Office of the Auditor General
Follow-Up Report on Prior Audit Recommendations

Children's Protective Services Investigations

Michigan Department of Health and Human Services

July 2024

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

431-1285-16F

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.

The auditor general may make investigations pertinent to the conduct of audits.

Article IV, Section 53 of the Michigan Constitution

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Report Summary

Follow-Up Report
Children's Protective Services (CPS) Investigations
Michigan Department of Health and Human Services (MDHHS)

Report Number:
431-1285-16F

Released:
July 2024

We conducted this follow-up to determine whether MDHHS had taken appropriate corrective measures in response to the 17 material conditions noted in our September 2018 audit report.

Observations Related to This Follow-Up	Follow-Up Results		
	Conclusion	**Finding**	**Agency Preliminary Response**
Evaluation of the CPL's commencement requirement is likely needed to ensure the overall intent of the law is met and to help ensure the best protection for suspected child victims of abuse and neglect (Observation 1).	Not applicable for observations.		

Prior Audit Information	Follow-Up Results		
	Conclusion	**Finding**	**Agency Preliminary Response**
Finding 1 - Material condition Improvement needed to ensure that investigations are commenced in a timely manner. Agency partially agreed.	Partially complied	Material condition still exists. See Finding 1.	Disagrees
Finding 2 - Material condition Considerable improvement needed in documentation of Central Registry clearances. Agency partially agreed.	Partially complied	Material condition still exists. See Finding 2.	Disagrees

Prior Audit Information *(Continued)*	Follow-Up Results		
	Conclusion	**Finding**	**Agency Preliminary Response**
Finding 3 - Material condition Considerable improvement needed in completion of required criminal history checks. Agency agreed.	Partially complied	Material condition still exists. See Finding 3.	Disagrees
Finding 4 - Material condition Documentation of a complete review of CPS history for family and household members needed. Agency agreed.	Partially complied	Material condition still exists. See Finding 4.	Disagrees
Finding 5 - Material condition Significant improvement needed in the documentation of communication with mandated reporters. Agency agreed.	Partially complied	Material condition still exists. See Finding 5.	Disagrees
Finding 6 - Material condition Improvement needed in completing timely face-to-face contact with alleged child victims. Agency agreed.	Partially complied	Reportable condition exists. See Finding 6.	Disagrees
Finding 8 - Material condition Documentation of safety planning at initial contact with family and completion, accuracy, and timeliness of safety assessments need improvement. Agency partially agreed.	Partially complied	Material condition still exists. See Finding 8.	Disagrees
Finding 9 - Material condition Improvements needed to ensure compliance with the Child Protection Law (CPL) court petition filing requirements. Agency agreed.	Complied	Not applicable.	
Finding 10 - Material condition Significant improvements needed to ensure compliance with CPL-required referrals to county prosecuting attorneys. Agency agreed.	Complied	Not applicable.	

Prior Audit Information *(Continued)*	Follow-Up Results		
	Conclusion	**Finding**	**Agency Preliminary Response**
Finding 13 - Material condition Significant improvement needed to ensure accurate assessment of the risk of future harm to children. Agency agreed.	Not complied	Material condition still exists. See Finding 13.	Agrees
Finding 14 - Material condition Impact assessments needed to identify and evaluate the effect of Michigan Statewide Automated Child Welfare Information System (MiSACWIS) risk assessment functionality changes. Agency agreed.	Complied	Not applicable.	
Finding 16 - Material condition Improvement needed in timely completion of CPS investigations. Agency agreed.	Substantially complied	Not applicable.	
Finding 17 - Material condition Significant improvement needed in supervisory oversight of CPS investigations. Agency agreed.	Partially complied	Material condition still exists. See Finding 17.	Disagrees
Finding 18 - Material condition Monitoring of families' participation in post-investigative services needed for all Category III investigations. Agency disagreed.	Not complied	Material condition still exists. See Finding 18.	Disagrees
Finding 20 - Material condition Improvement needed in appropriately adding confirmed perpetrators to the Central Registry as required by the CPL. Agency agreed.	Complied	Not applicable.	

Prior Audit Information *(Continued)*	Follow-Up Results		
	Conclusion	**Finding**	**Agency Preliminary Response**
Finding 21 - Material condition The notification process to inform individuals whose names MDHHS adds to the Central Registry needs significant improvement. Agency agreed.	Partially complied	Reportable condition exists. See Finding 21.	Disagrees
Finding 24 - Material condition Improvement needed to ensure that MDHHS captures complete, accurate, and valid MiSACWIS data related to investigation commencement. Agency agreed.	Complied	Not applicable.	

Observations Related to This Follow-Up	Follow-Up Results		
	Conclusion	**Finding**	**Agency Preliminary Response**
Further guidance to investigate allegations of physical abuse may be necessary to produce desired outcomes and appropriate CPS investigation conclusions (Observation 2).	Not applicable for observations.		

