completion. MDHHS uses the aggregate reports internally to evaluate strengths and weaknesses and to formulate strategies to improve areas of substandard performance. MDHHS also provides aggregated MiSACWIS reports to external users to demonstrate the MDHHS's compliance related to the investigation timeliness standards.

The State of Michigan has adopted COBIT as a generally applicable and accepted standard for good practices for controls over IT.

AUDIT OBJECTIVE

To determine the effectiveness* of MDHHS's efforts to accurately capture data used to report its compliance with selected CPS investigation timeliness requirements.

CONCLUSION

Moderately effective.

** See glossary at end of report for definition.*

FACTORS IMPACTING CONCLUSION

- MDHHS accurately captured data in MiSACWIS that appropriately reflected the timing of the investigators' submission of the completed investigation for all investigations reviewed.
- MDHHS accurately captured data in MiSACWIS related to the timing of investigators' face-to-face contact for 91% of the alleged child victims in the investigations we reviewed.
- Material condition related to improvement needed in capturing MiSACWIS investigation commencement data (Finding #24).

FINDING #24

A MATERIAL CONDITION

Improvement needed to ensure that MDHHS captures complete, accurate, and valid MiSACWIS data related to its commencement of investigations.

MDHHS needs to strengthen its controls over MiSACWIS commencement data to help ensure that it captures complete, accurate, and valid information that is consistent with established commencement policy. Capturing this data in this fashion is necessary to help MDHHS ensure that it properly reports its compliance with the CPL's investigation commencement requirement. Also, gathering sound information would help MDHHS effectively identify areas of systematic strengths and weaknesses and formulate strategies to improve areas of substandard performance.

The OAG used the following criteria for this finding:

- The CPL states: "Within 24 hours after receiving a report made under this act, the department . . . shall commence an investigation of the child suspected of being abused or neglected." MDHHS policy in effect during the audit period defined commencement as contact with someone other than the reporting person within 24 hours of the receipt of the complaint to assess the safety of the alleged child victim.

- The ISEP requires MDHHS to commence all investigations of reports of child abuse or neglect within the time frames required by State law. The ISEP also requires MDHHS to ensure accurate data collection and data verification and to provide information regarding Statewide performance related to ISEP requirements.

- Federal Information System Controls Audit Manual* (FISCAM) states that systems should include controls to ensure that data processing is complete, accurate, and valid. In addition, COBIT indicates that data should be validated to ensure that information is accurate, complete, and valid and that management should obtain regular confirmation of compliance with internal policies from business and IT process owners.

- MDHHS instructs CPS investigators to check the MiSACWIS "investigation commencement" box for the applicable commencement contact to ensure that documentation accurately reflected a worker commencing an investigation in a timely manner. MDHHS summarized contacts that investigators marked as "investigation commencement" to prepare aggregate reports regarding the department's compliance with the CPL's 24-hour commencement mandate.

We examined the "investigation commencement" contacts marked by investigators for 160 CPS investigations and

** See glossary at end of report for definition.*

We determined that the commencement data captured for 26% of reviewed investigations was not always complete, accurate, valid, and/or consistent with policy.

determined that the commencement data captured for 42 (26%) unique investigations was not always complete, accurate, valid, and/or consistent with policy (3 of the investigations had more than one of the errors described below):

a. The "investigation commencement" contact that investigators marked for 26 investigations was not consistent with MDHHS's commencement policy because the contact did not provide information to allow the investigator to assess the safety of all alleged child victims. In these instances, MDHHS's aggregate reporting of commencement timeliness would indicate that commencement occurred when the investigator checked the investigation commencement contact in MiSACWIS; however, the investigator had not garnered information to assess the safety of ***all*** of the alleged child victims at that time.

   In contrast to its commencement policy, MDHHS asserts that, in its interpretation, it satisfies the CPL commencement requirement at the time the investigator undertakes the first action reasonably calculated to lead to information related to or relevant to any child involved in the assigned investigation of abuse or neglect, and MDHHS captures commencement data accordingly (see Finding #1).

b. Investigators failed to check a MiSACWIS "investigation commencement" checkbox for any contact for 7 investigations. In these instances, MDHHS's aggregate reporting of commencement timeliness would be incomplete and not include those investigations that do not have an investigation commencement box marked in MiSACWIS.

   MiSACWIS did not have an edit to prevent submission of an investigation without an "investigation commencement" checkbox marked.

c. Investigators entered a commencement date that ***preceded*** the complaint date for 6 investigations. The calculation of compliance with the 24-hour commencement requirement requires the comparison of the complaint date to the investigator-entered commencement date. In these instances, MiSACWIS would be unable to accurately calculate whether timely commencement occurred and would likely result in misreported commencement timeliness.

   MiSACWIS did not have an edit to prevent submission of an investigation with a commencement date that preceded the complaint date.

d. Investigators captured investigation commencement contact data in MiSACWIS that differed from their written

narrative for 6 investigations. For example, investigators marked the MiSACWIS box to indicate that a successful contact had occurred when the narrative indicated that a contact had not been made, or the investigator failed to mark a successful contact when it had occurred. In these instances, MDHHS's aggregate reporting of investigation timeliness would likely be inaccurate regarding MDHHS's compliance or noncompliance with the 24-hour commencement requirement.

MDHHS supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct the deficiencies noted in parts b. through d. (see Finding #17).

We consider this finding to be a material condition because of the significant exception rate and the potential negative impact on internal and external decision-makers with regard to the reliability of MDHHS's reporting of its compliance with commencement timeliness requirements.

RECOMMENDATION

We recommend that MDHHS strengthen its controls over MiSACWIS commencement data to help ensure that it captures complete, accurate, and valid information that is consistent with established commencement policy.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that improved data input by end users could yield better commencement data. The department provided outreach and communications to staff identifying the importance of accurate documentation for, among other items, investigation commencement. Managers were provided guidance for instructing staff to only select "investigation commencement" for the contact that meets commencement requirements. In December of 2017, statewide commencement policy was further clarified for the field. This guidance provides an accurate and consistent understanding for commencement requirements.

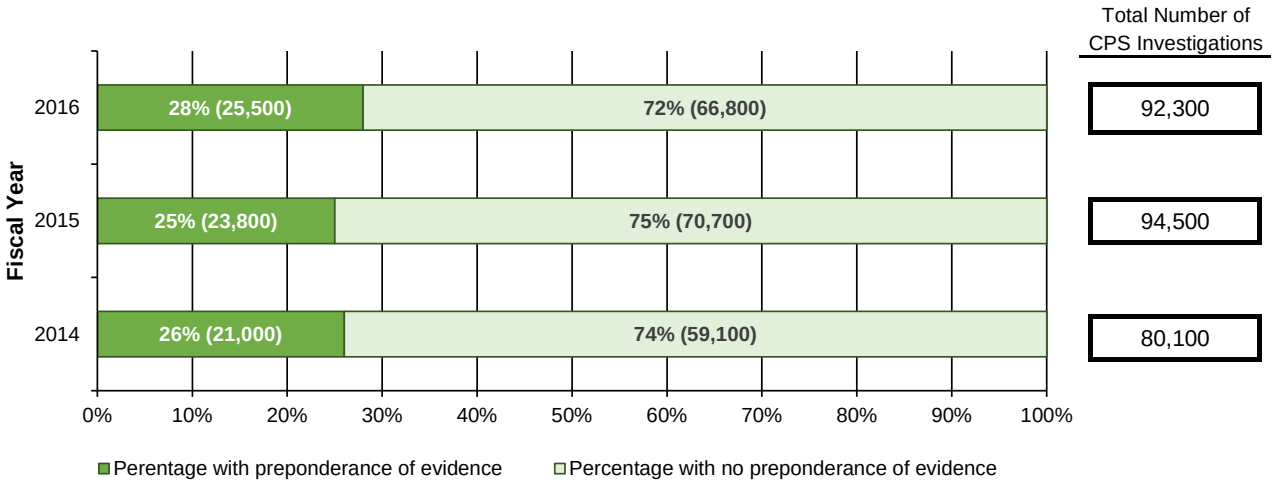
The department is currently evaluating potential MiSACWIS updates that may further assist CPS staff with documentation and provide additional oversight.