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July 9, 2024

Elizabeth Hertel, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Director Hertel:

This is our follow-up report on the 17 material conditions (Findings 1 through 6, 8 through 10, 13, 14, 16 through 18, 20, 21, and 24) and 22 corresponding recommendations reported in our performance audit of Children's Protective Services Investigations, Michigan Department of Health and Human Services. That audit report was issued and distributed in September 2018. Additional copies are available on request or at audgen.michigan.gov.

Your agency provided preliminary responses to the follow-up recommendations included in this report. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, 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.

We appreciate the courtesy and cooperation extended to us during our follow-up. If you have any questions, please call me or Laura J. Hirst, CPA, Deputy Auditor General.

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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CHILDREN'S PROTECTIVE SERVICES INVESTIGATIONS

INTRODUCTION, PURPOSE OF FOLLOW-UP, AND CPS INVESTIGATION DESCRIPTION

INTRODUCTION

This report contains the results of our follow-up of the 17 material conditions* (Findings 1 through 6, 8 through 10, 13, 14, 16 through 18, 20, 21, and 24) and 22 corresponding recommendations reported in our performance audit* of Children's Protective Services (CPS) Investigations, Michigan Department of Health and Human Services (MDHHS), issued in September 2018.

PURPOSE OF FOLLOW-UP

To determine whether MDHHS had taken appropriate corrective measures to address our corresponding recommendations.

CPS INVESTIGATION DESCRIPTION

The Child Protection Law* (CPL) provides for the protection of children* from child abuse* or child neglect* and a framework for MDHHS's performance of child abuse and/or neglect (CA/N) investigations. MDHHS's CPS program is located within MDHHS's Children's Services Agency (CSA).

CSA is responsible for establishing CPS policy and guidance. Within CSA, five geographically organized MDHHS Business Service Centers (BSCs) oversee the applicable MDHHS local county offices. CPS investigators carry out CPS field investigations of complaints* of CA/N assigned to the local offices. CPS supervisors oversee the investigators and are responsible for reviewing and approving CPS investigations to ensure compliance with MDHHS policy and the CPL.

MDHHS utilizes the Michigan Statewide Automated Child Welfare Information System (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. Also, MDHHS summarizes the data entered in MiSACWIS to aggregately report department-wide compliance with established timeliness requirements, including investigation commencement.

MDHHS assigned approximately 68,000 complaints of CA/N for a CPS investigation between June 1, 2021 and May 31, 2022.

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

PRIOR AUDIT FINDINGS AND RECOMMENDATIONS; AGENCY PLAN TO COMPLY; FOLLOW-UP CONCLUSIONS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES; AND OBSERVATIONS

AUDITOR'S NOTE

Observation 1 is integral to our Finding 1 follow-up conclusion and is presented as a precursor to the finding to provide additional information justifying the need for clear consistency between State statutes and MDHHS policy.*

OBSERVATION 1

Evaluation of the CPL's commencement requirement likely needed.

An evaluation of the CPL's current statutory language related to commencement of CPS investigations is likely needed to help ensure the law's overall intent is consistently being met and provides for the best protection of Michigan's children who are suspected of being abused or neglected.

The CPL and MDHHS policy provide the framework and requirements for the CPS program to carry out its investigations. We noted:

- Section 8(1) of the CPL states that "within 24 hours after receiving a report made under this act, the department. . . must commence an investigation of the child suspected of being abused or neglected." The CPL neither defines commencement nor prescribes activities the law intends MDHHS to carry out during the 24-hour time frame requirement specified by the law.

- MDHHS policy defines commencement as any activity to "**begin the investigation**" and includes activities such as reviewing case history, gathering evidence, conducting case planning with the CPS supervisor, and making successful investigation contacts as acceptable actions to commence the CPS investigation. This policy represents a significant departure from the policy in place during our September 2018 audit report that had been in place since at least December 2000, **because MDHHS no longer requires an assessment** of the alleged child victim's safety to occur within 24 hours as a part of commencement (see follow-up conclusion for Finding 1). Under MDHHS's prior policy, commencement was defined 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 policy also stated an acceptable ***contact*** was an individual with direct knowledge relevant to the issues in the complaint and the information could be ***used to assess the alleged child victim's safety***.

- MDHHS informed us it now utilizes the investigator's face-to-face contact with the alleged victim to assess safety; however, MDHHS's established face-to-face time frame for most CA/N complaints is 72 hours.

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

- For each CPS complaint, MDHHS's Centralized Intake completes a priority response evaluation based on the information received by the complainant to classify the risk to the child and define the time frames required for the investigator to commence the investigation and conduct face-to-face contact with the alleged victim, as follows:

Priority Response Evaluation Conclusion	MDHHS Required Commencement Time Frame	MDHHS Required Face-to-Face Time Frame
Victim is in imminent danger of harm	12 hours	24 hours
All other assigned investigations	24 hours	72 hours

Other jurisdictions have varying requirements prescribed in statute and/or program policy related to initiating a CPS investigation. Our review of five other jurisdictions disclosed that, when investigation initiation time frames are prescribed in statute, the corresponding policies of these CPS programs generally require an assessment of safety to occur within the statute prescribed time frames.

For example, North Carolina has established the following response times for complaints of CA/N within statute:

Complaint Allegations	Investigation Initiation Time Frame Defined by Statute
Abandonment or unlawful transfer of custody	Immediately
Abuse	24 hours
Neglect or dependency	72 hours

Within its CPS program policy, North Carolina requires face-to-face contact with all victim children to occur within these initiation time frames, thereby supporting the safety of all alleged child victims is assessed within the time frames that correspond to state statute.

Michigan's CPL only prescribes a 24-hour investigation initiation time frame (commencement) within the statute. Therefore, MDHHS's CPS program policy of assessing alleged child victim's safety through initial face-to-face contact with the child may occur within 24 hours or take up to 72 hours based on MDHHS's priority response evaluation time frames. This is not consistent with other jurisdictions we reviewed because the 72-hour response time frame does not correlate with State statute.

We encourage collaborative efforts by relevant stakeholders such as the Legislature, MDHHS, advocacy groups, and other partners to evaluate the need for legislative clarification and/or changes to best protect child victims of abuse and neglect and ensure the overall intent of Michigan's CPL is met.

FINDING 1

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
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.

Recommendations Reported in September 2018:
We recommended that MDHHS commence CPS investigations of suspected CA/N within required time frames.

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

AGENCY PLAN TO COMPLY*

Regarding our first recommendation, MDHHS's December 5, 2018 plan to comply indicated it:

- Updated its commencement policy in December 2017 to align with practice and further clarified the policy in August 2018.
- Developed a Supervisory Control Protocol (SCP) to increase the frequency and effectiveness* of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements, and verify that required documentation occurred, including supervisory verification of the timeliness of commencement.
- Created a Compliance Review Team (CRT) to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether sampled investigations were commenced within the required time frame.
- Developed a Peer Case Review (PCR) process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.
- Was creating a MiSACWIS mobile software application to document completion of required investigation activities in real time from the field, including commencement contacts.

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

Regarding our second recommendation, MDHHS's agency preliminary response at the time of our report indicated it did not agree with our recommendation to seek legislative clarification to validate its interpretation of, and compliance with, the Section 8(1) CPL commencement requirement and its December 5, 2018 plan to comply did not address the recommendation.

FOLLOW-UP CONCLUSION

Partially complied. A material condition still exists.

Our follow-up noted:

a. MDHHS revised its commencement policy in December 2017 to no longer always require an assessment of child safety within the CPL's 24-hour required investigation commencement time frame (see Observation 1).

   We noted the following regarding the revised policy in place during the follow-up:

   (1) It is not supported by best practices for child protection agencies. Specifically:

      (a) The Child Welfare League of America* (CWLA) publication entitled *CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families* indicates a child protection agency's ***primary concern*** when receiving a complaint of CA/N should be to ***establish whether the child is safe, pending a face-to-face contact by the agency***. The CWLA also indicates the child protection agency's ***initial collection*** of information and subsequent contact with the child should include ***an assessment of the child's immediate safety*** and a plan to address all safety concerns.

      (b) *Child Protective Services: A Guide for Caseworkers*, published by the U.S. Department of Health and Human Services (HHS), indicates ***after*** a report of CA/N is assigned for investigation, the CPS agency should conduct an ***initial assessment to determine whether the child is in immediate or imminent danger***. The Guide outlines steps to take place during the ***initial assessment*** and prefaces them with occurring "***after a child's immediate safety has been secured***."

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

Although these best practices do not delineate a specific time frame in which safety *must* be assessed for alleged child victims, they clearly indicate the child protection agency should obtain information regarding the alleged victim's immediate safety during the initial assessment period, after the complaint of CA/N has been assigned for investigation. Under its previous policy, MDHHS defined this time frame to be within 24 hours which aligned with the CPL's investigation commencement requirement.

(2) MDHHS could not provide evidence of an evaluation regarding the potential impact of removing the assessment of child safety from its commencement policy.

(3) MDHHS did not seek legislative clarification of its interpretation of, and compliance with, the law's commencement requirement. The Section 8(1) CPL commencement requirement has remained unchanged since our 2018 audit.

(4) MDHHS's revised commencement policy, coupled with its reliance on the priority response time frames for conducting face-to-face contacts within either 24 or 72 hours, does not ensure an assessment of child safety for the alleged child victims occurs as outlined by best practices, and/or within the CPL's 24-hour commencement time frame requirement.

b. Applying MDHHS's new commencement policy, CPS investigators commenced 100 (100%) of the 100 sampled CPS investigations within the required time frames. However, MDHHS did not complete any investigative activities assessing child safety for 37 (37%) of these investigations within the commencement time frame required by the CPL or the MDHHS assigned priority response level.

We noted:

(1) In 29 (29%) investigations, MDHHS investigative activities to assess child safety ranged from just over 1 day to 45.3 days after receipt of the CA/N complaint, with a median of 1.9 days. These 29 investigations included 40 alleged child victims.