SUPPLEMENTAL INFORMATION

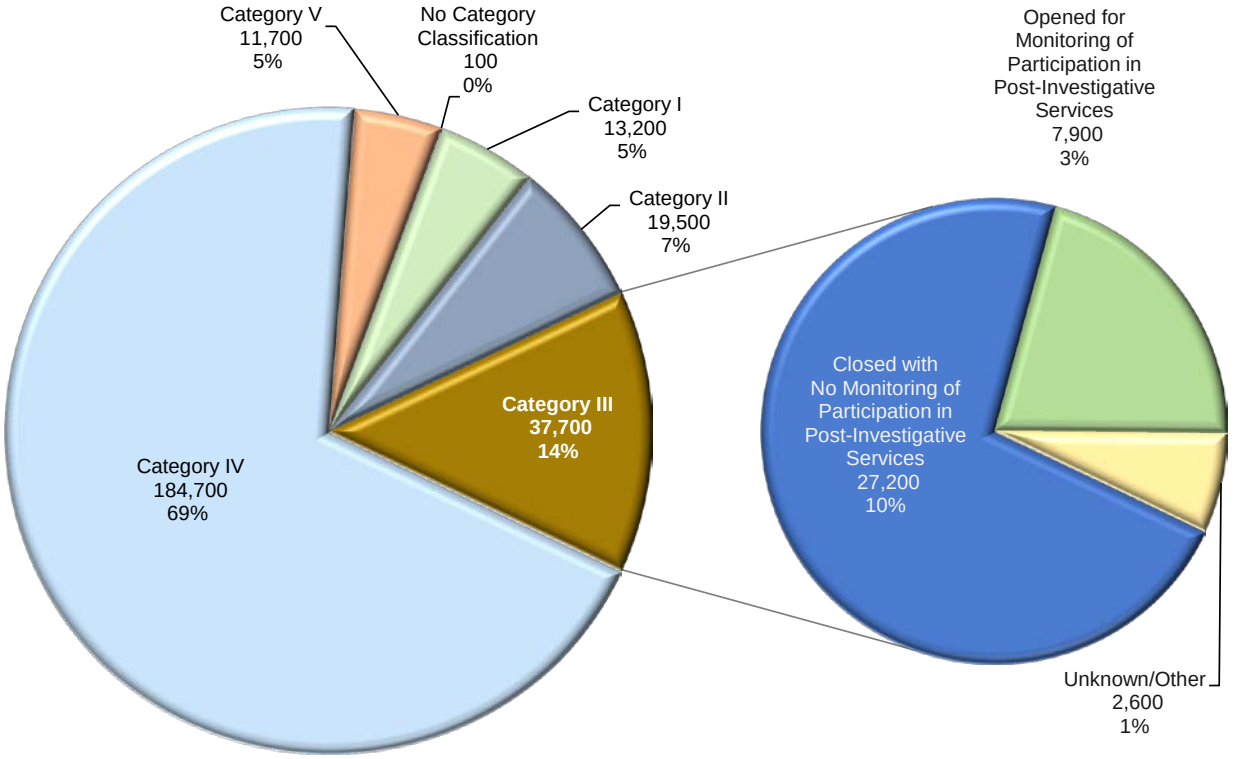
UNAUDITED
Exhibit #1

CHILDREN'S PROTECTIVE SERVICES INVESTIGATIONS
Michigan Department of Health and Human Services

A. Number of Completed CPS Investigations by Year (Rounded)



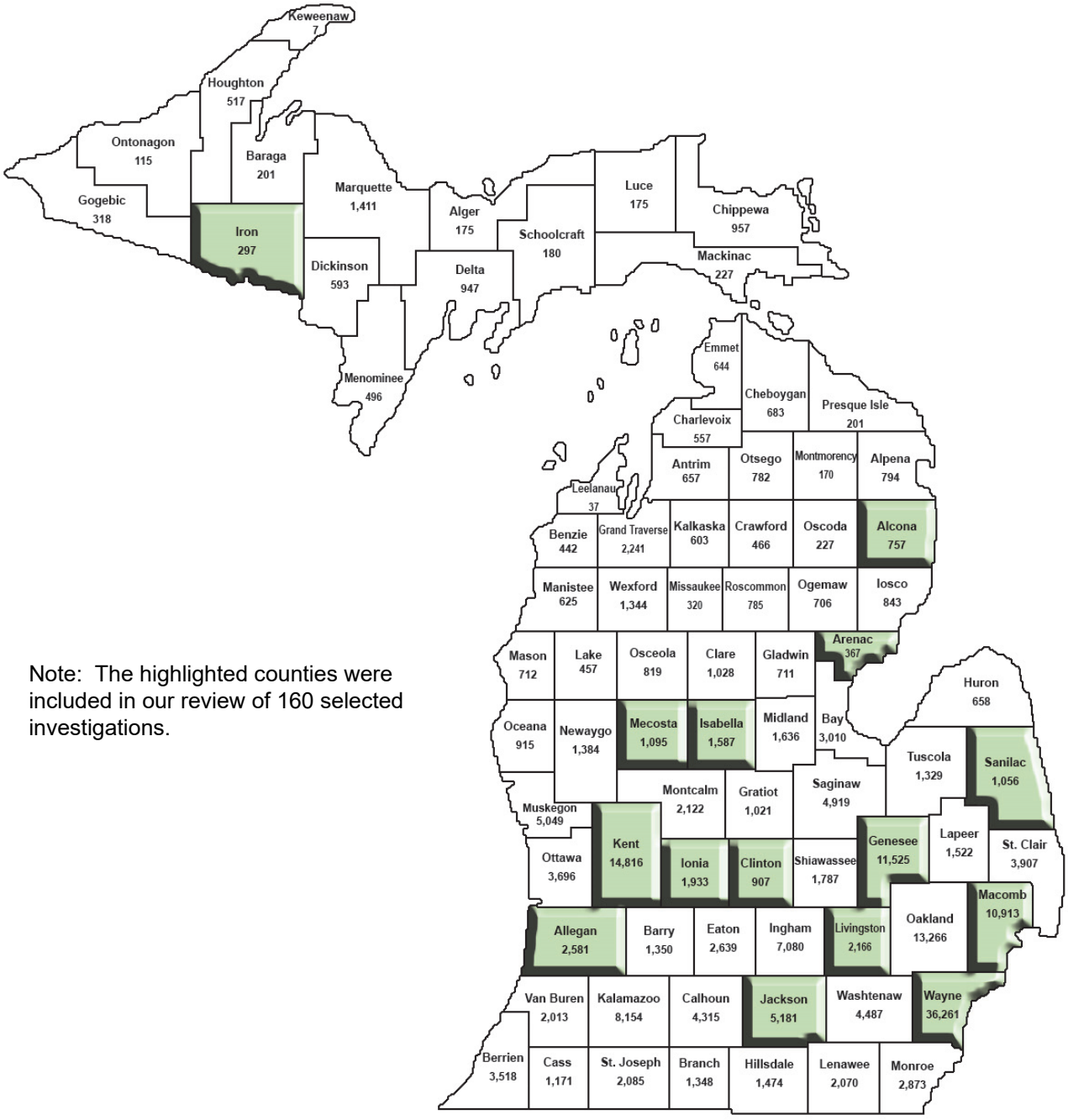
B. Category Disposition for Completed CPS Investigations (Rounded)



Source: The OAG created this exhibit using data obtained from MDHHS's CPS annual legislative comprehensive reports.

CHILDREN'S PROTECTIVE SERVICES INVESTIGATIONS
Michigan Department of Health and Human Services

Number of Completed CPS Investigations by County
From May 1, 2014 Through July 31, 2016



Note: The highlighted counties were included in our review of 160 selected investigations.

Source: The OAG created this map using data obtained from MDHHS.

CHILDREN'S PROTECTIVE SERVICES INVESTIGATIONS
Michigan Department of Health and Human Services

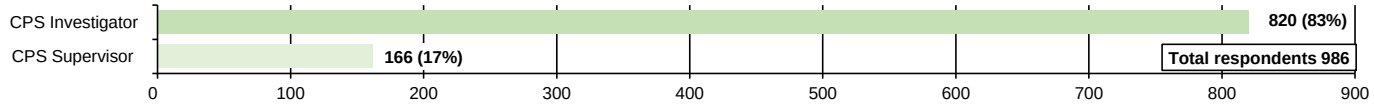
CPS Investigator and CPS Supervisor Survey Results

INFORMATIONAL QUESTIONS

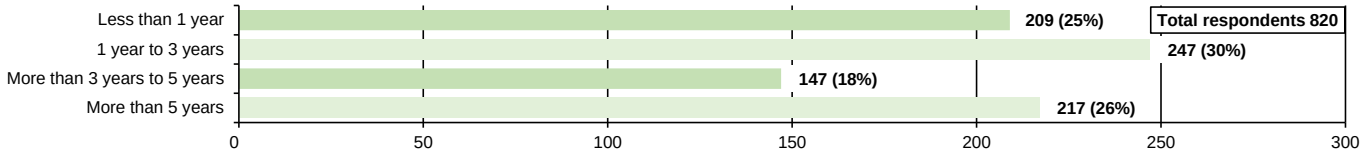
1. Please select your MDHHS county.

	Total		Total		Total		Total
Alcona	0 (0%)	Eaton	16 (2%)	Leelanau	0 (0%)	Osceola	0 (0%)
Alger	1 (0%)	Emmet	8 (1%)	Lenawee	12 (1%)	Oscoda	2 (0%)
Allegan	17 (2%)	Genesee	61 (6%)	Livingston	8 (1%)	Otsego	6 (1%)
Alpena	8 (1%)	Gladwin	4 (0%)	Luce	3 (0%)	Ottawa	21 (2%)
Antrim	5 (1%)	Gogebic	4 (0%)	Mackinac	3 (0%)	Presque Isle	0 (0%)
Arenac	4 (0%)	Grand Traverse	18 (2%)	Macomb	29 (3%)	Roscommon	6 (1%)
Baraga	1 (0%)	Gratiot	8 (1%)	Manistee	4 (0%)	Saginaw	26 (3%)
Barry	10 (1%)	Hillsdale	12 (1%)	Marquette	8 (1%)	Sanilac	5 (1%)
Bay	21 (2%)	Houghton	1 (0%)	Mason	8 (1%)	Schoolcraft	1 (0%)
Benzie	5 (1%)	Huron	3 (0%)	Mecosta	13 (1%)	Shiawassee	7 (1%)
Berrien	20 (2%)	Ingham	25 (3%)	Menominee	3 (0%)	St. Clair	15 (2%)
Branch	10 (1%)	Ionia	9 (1%)	Midland	14 (1%)	St. Joseph	11 (1%)
Calhoun	18 (2%)	Iosco	8 (1%)	Missaukee	0 (0%)	Tuscola	8 (1%)
Cass	10 (1%)	Iron	3 (0%)	Monroe	14 (1%)	Van Buren	15 (2%)
Charlevoix	3 (0%)	Isabella	6 (1%)	Montcalm	11 (1%)	Washtenaw	17 (2%)
Cheboygan	6 (1%)	Jackson	26 (3%)	Montmorency	0 (0%)	Wayne	92 (9%)
Chippewa	8 (1%)	Kalamazoo	43 (4%)	Muskegon	32 (3%)	Wexford	10 (1%)
Clare	9 (1%)	Kalkaska	4 (0%)	Newaygo	14 (1%)	I would prefer not to answer.	14 (1%)
Clinton	7 (1%)	Kent	47 (5%)	Oakland	44 (4%)	**Total respondents**	**986**
Crawford	3 (0%)	Keweenaw	0 (0%)	Oceana	4 (0%)		
Delta	5 (1%)	Lake	4 (0%)	Ogemaw	6 (1%)		
Dickinson	4 (0%)	Lapeer	15 (2%)	Ontonagon	0 (0%)		

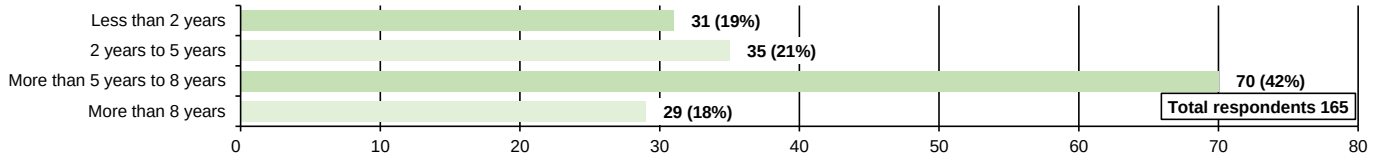
2. Which of the following best describes your job title?



3. How many years of CPS investigation experience do you have?



4. How many years of CPS supervisory experience do you have?



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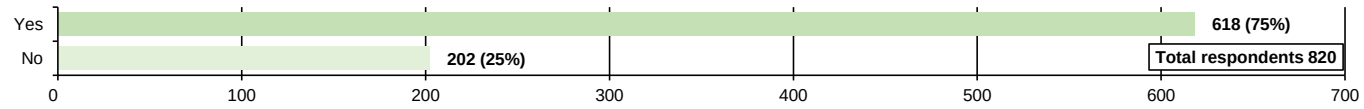
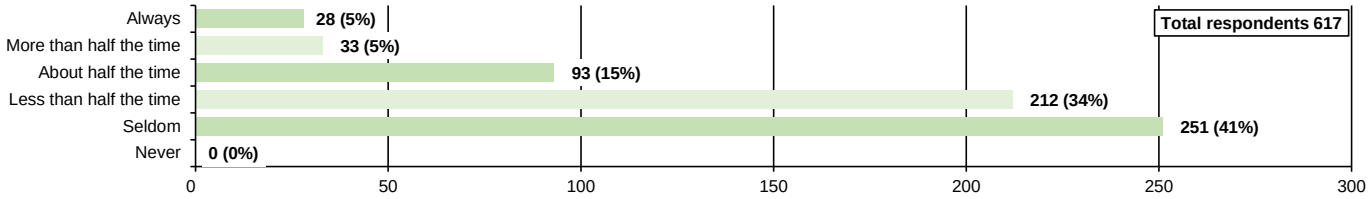
INVESTIGATOR SAFETY QUESTIONS

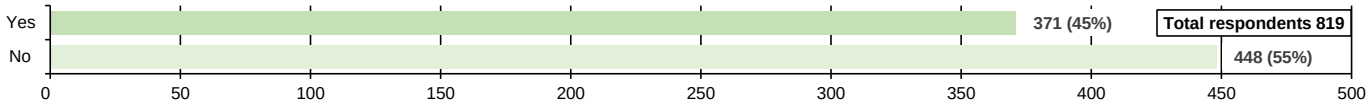
5. Have you ever feared for your physical safety as it relates to your job as a CPS investigator?



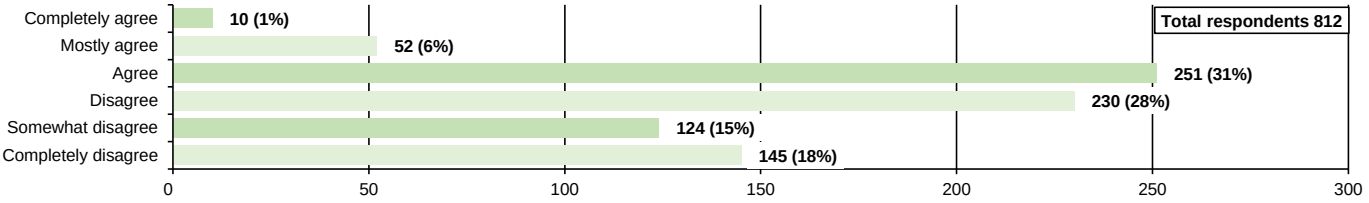
6. How often have you feared for your physical safety as it relates to your job as a CPS investigator?



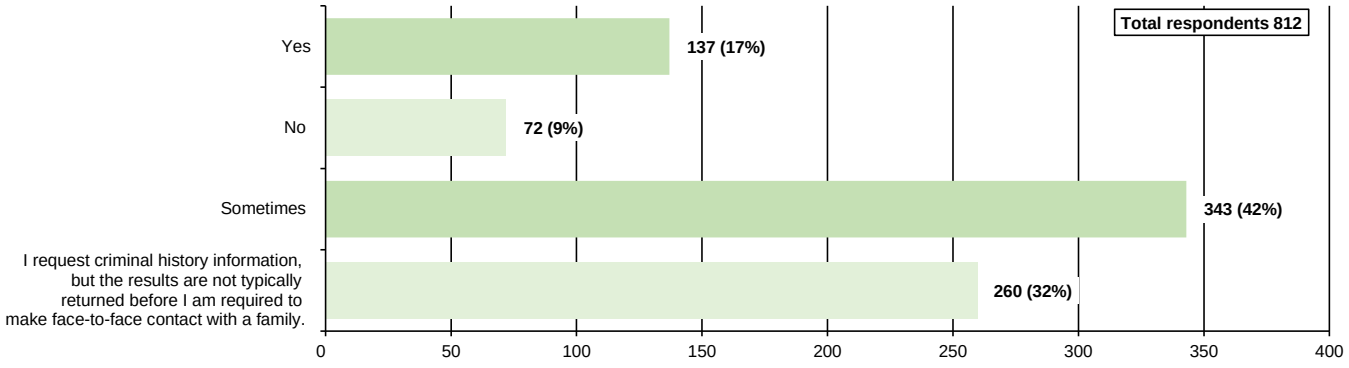
7. During calendar years 2014, 2015, or 2016, did you participate in any physical safety training?



8. The physical safety training provided by MDHHS adequately prepares me for unsafe situations.



9. Do you conduct a criminal history check for your personal physical protection prior to making face-to-face contact with a family for the first time?



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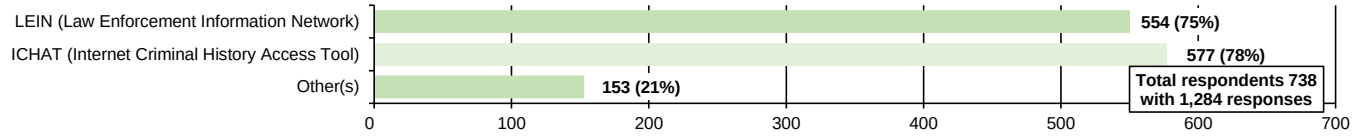
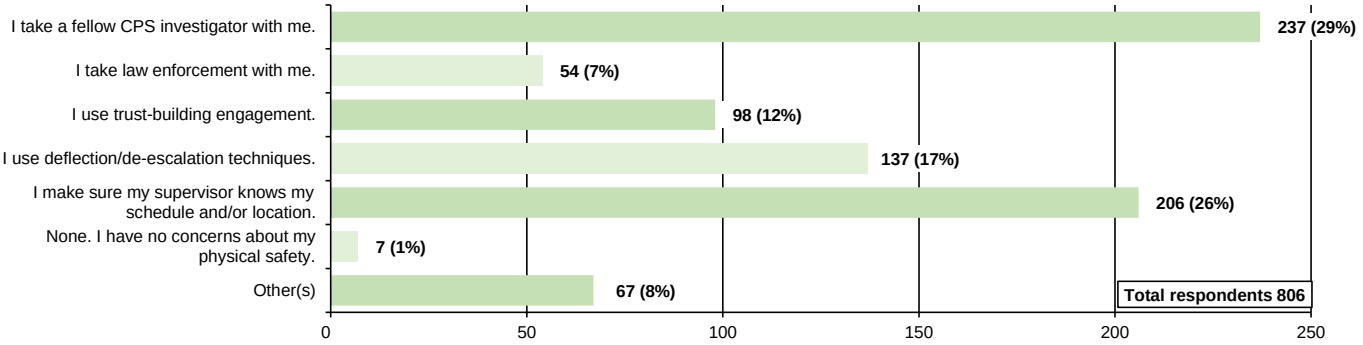
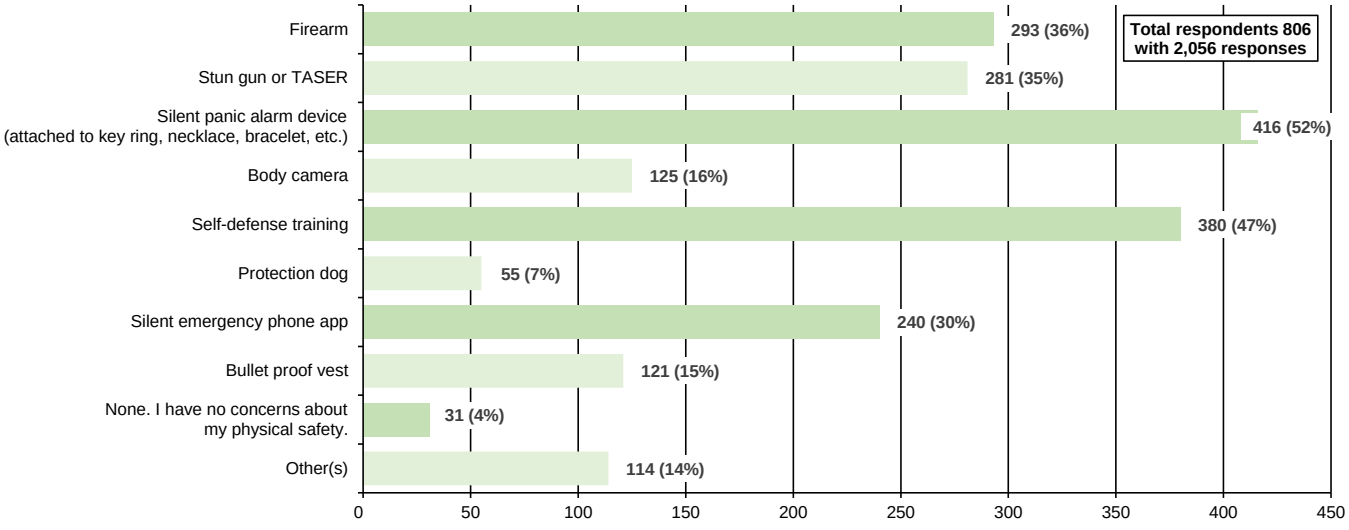
10. What type of criminal history check(s) do you conduct for your personal physical protection prior to making face-to-face contact with a family for the first time? (check all that apply)