In addition, consistent with the revised policy, investigators recorded "investigation commencement" information in MiSACWIS indicating timely commencement of these 29 investigations (see follow-up conclusion for Finding 24, part a.). MDHHS utilizes aggregated

MiSACWIS information to assess and report its compliance with the CPL's 24-hour commencement mandate to the Legislature and other external stakeholders; however, this information includes cases not meeting commencement best practices. Therefore, this could impact the reliability of the reported information and may adversely affect the judgment of interested persons concerning the effectiveness of MDHHS's CPS investigation procedures.

(2) In 8 (8%) investigations, MDHHS did not complete any investigative activity to assess child safety within the 12-hour commencement time frame established by its priority response evaluation for the investigation. Instead, the assessments ranged from 17 to 110 hours (4.6 days) after receipt of the CA/N complaint, with a median of 21 hours. The 12-hour priority response level is assigned to investigations when MDHHS determines the alleged child victim(s) is in imminent danger or harm. These 8 investigations included 8 alleged child victims and, for 6 (75%) of these investigations, MDHHS completed investigative activities to assess child safety within 24 hours.

We still consider this finding to be a material condition because:

- The importance of timely assessment of an alleged child victim's immediate safety ***pending face-to-face contact*** with MDHHS and the potential risks to those children.

- The significant percentage of alleged child victims impacted by MDHHS's policy revision during our review period and beyond.

- Given the sensitivity of CPS and its crucial role in providing for the protection of children who are abused and neglected, it is imperative any perceived inconsistencies between the department's policy and State laws governing investigations are resolved to help ensure they clearly align in terms of legislative intent and program best practices.

- The significant percentage of investigations reported in MiSACWIS as timely commenced without an assessment of safety for the alleged child victims and the potential negative impact on internal and external decision-makers related to MDHHS's reporting of its compliance with the CPL's 24-hour commencement requirement.

FOLLOW-UP RECOMMENDATIONS

We recommend MDHHS commence CPS investigations of suspected CA/N, including completion of activities to assess the

safety of alleged child victims, in accordance with times frames required in the CPL and recognized best practices for child protection agencies.

We also recommend MDHHS evaluate the impact of policy departures from best practices recommendations.

In addition, we recommend MDHHS actively collaborate with the Legislature to ensure its CPS investigation commencement and priority response evaluation time frame policies align with, and achieve the intent of, the CPL.

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with our follow-up conclusion.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE*

The agency preliminary response and our auditor's comments to Finding 1 are presented on pages 62 and 63.

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

FINDING 2

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
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) who has previously been confirmed to be a perpetrator of CA/N.

Our review of 156 selected CPS investigations noted investigators did not document performance of a required Central Registry clearance for 262 individuals associated with 112 (72%) of the investigations. We conducted a Central Registry clearance for 236 of these individuals and determined 25 (11%) were named in the Central Registry as a confirmed perpetrator of CA/N.

Recommendation Reported in September 2018:
We recommended that MDHHS document its performance of a Central Registry clearance for all required individuals associated with a CPS investigation.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it:

- Issued a communication in February 2018 to clarify documentation expectations for performing Central Registry clearances. In addition, it was actively working on technology enhancements to improve the readability of reports and increase compliance of worker documentation and supervisory review with the first release to occur in December 2018.

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements, and verify that required documentation occurred, including supervisory verification that the investigator sufficiently documented the completion of all required Central Registry clearances.

- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether sampled investigations adequately documented Central Registry clearances.

- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

FOLLOW-UP CONCLUSION

Partially complied. A material condition still exists.

We reviewed CPS investigations in which a Central Registry clearance was required for at least one individual, according to MDHHS policy. In addition, we evaluated MDHHS's February 2019 change to its Central Registry clearance policy and noted:

- CPS investigators did not document the performance of a Central Registry clearance for alleged victims' parents or guardians associated with 14 (14%) of 100 sampled investigations, as required by MDHHS policy.

  We obtained information from MDHHS's investigation documentation and conducted a Central Registry clearance for 13 of these individuals. We determined 2 (15%) individuals were named in the Central Registry as confirmed perpetrators of CA/N, in conjunction with a prior CPS investigation. MDHHS's CPS investigation documentation did not contain sufficient detail, such as full name and date of birth, to allow for a Central Registry clearance for the 1 remaining individual.

- Subsequent to our 2018 audit, MDHHS revised its Central Registry clearance policy and discontinued required checks for many adults living in the home of alleged victims and responsible for the child's health or welfare. MDHHS could not provide evidence of an evaluation regarding the potential impact of the policy change on its ability to fully assess the safety of alleged child victims.

  Under its previous policy, CPS investigators were required to perform Central Registry clearances on ***parents or persons responsible for the child's health or welfare*, and all persons listed on the complaint who are age 18 or older***. The CPL defines a person(s) responsible for the health and welfare of the child as any parent, legal guardian, and/or a person 18 years of age or older who resides for any length of time ***in the same home in which the child resides***.

  Comparatively under MDHHS's revised policy, MDHHS requires CPS investigators to complete Central Registry clearances on ***legal and putative* parent(s) involved in the care of the alleged child victim, legal guardian(s) of the alleged child victim, and alleged/confirmed perpetrators***.

  We evaluated the 140 individuals associated with 56 sampled CPS investigations no longer subject to Central Registry clearances because of MDHHS's policy change.

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

These individuals included:

- 4 alleged victims' parents who were not alleged perpetrators and reportedly not involved in care of the alleged victim(s).
- 5 alleged victims' parents' significant others who lived in the home.
- 131 other adults residing in the home with the alleged victim(s).

We obtained information available from MDHHS's investigation documentation and conducted Central Registry clearances for 81 of these individuals. Central Registry information indicated that 10 (12%) of the individuals were named as a confirmed perpetrator of CA/N in a previous CPS investigation. MDHHS's CPS investigation documentation did not contain sufficient information for the 59 remaining individuals to allow us to perform a Central Registry clearance; therefore, it is undeterminable whether they are in the Central Registry as a previously confirmed perpetrator of CA/N.

Obtaining and evaluating Central Registry perpetrator information for adults living in the home of alleged victims provide investigators pertinent information to identify factors influencing child vulnerability; determine appropriate protective interventions to help ensure the safety of the alleged child victim(s); and promote CPS's program objective of strengthening families through services to parents or other responsible adults and engaging extended family members, whenever possible, to ensure adequate care of the children.

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

- Persistent and significant exception rate related to MDHHS not performing required Central Registry clearances, despite the substantial reduction in clearances required by policy.
- Potential impact of unidentified risks to an alleged child victim's safety related to MDHHS discontinuing required Central Registry clearances for individuals responsible for the child's health or welfare.
- 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).

FOLLOW-UP RECOMMENDATIONS

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

We also recommend MDHHS evaluate the impact of its Central Registry policy change on its ability to identify and appropriately address potential safety concerns for alleged child victims and promote CPS program objectives.

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with our follow-up conclusion.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The agency preliminary response and our auditor's comments to Finding 2 are presented on page 64.

FINDING 3

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
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.

We reviewed 102 CPS investigations requiring a Law Enforcement Information Network* (LEIN) check to be completed for at least one individual. We determined investigators did not conduct LEIN checks for all required individuals in 53 (52%) of the 102 investigations, pertaining to 143 individuals. The Michigan Department of State Police (MSP) criminal history record information indicated 54 felony and 119 misdemeanor convictions occurred prior to the investigation for 37 (26%) of the individuals.

Recommendation Reported in September 2018:
We recommended that MDHHS complete a criminal history check for all required individuals when conducting investigations of CA/N.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it:

- Updated policy to clarify LEIN requirements in 2017 and finalized and published the policy in 2018.
- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements, and verify required documentation occurred, including supervisory verification that the worker completed and sufficiently documented criminal history clearances.
- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including identification of whether the criminal history was properly documented.
- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

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

FOLLOW-UP CONCLUSION

Partially complied. A material condition still exists.

We reviewed CPS investigations requiring a LEIN check for at least one individual, according to MDHHS policy. In addition, we evaluated MDHHS's January 2020 change to its LEIN check policy. We noted:

- CPS investigators did not conduct LEIN checks for all required individuals for 12 (27%) of 44 sampled investigations, pertaining to 25 individuals. The 25 individuals included:

    - 1 alleged perpetrator.
    - 24 other adults residing in the home of the alleged perpetrator.

    MDHHS policy required CPS investigators to complete LEIN checks for all alleged perpetrators and adults residing in the home of the alleged perpetrator household when there are sexual abuse, physical abuse, and human trafficking allegations.

    We obtained information from MDHHS's investigation documentation and matched it with MSP criminal history record information of these 25 individuals. The match indicated 7 felony and 23 misdemeanor convictions occurred prior to the sampled CPS investigations for 4 (16%) of the individuals based on an exact match of name, date of birth, and social security number. The convictions included, but were not limited to:

    - 1 felony child abuse conviction.
    - 2 felony drug related convictions.
    - 1 misdemeanor domestic violence conviction.

    MSP criminal history record information did not include felony or misdemeanor convictions for 13 (52%) of the individuals, and MDHHS did not maintain sufficient identity information in its investigation documentation for the 8 (32%) remaining individuals to allow for a criminal history record check.

- Subsequent to our 2018 audit, MDHHS significantly changed its LEIN check policy and discontinued previously required checks for many individuals associated with CPS investigations.

    Under its previous policy, MDHHS required CPS investigators to complete criminal history checks using 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.

Comparatively under its revised policy, MDHHS requires the LEIN checks for ***alleged perpetrators and adults residing in the home of the alleged perpetrator when there are sexual abuse, physical abuse, and human trafficking allegations***.

We noted the following regarding MDHHS's revised policy:

a. MDHHS's removal of all non-perpetrator parents, person(s) responsible for the health and welfare of the child, and all household members, including in cases where domestic violence may be present, from its LEIN check requirements is not supported by best practices for child protection agencies.