11. Which personal protection method do you use most often when conducting a CPS investigation?



12. Which personal protection item(s) would you prefer to have available to you? (check all that apply)



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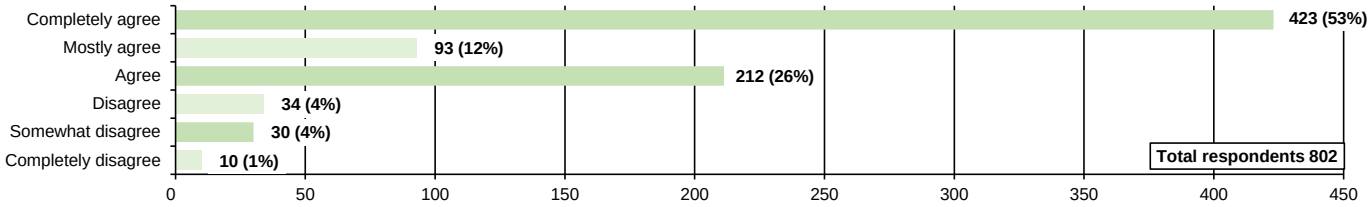
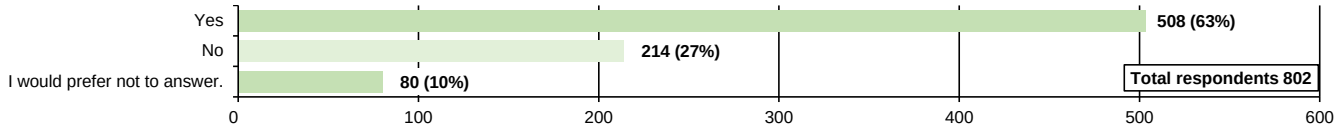
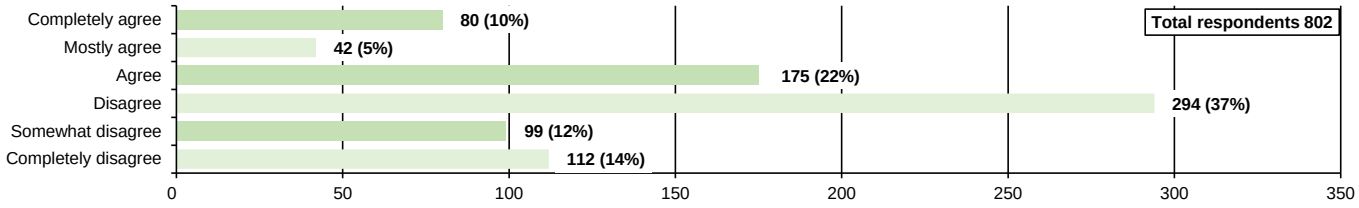
13. My CPS supervisor takes my physical safety seriously.



14. Do you feel that the pressure to meet standard of promptness requirements (commencement, face-to-face contact with alleged victim(s), and 30-day investigation completion) puts you in unsafe situations?

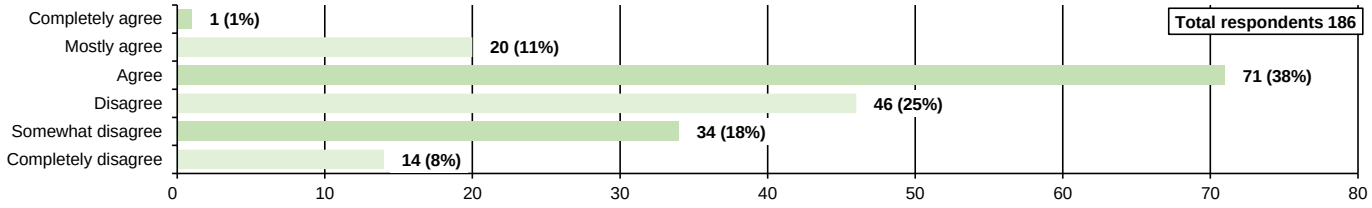


15. I have considered leaving my position as a CPS investigator due to physical safety concerns.

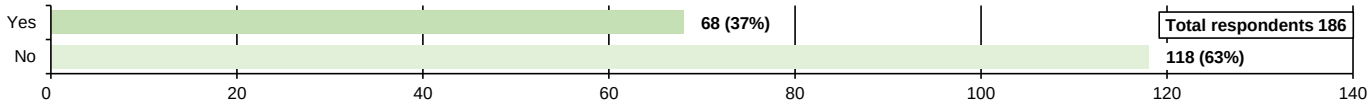


SUPERVISOR SAFETY QUESTIONS

16. The physical safety training provided to CPS investigators adequately prepares CPS investigators for unsafe situations.



17. Are you aware of instances in which personal safety was a contributing factor to employee turnover?



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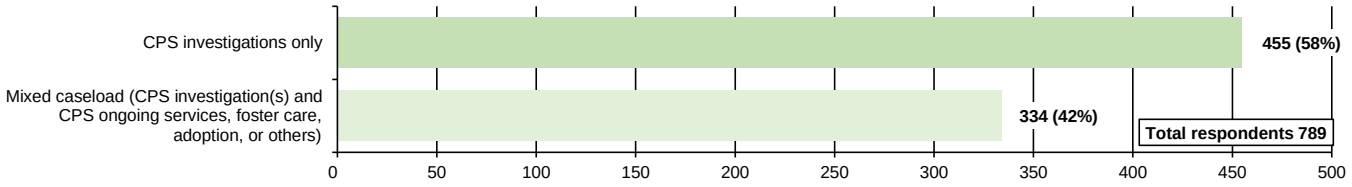
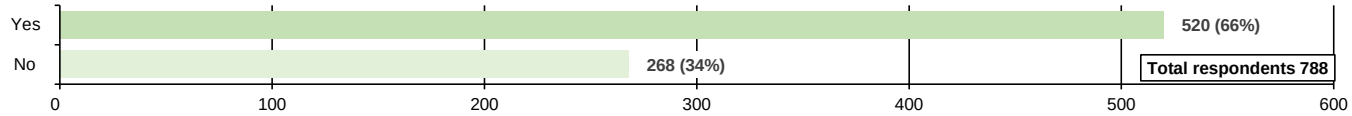
INVESTIGATOR CASELOAD QUESTIONS

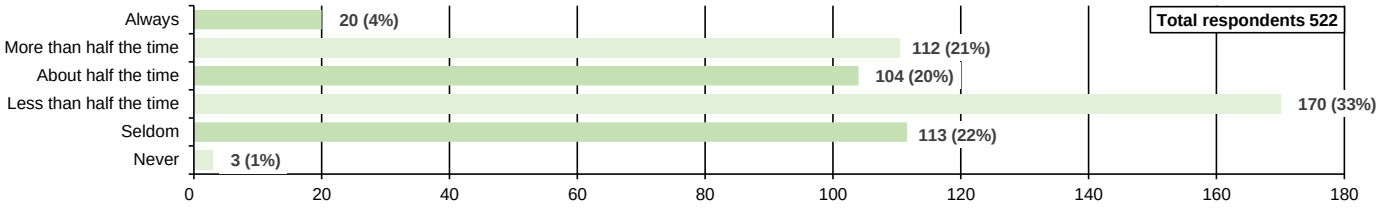
18. What is your current caseload?



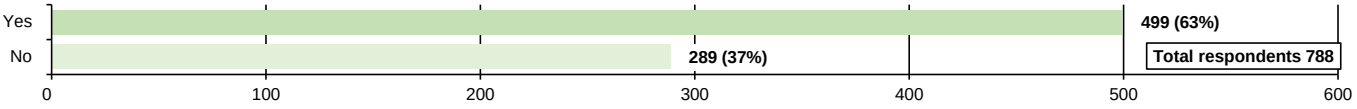
19. At any time during calendar years 2014, 2015, or 2016, did you ever have a CPS investigation caseload of 13 or greater?



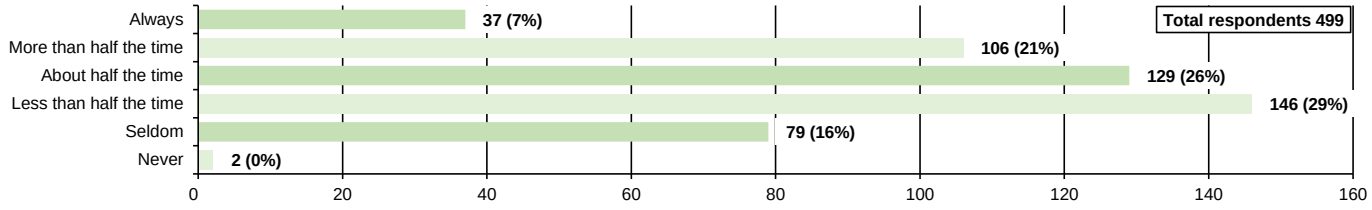
20. How often did you have a CPS investigation caseload of 13 or greater?



21. Has your caseload negatively impacted your ability to conduct CPS investigations in compliance with MDHHS policy?



22. How often has your caseload negatively impacted your ability to conduct a CPS investigation in compliance with MDHHS policy?



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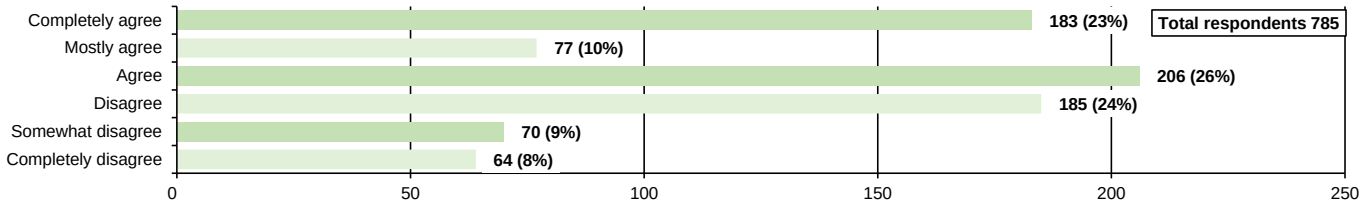
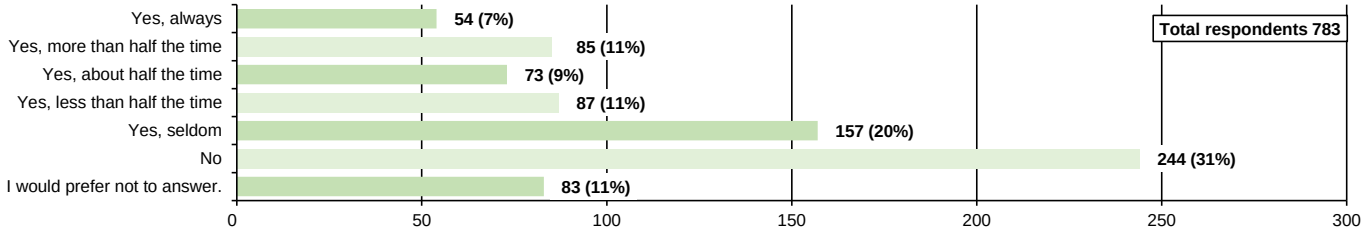
23. I have considered leaving my position as a CPS investigator because of my caseload.

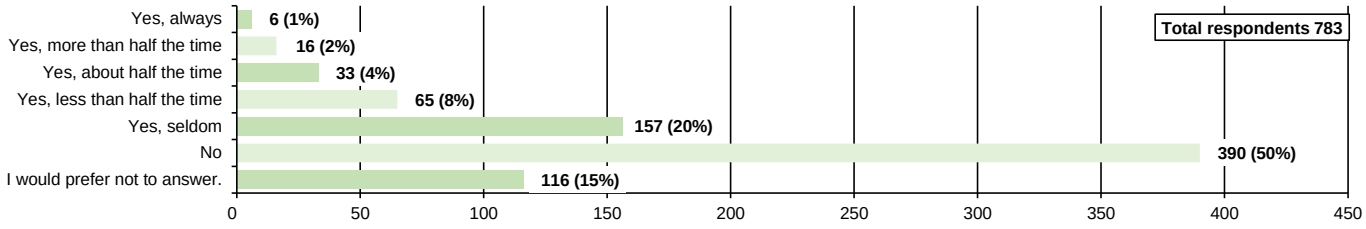


INVESTIGATOR STANDARD OF PROMPTNESS QUESTIONS

24. Have you ever felt pressure to submit a CPS investigation for approval to meet standard of promptness requirements (30-day) knowing that a policy requirement was not met?

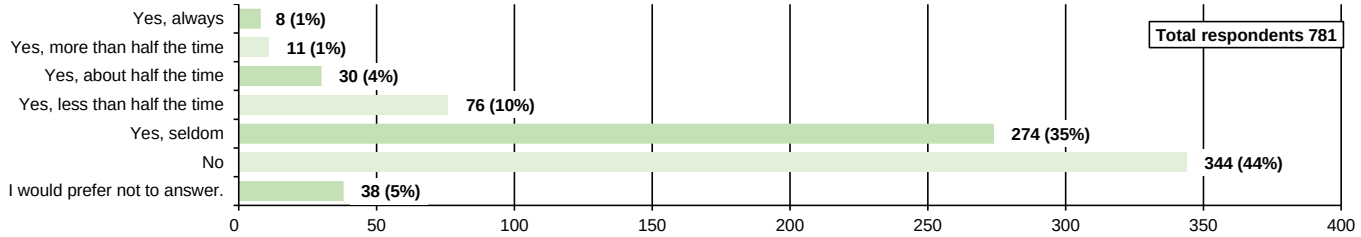


25. Have you ever submitted a CPS investigation for approval to meet standard of promptness requirements (30-day) knowing that a policy requirement was not met?



INVESTIGATOR PREPONDERANCE QUESTIONS

26. Have you felt pressure from management to assign a preponderance of evidence disposition in your CPS investigations when you disagreed?



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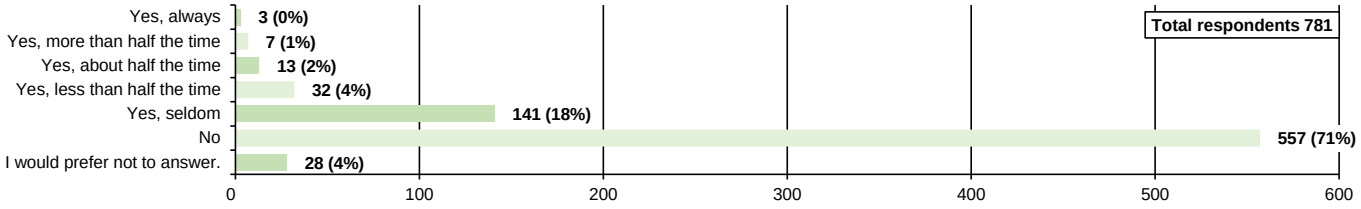
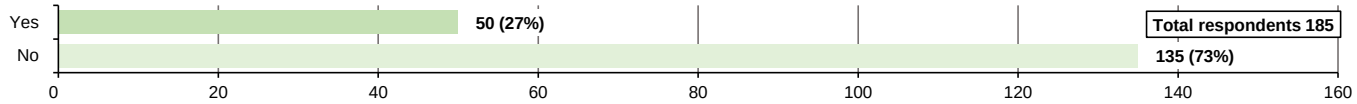
27. Have you felt pressure from management to assign a no preponderance disposition in your CPS investigations when you disagreed?

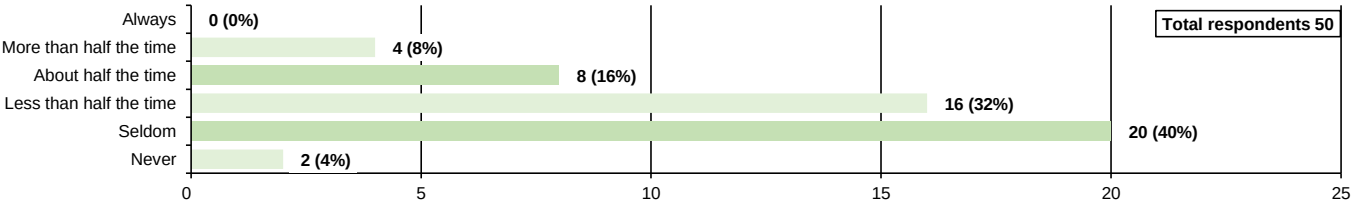


SUPERVISION QUESTIONS

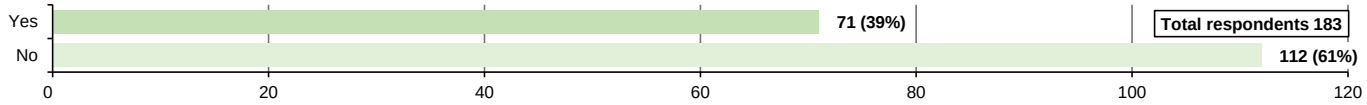
28. At any time during calendar years 2014, 2015, or 2016, did you ever supervise more than 5 CPS investigators?



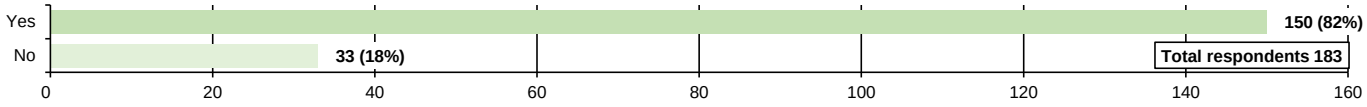
29. How often did you supervise more than 5 CPS investigators?



30. Does the number of staff that you are supervising negatively impact your ability to thoroughly review and approve CPS investigations?



31. Are you aware of instances in which CPS caseloads were a contributing factor to employee turnover?



Source: The OAG created this exhibit to summarize all responses received in our survey of MDHHS's CPS investigators and CPS supervisors.

Exhibit #4

CHILDREN'S PROTECTIVE SERVICES INVESTIGATIONS
Michigan Department of Health and Human Services

Summary of Investigation Deficiencies for Five Selected CPS Investigations

We selected and reviewed 160 CPS investigations for evaluation to conclude on our audit objectives. We reported deficiencies in 159 (99%) of the 160 investigations, ranging from 1 to 13 reported deficiencies per investigation, and averaging 5. This exhibit illustrates the full scope of the uncorrected deficiencies that we reported in 5 reviewed investigations and provides perspective regarding the frequency and pervasiveness of deficiencies noted during our review of the 160 investigations. The 5 example cases were chosen because they represent both types of investigation conclusions (preponderance and no preponderance of evidence of CA/N) and provide a range of deficiencies from near average number to near maximum. MDHHS supervisory oversight did not detect or correct the investigation deficiencies summarized below (see Finding #17).