   Specifically, HHS's *Child Protective Services: A Guide for Caseworkers* indicates CPS investigation records should include a description of ***any*** criminal activity that may involve ***specific family members***. Also, the Guide states interviews with the alleged perpetrator and ***other adults in the home*** should include information on ***any*** history of criminal activity. Further, the Guide indicates ***the family's criminal history should be assessed in domestic violence situations***.

   Although the Guide does not define the specific individuals of the "family" who should be subjected to criminal history checks, it indicates clearly the child protection agency should obtain criminal history information ***on all adults in the home, including in domestic violence situations***. Under MDHHS's revised policy, LEIN checks occur for adults *in the home of the alleged perpetrator*, which often may not be the only home in which the child resides. Under its prior policy, LEIN checks occurred for *all persons responsible for the health and welfare of the child*. The CPL defines these individuals as a parent, legal guardian, and/or a person 18 years of age or older who resides for any length of time *in the same home in which the child resides*. In addition, contrary to best practice recommendations, MDHHS no longer requires investigators to conduct LEIN checks in domestic violence situations.

b. MDHHS could not provide evidence of an evaluation regarding the potential impact of the policy change on its ability to fully assess the safety of alleged child victims.

We evaluated the 169 individuals associated with 49 sampled CPS investigations not subject to LEIN checks because of MDHHS's policy change. These individuals included:

- 26 alleged perpetrators.
- 45 non-perpetrator parents.
- 3 parents' significant others who lived in the home.
- 95 other adult household members or persons responsible for the child's health and welfare.

We obtained information available from MDHHS's investigation documentation and matched it with MSP criminal history record information to assess the criminal histories of these 169 individuals. MSP criminal history records indicated 47 felony and 141 misdemeanor convictions occurring prior to the CPS investigation for 33 (20%) of these individuals based on an exact match of name, date of birth, and social security number. The convictions included, but were not limited to:

- 2 felony and 6 misdemeanor child abuse convictions.
- 1 felony criminal sexual conduct conviction.
- 11 felony and 17 misdemeanor assault convictions.
- 21 misdemeanor domestic violence convictions.
- 10 felony and 19 misdemeanor drug related convictions.

MSP criminal history record information did not include felony or misdemeanor convictions for 92 (54%) of the individuals, and MDHHS did not maintain sufficient identity information in its investigation documentation to allow for a criminal history record check for 44 (26%).

Acquiring and evaluating information of this nature could help MDHHS better achieve the purpose of the CPS program by providing investigators with pertinent information for developing and implementing plans that help ensure the safety of the alleged child victim(s) and stabilize and

strengthen families. In addition, this information could help CPS investigators identify and assess potential worker safety concerns prior to conducting in-person visits with the family.

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

- The significant exception rate related to required LEIN checks not conducted.
- The significant number of individuals associated with CPS investigations, contrary to best practice recommendations, are no longer required to be subject to a LEIN check.
- The impact on MDHHS's ability to identify, evaluate, and address potential safety risks to the alleged child victim(s) and/or the investigator related to criminal history activity.

FOLLOW-UP RECOMMENDATIONS

We recommend MDHHS complete a criminal history check for all required individuals and those recommended by best practices when conducting investigations of CA/N.

We also recommend MDHHS evaluate the impact of policy departures from best practices recommendations.

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with our follow-up conclusion.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The agency preliminary response and our auditor's comments to Finding 3 are presented on pages 65 and 66.

FINDING 4

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
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).

We examined pertinent records for 160 selected investigations. We noted:

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 the previous two bullets 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.

Recommendation Reported in September 2018:
We recommended that MDHHS maintain documentation to support that CPS investigators conducted a complete review of CPS history for family and household members.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018, plan to comply indicated it:

- Was actively working on technology enhancements to be released in December 2018 that would improve person search and case history search functionality, improve readability of reports, and enhance worker documentation functionality and supervisory review.

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements, and verify that required documentation occurred, including verification by the

supervisor that the investigator reviewed and sufficiently documented CPS history.

- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including identification of whether the CPS history was properly documented.

- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

FOLLOW-UP CONCLUSION

Partially complied. A material condition still exists.

We reviewed CPS investigations requiring a complete review of CPS history for at least one individual, according to MDHHS policy. In addition, we evaluated MDHHS's September 2019 change to its CPS history policy. We noted:

- MDHHS could not provide documentation to support that CPS investigators conducted a complete review of CPS history for required individuals.

  MDHHS policy requires CPS investigators to document a thorough search of CPS history and trends for legal and putative parent(s) involved in the care of the alleged child victim, legal guardian(s) of the alleged child victim, and alleged or confirmed perpetrators and child victims. Our review of MDHHS's records for 100 sampled investigations noted:

  - In 20 (20%), investigators did not document a review of CPS history records for at least one of the required investigation persons.

  - In 46 (46%), investigators did not document a complete review of previous CPS history for at least one of the required investigation persons. In these instances, the documentation indicated the investigator reviewed some of the pertinent CPS history but not all.

  - In 11 (11%), both conditions in the previous two bullets existed and the documentation simultaneously lacked support for a CPS history review for at least one required investigation person and complete review of previous CPS history for at least one other required investigation person.