Investigation Example Case #1

Investigation Overview
The complaint originated from a mandated reporter. The complaint alleged improper supervision and threatened harm of an infant as a result of a domestic violence incident that occurred between the parents with the child present. There were also allegations of drug use by the father. The CPS investigator completed a home visit and interviewed the father. The father denied that a physical altercation had occurred and he indicated that the mother had taken the alleged child victim out of the State following the alleged incident. The CPS investigator interviewed the mother over the phone, at which time the mother indicated that she lied about the alleged incident and stated that the alleged child victim was with her in California. The investigator obtained and reviewed the applicable police report and drug-tested the father. Through review of the mother's CPS history, the CPS investigator learned that the mother had her parental rights terminated for her five previous children.

Investigation Conclusion
The CPS investigator concluded that there was no preponderance of evidence of improper supervision or threatened harm and closed the investigation as a Category IV with a moderate-risk level. Neither parent was added to the Central Registry.

Investigation Deficiencies
Our review of MDHHS's investigation documentation noted that the CPS investigator ***did not***:

- Complete a criminal history check for the mother, an alleged perpetrator (see Finding #3).
- Document review of CPS history for the father, an alleged perpetrator (see Finding #4).
- Document contact with the mandated reporter for additional information or for clarification/verification of information received in the complaint (see Finding #5).
- Document written notification to the mandated reporter of the investigation disposition (see Finding #5).
- Make face-to-face contact with the alleged child victim and did not contact the California child welfare agency to request verification of the child's safety through face-to-face contact (see Finding #6).
- Document verification of the safety and whereabouts of the alleged victim or the father's three other children (see Finding #7).
- Document that a safety plan was established during initial contact with the family or document why an immediate safety plan was not needed (see Finding #8).

This exhibit continued on next page.

Investigation Example Case #1 *(Continued)*

- Complete the safety assessment timely following initial face-to-face contact with the family. The assessment was completed 65 days after initial face-to-face contact (see Finding #8).
- Complete the required sibling placement evaluation to document how the child remained safe in the mother's care when the child's siblings had been previously removed from the mother's care (see Finding #11).
- Accurately assess the risk of future harm to the child, resulting in an assessed risk level that was too low (see Finding #13).
- Complete the investigation within 30 days of receipt of the complaint. The investigation was completed 39 days late (see Finding #16).

Our review of MDHHS's investigation documentation also noted that the CPS supervisor did not complete the supervision checklist to determine whether child safety needs and investigation requirements had been met (see Finding #17).

Investigation Example Case #2

Investigation Overview

The complaint alleged sexual abuse of a child by a mother's live-in boyfriend. The CPS investigator performed a home visit and interviewed the mother, the child victim, and one other child living in the home. The child victim disclosed sexual abuse by the live-in boyfriend, although the mother denied any prior knowledge of it. Upon learning of the sexual abuse, the mother evicted the perpetrator from the home, filed a police report, and had medical examinations completed for both of the children. The investigator also conducted a CPS history check for the mother, conducted criminal history checks for both adults, interviewed other family members, and referred the investigation to local law enforcement as required by the CPL. The CPS investigator attempted to contact the alleged perpetrator on multiple occasions for an interview but was unsuccessful. In the final days of the investigation, the investigator learned that the mother continued to allow the perpetrator access to the children during the course of the investigation.

Investigation Conclusion

The CPS investigator concluded that there was a preponderance of evidence that the mother's live-in boyfriend had perpetrated sexual abuse against the child and also concluded that the mother had failed to protect the child from the sexual abuse by allowing the perpetrator continued access to the children during the investigation. The investigation was closed as a Category III, with no monitoring of post-investigative services and a moderate-risk level. Neither perpetrator was added to the Central Registry.

This exhibit continued on next page.

Investigation Example Case #2 *(Continued)*

Investigation Deficiencies

Our review of MDHHS's investigation documentation noted that the CPS investigator ***did not***:

- Document performance of a Central Registry clearance for the mother or the mother's live-in boyfriend, both alleged perpetrators (see Finding #2).
- Document review of CPS history for the mother's live-in boyfriend, an alleged perpetrator (see Finding #4).
- Document that a safety plan was established during initial contact with the family or document why an immediate safety plan was not needed (see Finding #8).
- Accurately complete the safety assessment (see Finding #8).
- Complete the safety assessment in a timely manner following initial face-to-face contact with the family. The assessment was completed 29 days after initial face-to-face contact (see Finding #8).
- File a court petition, as required by the CPL in situations of confirmed sexual abuse and failure to protect by the parent (see Finding #9). This deficiency also resulted in MDHHS's:
    - Misclassification of the investigation as a Category III investigation; however, proper filing of the court petition would have required a Category I investigation classification.
    - Omission of the perpetrators from the Central Registry; however, an appropriate Category I classification would have required that the perpetrators be added to the Central Registry (see Finding #20).
- Refer the investigation to the county prosecuting attorney, as required by the CPL (see Finding #10).
- Accurately assess the risk of future harm to the child, resulting in an assessed risk level that was too low (see Finding #13).
- Complete a child assessment of needs and strengths for the one non-victim child in the household (see Finding #15).
- Complete the investigation within 45 days of receipt of the complaint, as allowed by a supervisor-approved time frame extension. The investigation was completed 14 days after the approved extension date (see Finding #16).
- Open this Category III investigation for monitoring of the family's participation in post-investigative services; instead, the investigation was closed and MDHHS performed no monitoring of the family's participation in post-investigative services (see Finding #18).
- Properly capture investigation commencement data in MiSACWIS. The CPS investigator captured a commencement date that preceded the complaint receipt date (see Finding #24).

This exhibit continued on next page.

Investigation Example Case #3

Investigation Overview

The complaint alleged that a father abused alcohol and was sexually and physically abusing and improperly supervising his preteen daughter. The investigator interviewed the father and the child during a home visit, where the child confirmed the alleged abuse. After interviewing the alleged victim, the CPS investigator determined that the child needed to be outside of the father's care during the CPS investigation to ensure the child's safety. The father was unable to secure appropriate outside care for his child through family or friends so MDHHS sought and received a petition for an emergency removal order from the court. The child was removed from the home and later placed in licensed foster care. The investigator made phone contact with the child's mother, who lived out of the State. The mother did not attend any of the related court proceedings. During the investigation, the child acknowledged to a trained forensic interviewer that the allegation of being sexually and physically abused was false and that the child was angry with her father. Based on this information, the court dismissed the earlier court petition for removal and MDHHS returned the child to her father's care. At the conclusion of the investigation, MDHHS had no evidence that CA/N occurred.

Investigation Conclusion

The CPS investigator concluded that there was a preponderance of evidence of sexual abuse and improper supervision by the father and failure to protect and abandonment by the mother. The investigation was classified as a Category I investigation with an intensive-risk level. The mother and father were added to the Central Registry.

Investigation Deficiencies

Our review of MDHHS's investigation documentation noted that the CPS investigator ***did not***:

- Accurately complete the safety assessment (see Finding #8).
- Complete the safety assessment in a timely manner following initial face-to-face contact with the family. The safety assessment was completed 30 days after initial face-to-face contact (see Finding #8).
- Accurately assess the risk of future harm to the child, resulting in an assessed risk level that was too high (see Finding #13).
- Complete the investigation within 30 days of receipt of the complaint. The investigation was completed 6 days late (see Finding #16).
- Properly classify the investigation. The investigation was improperly classified as a Category I investigation. However, documented investigation evidence did not support a preponderance of evidence of CA/N, and we concluded that the investigation should have been classified as a Category IV investigation (see Finding #19).
- Take appropriate Central Registry actions. The investigator improperly added the mother and father to the Central Registry as a result of MDHHS's improper Category I classification (see Finding #19).

Our review of MDHHS's investigation documentation also noted that the CPS supervisor did not review and approve the investigation within the 14-day required time frame. The supervisory review and approval was 6 days late (see Finding #17).

This exhibit continued on next page.

Investigation Example Case #4

Investigation Overview

The complaint originated from a mandated reporter and alleged that a mother left two of her three young children unattended in an unlocked car for 45 minutes while shopping at a shopping center. The allegations noted that one child, who was less than 2 years old, was very thin for his age. The CPS investigator reviewed CPS history, conducted criminal history checks, conducted a home visit, interviewed the mother and the oldest child, and made successful and unsuccessful contacts with the children's fathers. The investigator obtained and reviewed the associated police report, which confirmed the allegations.

Investigation Conclusion

The CPS investigator concluded that there was a preponderance of evidence to support improper supervision and threatened harm by the mother against her children. The investigation was closed as a Category III with no monitoring of post-investigative services and a moderate-risk level. The mother was not added to the Central Registry.

Investigation Deficiencies

Our review of MDHHS's investigation documentation noted that the CPS investigator ***did not***:

- Document contact with the mandated reporter for additional information or for clarification/verification of information received in the complaint (see Finding #5).
- Obtain required medical examinations for the children or document why the medical examinations were not obtained (see Finding #12).
- Document meeting with the CPS supervisor for a case consultation prior to disposition of the investigation (see Finding #17).
- Open this Category III investigation for monitoring of the family's participation in post-investigative services; instead, the investigation was closed and MDHHS performed no monitoring of the family's participation in post-investigative services (see Finding #18).

Our review of MDHHS's investigation documentation also noted that the CPS supervisor ***did not***:

- Review and approve the investigation within the 14-day required time frame. The supervisory review and approval was 30 days late (see Finding #17).
- Complete the supervision checklist to determine whether child safety needs and investigation requirements had been met (see Finding #17).

This exhibit continued on next page.

Investigation Example Case #5

Investigation Overview

The complaint originated from a mandated reporter and alleged that a child and his belongings consistently smelled of animal urine and feces because of unsanitary conditions in the child's home. The child's three siblings were also identified as possible child victims of physical neglect by the children's mother and her live-in boyfriend. The CPS investigator conducted two unannounced home visits to observe the cleanliness of the home and noted hygiene and cleanliness issues. The investigator interviewed the mother, live-in boyfriend, children, children's biological father, stepmother, and two of the children's school teachers.

Investigation Conclusion

The CPS investigator concluded that there was no preponderance of evidence of physical neglect because the home cleanliness issues did not appear to be presenting a substantial risk to the children at the time and closed the investigation as a Category IV with an intensive-risk level. No one was added to the Central Registry.

Investigation Deficiencies

Our review of MDHHS's investigation documentation noted that the CPS investigator ***did not***:

- Commence the investigation pertaining to all alleged child victims within 24 hours of receipt of the complaint (see Finding #1).
- Document performance of a Central Registry clearance for the children's father or stepmother (see Finding #2).
- Document written notification to the mandated reporter of the investigation disposition (see Finding #5).
- Document that a safety plan was established during initial contact with the family or document why an immediate safety plan was not needed (see Finding #8).
- Complete the safety assessment timely following initial face-to-face contact with the family. The assessment was completed 27 days after initial face-to-face contact (see Finding #8).
- Accurately assess the risk of future harm to the child, resulting in an assessed risk level that was too high (see Finding #13).
- Properly capture investigation commencement data in MiSACWIS. The CPS investigator captured commencement data allowing for assessment of the safety of only 1 of the 4 alleged child victims (see Finding #24).

Source: This exhibit summarizes investigation information from MDHHS's electronic and hard-copy CPS investigation casefiles.

CPS INVESTIGATION DESCRIPTION

The CPL provides for the protection of children who are abused or neglected and a framework for MDHHS's performance of CA/N investigations. MDHHS's CPS program is located within MDHHS's CSA.

CPS policy and guidance are created centrally by CSA. CPS field investigations are carried out by CPS investigators located at the applicable MDHHS local county offices, which are overseen by five geographically organized MDHHS's BSC directors.

MDHHS completed approximately 206,000 CPS investigations between May 1, 2014 and July 31, 2016 and employed 1,427 full-time CPS workers as of June 18, 2016.

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine activities and records related to MDHHS's CPS investigations. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our audit objectives and corresponding audit procedures were directed toward concluding on MDHHS operations related to CPS field investigations. Our audit objectives and procedures were not directed toward concluding on MDHHS's CPS complaint intake operations or service provision and intervention operations.

Generally accepted government auditing standards require us to report significant constraints imposed upon the audit approach. We encountered two issues that necessitate reporting:

1. We experienced a more than 5-month delay in MDHHS providing us with appropriate access to MiSACWIS, which contained vital information pertinent to our auditing procedures. MDHHS initially denied our system access requests based on its disagreement regarding the OAG's legal authority to access certain confidential information contained in MiSACWIS. Further delays occurred because MDHHS management did not understand the system capabilities that it assigned to the auditors and repeatedly assigned excess capabilities inconsistent with the audit function. These delays prevented a timely preliminary survey of CPS investigations to identify risks and develop the audit scope and methodology.

2. We experienced considerable and unnecessary delays in MDHHS's CSA management providing responses to our audit testing results, which delayed the preparation and issuance of this audit report. The OAG routinely provides agencies with audit testing results and requests that they provide any additional evidence that should be evaluated, explain why they think the findings occurred, and/or indicate a planned corrective action. It was our understanding that MDHHS local county offices ***and*** CSA management were simultaneously involved in this response process. However, once the MDHHS local county offices had provided responses, CSA management recanted regarding its involvement in the due process and indicated that it had not vetted the audit testing results. Ultimately, CSA management reassigned responsibility for an additional verification of the audit testing results to a CSA staff person, significantly adding to the audit processing time line.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered May 1, 2014 through July 31, 2016.

METHODOLOGY

We conducted a preliminary survey to gain an understanding of MDHHS's CPS field investigation operations in order to establish our audit objectives, scope, and methodology. During our preliminary survey, we:

- Interviewed MDHHS management, CPS supervisors, and CPS investigators to gain an understanding of CPS investigation practices and placed an emphasis on activities with the greatest impact on child safety because safety is the first priority of MDHHS's child welfare system.

- Reviewed applicable laws, regulations, contracts, policies, and guidance.

- Reviewed child welfare publications, including the *CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families* and *Supervising Child Protective Services Caseworkers* and *Child Protective Services: A Guide for Caseworkers* from the Administration for Children and Families, U.S. Department of Health and Human Services, to understand generally accepted professional guidelines and practices.

- Reviewed the Modified Settlement Agreement and Consent Order and the ISEP to understand the applicable CPS requirements imposed by those agreements.

- Analyzed available MDHHS's CPS investigation records, reports, data, and statistics.

- Performed preliminary testing of selected CPS investigations on site at four MDHHS local county offices to identify potential risk areas for review.

- Reviewed the MiSACWIS User Guide and applicable job aids and performed a MiSACWIS walk-through to understand the required data elements to properly capture data pertaining to select CPS investigation timeliness requirements.

OBJECTIVE #1

To assess the sufficiency of MDHHS's efforts to ensure the appropriate and consistent application of selected CPS investigation requirements.

To accomplish this objective, we:

- Judgmentally and randomly selected representative samples of 160 CPS investigations from the Statewide population of 206,000 CPS investigations that MDHHS completed between May 1, 2014 and July 31, 2016; conducted on-site reviews at 16 MDHHS local county offices in 14 Michigan counties to review the hard-copy casefile information that MDHHS maintained in conjunction with the electronic casefile information contained in MiSACWIS; and performed an off-site review of the selected investigation files for one additional county. We examined each selected investigation to determine whether MDHHS's casefile contained all required investigation documentation, and we performed the following audit procedures to evaluate MDHHS's compliance with applicable selected investigation requirements:
    - Compared the complaint receipt time with MDHHS's documented commencement activities to determine whether MDHHS appropriately commenced the investigation within 24 hours of receiving the complaint, as required.
    - Examined the investigation casefile and Central Registry information to determine whether all required Central Registry activities were completed, including:
        - Performing Central Registry clearances for all required individuals to determine whether an individual has previously perpetrated CA/N.
        - Adding confirmed perpetrators of CA/N to the Central Registry as required by the CPL.
        - Notifying the confirmed perpetrators that their name was added to the Central Registry.
    - Evaluated investigation documentation to determine whether MDHHS conducted all required criminal history checks.
    - Inspected the investigation casefile to determine whether the investigator performed complete CPS history checks to identify prior CPS involvement

and assessed its relevance to current conditions, as required.

- Assessed the investigators' performance of required home visits in situations where the allegations had a direct relationship to the home environment.

- Reviewed the investigators' required verification of a safe sleep environment in homes with infants aged 12 months or younger.

- Examined the investigators' inquiries regarding the prior addresses of individuals in order to assess possible previous CPS involvement in another state.

- Reviewed documentation of the investigators' required contact with mandated reporters to gather additional relevant information and notify the reporter of the investigation disposition.

- Compared the time of complaint receipt, assigned priority response, and casefile records to verify that investigators made the required face-to-face contact with the alleged child victim(s) within the required time frame.

- Reviewed documentation supporting the investigators' required interviews of the alleged perpetrator, the alleged child victim(s), and other children to gather investigative evidence to support investigation decisions and conclusions.

- Reviewed documentation to support the investigators' verification of the safety and whereabouts of all required children.

- Analyzed MDHHS's compliance with requirements for the selected abbreviated investigations.

- Verified that investigators established necessary safety plans at initial contact with families to immediately help eliminate or mitigate threats to the alleged child victim's safety.

- Determined whether investigators completed safety assessments in an accurate and timely manner.

- Verified that MDHHS filed CPL-required court petitions to provide the court with an opportunity to provide legal intervention in instances of severe CA/N.

- Verified that MDHHS made CPL-required referrals to the county prosecuting attorney, when appropriate.

- Verified that investigators completed the required sibling placement evaluation to demonstrate that risk and safety concerns that resulted in court actions for CA/N of the child's siblings had been addressed.

- Assessed whether investigators obtained required medical examinations.

- Reviewed documentation to support the investigator's evaluation of current and historical factors in investigations involving threatened harm.

- Recalculated risk assessment scores based on the documented casefile evidence, verified proper category classification, and evaluated the impact of inaccurately scored risk assessments on MDHHS's investigation category classification and omissions from the Central Registry.

- Determined whether investigators completed the required child and family needs and strengths assessments to help identify the services needed, gaps in resources, and strengths that may help the family provide a safer environment for the children.

- Inspected documentation to determine whether MDHHS completed the investigation within the required time frame, including consideration of approved extensions.

- Evaluated whether supervisors performed case reviews within established time frames and conducted case consultations with investigators, as required.

- Conducted criminal history record checks and Central Registry checks for any required individuals whom MDHHS failed to perform the required check during its investigation to evaluate risks regarding the safety of the child and the potential impact on MDHHS's investigation decisions and conclusions.

- Conducted procedures and identified nine MiSACWIS risk assessment system functionality errors that impacted the risk assessments for our selected investigations. We evaluated the impacts of the errors on our selected investigations and expanded our review by performing data analytics applied to the total population of 206,000

completed investigations to help identify the completed investigations that were impacted by the system functionality errors and those potentially impacted.

- Performed procedures to evaluate whether any of the alleged child victims from the 160 selected investigations reviewed were subsequently associated with investigations conducted by the Office of Children's Ombudsman.