- Subsequent to our 2018 audit, MDHHS revised its CPS history policy and discontinued required reviews for many adults living in the home of alleged child victims. Although this was a significant change, MDHHS could not provide evidence of an evaluation regarding the potential impact the policy change would have on its investigators' ability to fully and accurately assess the safety and risk of future harm to alleged child victims.

  Under its previous policy, MDHHS required CPS investigators to complete CPS history reviews on the ***family and all household members***.

  Comparatively, under MDHHS's revised policy, CPS history reviews occur for ***legal and putative parent(s) involved in the care of the alleged child victim, legal guardian(s) of the alleged child victim, and alleged/confirmed perpetrators***.

  We evaluated the 177 individuals associated with 66 of our sampled CPS investigations that were no longer required to have a CPS history review because of MDHHS's policy change. Investigators did not document a review of CPS history records for 150 (85%) of the 177 individuals associated with 56 investigations. Our review of investigation documentation and pertinent MiSACWIS CPS history records for these 150 individuals revealed 57 (38%) associated with 29 investigations had relevant CPS investigation history. MDHHS's CPS investigation documentation did not contain enough information to complete a CPS history review for 59 (39%) individuals associated with 27 investigations.

  CPS history information for adults living in the home of alleged victims provides investigators pertinent information to identify factors influencing child vulnerability and determine appropriate protective interventions to help ensure the safety of the alleged child victim(s). In addition, the information can help MDHHS promote CPS's program objective of strengthening families through services to parents or other responsible adults and engaging extended family members, whenever possible, to ensure adequate care of the children.

  Further, consistently obtaining and evaluating this information would help MDHHS ensure the accuracy of the investigation risk assessment*. When completing this assessment, CPS investigators are required to determine the number of prior assigned abuse or neglect complaints and/or findings (CPS history) where ***any household member*** identified in the current investigation was an alleged perpetrator. Therefore, without a complete CPS history review for all household members, investigators may not become aware when an individual(s) living with

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

the alleged victim was previously an alleged perpetrator of CA/N. Hence, obtaining and evaluating CPS history information for these individuals is critical to the investigation because MDHHS uses the risk assessment to determine the level of risk of future harm to the children. Also, in each case in which a preponderance of evidence* exists, the risk level determines which category the case must be classified which, in turn, dictates the type of protective interventions and services for the family in accordance with the CPL.

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

- Persistent and significant exception rate related to investigators not performing CPS history reviews for required individuals, despite a substantial reduction in individuals for whom MDHHS required reviews.

- Potential impact of unidentified risks to an alleged child victim's safety related to MDHHS discontinuing required CPS history reviews for individuals living with the alleged child victim(s).

- Significant exception rate noted in MDHHS's documentation of required Central Registry clearances, which would have helped investigators identify a significant aspect of CPS history for individuals previously confirmed as a perpetrator of CA/N (see Finding 2).

FOLLOW-UP RECOMMENDATIONS

We again recommend that MDHHS maintain documentation to support that CPS investigators conducted a complete review of CPS history on all required investigation persons.

We also recommend that MDHHS evaluate the impact of its CPS history policy change on its ability to identify and appropriately address potential safety concerns for alleged child victims and promote CPS program objectives.

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with our follow-up conclusion.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The agency preliminary response and our auditor's comments to Finding 4 are presented on page 67.

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

FINDING 5

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
MDHHS did not always document it had contacted mandated reporters to obtain additional information and to clarify and verify the information MDHHS received in the reporters' CA/N complaints. Also, MDHHS did not consistently document it provided the mandated reporters with written notification of its disposition of the investigation that resulted from the reporters' complaints. MDHHS's further contact with the mandated reporter is important to ensure the CPS investigator collects all relevant evidence.

We reviewed 119 CPS investigations initiated by mandated reporters' complaints during our audit period. We noted:

a. The CPS investigator did not document successful contact with the mandated reporter for additional information in 38 (33%) of the 115 CPS 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.

Recommendations Reported in September 2018:
We recommended that MDHHS document that it had 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 recommended 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 PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it:

- Issued a communication in February 2018 to clarify documentation expectations for mandated reporter contact and notification. Also, it was clarifying policy to require investigators to contact any reporting source if additional information is needed and removing the requirement to contact mandated reporters when no additional information is needed.

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements, and verify that required documentation occurred, including verification by the supervisor that the worker documented contact with the mandated reporter if additional information was needed

and that the worker sent notification of disposition to the mandated reporter.

- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including identification of whether the required notification to mandated reporters occurred and was documented.

- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

- Was creating a MiSACWIS mobile application to allow workers to access immediate physical safety features, remotely enter social work contacts, and document completion of other required investigation activities in real time from the field, including contacts with mandated reporters.

FOLLOW-UP CONCLUSION

Partially complied. A material condition still exists.

Our follow-up noted:

- Subsequent to our 2018 audit report, MDHHS revised its mandated report contact policy and discontinued the requirement for CPS investigators to make contact with the reporter for additional information or for clarification/verification of information received in the complaint. MDHHS could not provide evidence of an evaluation regarding the potential impact of the policy change on its ability to fully assess the safety of alleged child victims.