- Evaluated MDHHS's CPS investigation practices pertaining to use of the investigation checklist, monitoring of Category III investigations, and category assignment for certain investigations to determine whether investigation practices aligned with the related CPL requirements.

- Surveyed 1,680 CPS supervisors and investigators and examined the 990 responses received regarding CPS worker safety, worker caseloads and pressures related to meeting standards of promptness and assigning preponderance conclusions, and impacts of supervisory workloads (see Exhibit #3).

- Judgmentally selected a sample of 21 Michigan counties and requested the selected counties' local CA/N investigation protocol and evaluated each protocol for compliance with the CPL and adherence to the model protocol developed by the State of Michigan Governor's Task Force on Child Abuse and Neglect.

- Advised MDHHS of concerns that, based on the documented investigation evidence that we reviewed for several of the selected investigations, there could have been a potential lingering safety impact on the children associated with the investigations. Subsequent to our notification, MDHHS took steps to evaluate the status of these children with regard to the concerns.

Our random samples were selected to eliminate any bias and enable us to project the results to the population.

OBJECTIVE #2

To determine the effectiveness of MDHHS's efforts to accurately capture data used to report its compliance with selected CPS investigation timeliness requirements.

To accomplish this objective, we judgmentally and randomly selected representative samples of 160 CPS investigations from the Statewide population of 206,000 CPS investigations that MDHHS completed between May 1, 2014 and July 31, 2016; conducted on-site reviews at 16 MDHHS local county offices in 14 Michigan counties to review the hard-copy casefile information that MDHHS maintained in conjunction with the electronic casefile information contained in MiSACWIS; and performed an off-site

review of the selected investigation files for one additional county. We performed the following audit procedures to evaluate MDHHS's efforts to accurately capture investigation timeliness requirements:

- Identified the data captured in MiSACWIS for each investigation regarding the investigator's efforts to comply with timeliness requirements for investigation commencement, face-to-face contact with the alleged child victim, and investigation completion.

- Compared the MiSACWIS data with the underlying casefile documentation to verify that the captured data accurately reflected the investigators efforts and/or actions to comply with the timeliness requirements. Specifically, we verified that:

    - The dates and times of the MiSACWIS timeliness data for each investigation occurred after MDHHS received the complaint.

    - MiSACWIS investigation commencement data was supported by documentation of a successful contact with an individual(s) who provided information to assess the safety of all alleged victims.

    - MiSACWIS data pertaining to face-to-face contact with the alleged child victim was supported by the investigator's written narrative indicating successful in-person contact with all alleged child victims.

    - MiSACWIS investigation completion data was evidenced by a completed investigation.

Our random samples were selected to eliminate any bias and enable us to project the results to the population.

CONCLUSIONS

We base our conclusions on our audit efforts and any resulting material conditions or reportable conditions.

When selecting activities or programs for audit, we direct our efforts based on risk and opportunities to improve State government operations. Consequently, we prepare our performance audit reports on an exception basis.

AGENCY RESPONSES

Our audit report contains 24 findings and 32 corresponding recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion at the end of our fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of

Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require an audited agency to develop a plan to comply with the recommendations and to submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

PRIOR AUDIT FOLLOW-UP

Following is the status of the findings from our September 2010 performance audit of the Statewide Electronic Central Registry, Department of Human Services (431-2100-08):

Prior Audit Finding Number	Topic Area	Current Status	Current Finding Number
1	Adding Perpetrators to the Central Registry	Rewritten*	20
2	Completing and Reviewing CPS Investigations	Rewritten	16, 17
3	Expunging Perpetrators From the Central Registry	Not within the scope of this audit.	
4	Adding Enrolled Child Day-Care Provider Perpetrators to the CPL	Repeated*	22
5	Obtaining and Maintaining Perpetrator Identifying Information	Not within the scope of this audit.	
6	Converting Electronic Perpetrator Records	Not within the scope of this audit.	
7	Accessing and Editing Perpetrator Records	Not within the scope of this audit.	
8	Automated Clearance Processes	Not within the scope of this audit.	
9	Manual Clearance Process	Not within the scope of this audit.	

SUPPLEMENTAL INFORMATION

Our audit report includes supplemental information presented as Exhibits #1 through #4. Our audit was not directed toward expressing a conclusion on the information in Exhibits #1 and #2. The information presented in Exhibits #3 and #4 was used to support our findings and conclusion on Objective #1.

** See glossary at end of report for definition.*

GLOSSARY OF ABBREVIATIONS AND TERMS

BSC	Business Service Center.
CA/N	child abuse and/or neglect.
CDC	Child Development and Care.
Central Registry	The system maintained at MDHHS that is used to keep a record of all reports filed with MDHHS under the CPL in which relevant and accurate evidence of CA/N is found to exist. The Central Registry is not publicly searchable.
Central Registry case	A CPS case that MDHHS classifies under Sections 8 and 8d of the CPL as Category I or Category II.
child(ren)	A person(s) under 18 years of age.
child abuse	Harm or threatened harm to a child's health or welfare that occurs through nonaccidental physical or mental injury, sexual abuse, sexual exploitation, or maltreatment by a parent, a legal guardian, or any other person responsible for the child's health or welfare or by a teacher, a teacher's aide, or member of the clergy.
child care organization	A governmental or nongovernmental organization having as its principal function receiving minor children for care, maintenance, training, and supervision, notwithstanding that educational instruction may be given. Child care organization includes organizations commonly described as child caring institutions, child placing agencies, children's camps, children's campsites, children's therapeutic group homes, child care centers, day care centers, nursery schools, parent cooperative preschools, foster homes, group homes, or child care homes.
child neglect	Harm or threatened harm to a child's health or welfare by a parent, a legal guardian, or any other person responsible for the child's health or welfare that occurs through either of the following: (i) Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care. (ii) Placing a child at an unreasonable risk to the child's health or welfare by failure of the parent, legal guardian, or other person responsible for the child's health or welfare to intervene to eliminate that risk when that person is able to do so and has, or should have, knowledge of the risk.

Child Protection Law (CPL)	Sections 722.621 - 722.638 of the *Michigan Compiled Laws* (Public Act 238 of 1975, as amended).
Child Welfare League of America (CWLA)	A nationally recognized standard-setter for child welfare services. The CWLA provides direct support to agencies that serve children and families through its programs, publications, research, conferences, professional development, and consultation.
complaint	Written or verbal communication to MDHHS of an allegation of CA/N. The term "complaint" is interchangeable with the term "report" in the CPL.
Control Objectives for Information and Related Technology (COBIT)	A framework, control objectives, and audit guidelines published by the IT Governance Institute as a generally applicable and accepted standard for good practices for controls over IT.
CPS	Children's Protective Services.
CSA	Children's Services Agency.
effectiveness	Success in achieving mission and goals.
expunge	Physically remove or eliminate and destroy a record or report.
Federal Information System Controls Audit Manual (FISCAM)	A methodology published by the U.S. Government Accountability Office (GAO) for performing information system control audits of federal and other governmental entities in accordance with *Government Auditing Standards.*
Implementation, Sustainability, and Exit Plan (ISEP)	The agreement that supersedes and replaces the July 18, 2011 Modified Settlement Agreement and Consent Order.
IT	information technology.
Law Enforcement Information Network (LEIN)	A Statewide computerized information system, which was established July 1, 1967 as a service to Michigan's criminal justice agencies. The goal of LEIN is to assist the criminal justice community in the performance of its duties by providing and maintaining a computerized filing system of accurate and timely documented criminal justice information readily available to all criminal justice agencies.

material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program. Our assessment of materiality is in relation to the respective audit objective.
MDHHS	Michigan Department of Health and Human Services.
MiSACWIS	Michigan Statewide Automated Child Welfare Information System.
Modified Settlement Agreement and Consent Order (MSA)	The resulting agreement from a lawsuit filed by New York-based Children's Rights in which Michigan's child welfare system came under federal oversight in 2008. Michigan renegotiated the original agreement resulting in the modified settlement agreement that took effect on July 18, 2011.
OAG	Office of the Auditor General.
Office of Children's Ombudsman (OCO)	An independent State agency created by Public Act 204 of 1994 that investigates complaints and child deaths, advocates for children, and recommends ways to improve the child welfare system. OCO investigates complaints from individuals who allege that MDHHS and/or a private agency violated law or policy or made decisions harmful to a child's health and/or safety. OCO also investigates child death cases that may involve abuse or neglect.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision-making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
person responsible for the child's health or welfare	A parent, legal guardian, person 18 years of age or older who resides for any length of time in the same home in which the child resides, or, except when used in section 7(2)(e) or 8(8) of the CPL, nonparent adult; or an owner, operator, volunteer, or employee of 1 or more of the following: (i) A licensed or registered child care organization. (ii) A licensed or unlicensed adult foster care family home or adult foster care small group home as defined in Section 3 of the

Adult Foster Care Facility Licensing Act, Public Act 218 of 1979, Section 400.703 of the *Michigan Compiled Laws.*

(iii) A court-operated facility as approved under Section 14 of the Social Welfare Act, Public Act 280 of 1939, Section 400.14 of the *Michigan Compiled Laws*.

preponderance of evidence	Evidence that is of greater weight or more convincing than evidence that is offered in opposition to it; a 51% likelihood that CA/N occurred.
repeated	The same problem was noted in the current audit and the wording of the current recommendation remains essentially the same as the prior audit recommendation.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
rewritten	The recurrence of similar conditions reported in a prior audit in combination with current conditions that warrant the prior audit recommendation to be revised for the circumstances.
risk assessment	Determines the risk of future harm to a child.
structured decision-making (SDM) tool	MDHHS's document labeled "DSS-4752 (P3) (3-95)" or a revision of that document that better measures the risk of future harm to a child. Also known as the "risk assessment tool."

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