- The MDHHS *Mandated Reporters' Resource Guide* states mandated reporters are an essential part of the child protection system because of their enhanced capacity, through their expertise and direct contact with children, to identify suspected child abuse and neglect. The Guide also indicates CA/N reports made by mandated reporters are confirmed at nearly double the rate of those made by non-mandated reporters.

  We evaluated 82 sampled investigations initiated by a mandated reporter and noted MDHHS:

  (1) Contacted the mandated reporter for 43 (52%) of the investigations. For 25 (58%), the mandated reporter was able to provide additional information

to assist the investigator in assessing the complaint allegations and/or the safety of the alleged child victim(s).

(2) Did not contact the mandated reporter for 39 (48%) of the investigations. For 31 (79%), the investigator did not attempt to contact the mandated reporter. For 8 (21%), the investigator was unsuccessful in their attempt(s).

- The CPS investigator did not document the written investigation disposition was provided to the mandated reporter as required by the CPL for 8 (10%) investigations.

  MDHHS policy requires the investigator to document a copy of the mandated reporter letter in the investigation casefile ***and*** enter a social work contact indicating that the letter has been sent.

  Although MDHHS made improvements in its documentation, our review still noted instances of noncompliance.

We continue to consider this finding to be a material condition because of the unknown impact on alleged child victims and families resulting from MDHHS discontinuing its requirement that CPS investigators contact mandated reporters. Also, the frequency in which mandated reporters in our sampled investigations demonstrated they can provide additional information to assist investigators in assessing the complaint allegations and/or the safety of the alleged child victim(s).

FOLLOW-UP RECOMMENDATIONS

We recommend MDHHS evaluate the impact of its mandated reporter contact policy change on alleged child victims and families.

We also again recommend MDHHS consistently document that it provided the mandated reporter with written notification of its disposition of the investigation that resulted from the reporter's complaint.

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with our follow-up conclusion.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The agency preliminary response and our auditor's comments to Finding 5 are presented on page 68.

FINDING 6

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
MDHHS did not consistently make face-to-face contact with alleged child victims within the required time frames. MDHHS policy requires 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 CPS investigations representing 269 alleged child victims and noted investigators did not make face-to-face contact with 25 alleged child victims within the required time frames for 18 (11%) of the investigations.

Recommendation Reported in September 2018:
We recommended that MDHHS consistently make face-to-face contact with all alleged child victims within required time frames.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it:

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, including supervisory verification that the worker made face-to-face contacts and that they were timely and sufficiently documented.
- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law.
- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.
- Was creating a MiSACWIS mobile software application to document completion of required investigation activities in real time from the field, including face-to-face contacts.

FOLLOW-UP CONCLUSION

Partially complied. A reportable condition* exists.

Our review of 99 CPS investigations representing 144 alleged child victims noted investigators did not make face-to-face contact with 7 alleged child victims within the required time frames for 5 (5%) of the investigations. MDHHS's face-to-face contact with these 7 alleged child victims ranged from 17 hours to over 42 days late.

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

We considered this a reportable condition because MDHHS informed us that it utilizes the investigator's face-to-face contact with alleged child victims to assess child safety in conjunction with its commencement policy change (see follow-up conclusion for Finding 1).

FOLLOW-UP RECOMMENDATION

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

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with our follow-up conclusion.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The agency preliminary response and our auditor's comments to Finding 6 are presented on page 69.

FINDING 8

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
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.

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:

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.

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.

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.

Recommendations Reported in September 2018:
We recommended 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 recommended that CPS investigators improve their completion, accuracy, and timeliness of safety assessments.

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

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it:

- Was in the process of amending policy to clarify expectations for safety planning.
- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements, and verify required documentation occurred, including supervisory verification that safety planning expectations were met, the Safety Assessment Tool was completed accurately, and both were sufficiently documented.
- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including identification of whether safety planning and completion of the Safety Assessment Tool met policy expectations.
- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.
- Was creating a MiSACWIS mobile software application to document completion of required investigation activities in real time from the field.

FOLLOW-UP CONCLUSION

Partially complied. A material condition still exists.

We reviewed CPS investigations requiring a safety plan and/or safety assessment to be completed, according to MDHHS policy. In addition, we evaluated MDHHS's revision to its safety planning and safety assessment policies. We noted:

- Investigators did not always accurately complete and/or document safety plans and safety assessments according to MDHHS policies that addressed all safety concerns of alleged child victim(s). We noted:

  (1) For safety plans, investigators did not implement an appropriate initial safety plan for 19 (21%) of 90 reviewed investigations. One investigation did not have a safety plan completed or document the reason why a plan was not necessary, for the remaining 18 investigations the plans did not address all immediate safety concerns, including proactive and reactive steps, for the alleged child victims.

(2) For safety assessments, investigators improperly excluded one or more safety factors from the safety assessments for 6 (6%) of the 98 sampled investigations, according to information in the investigation casefile. Consequently, all 6 indicated an incorrect safety assessment decision for the alleged child victims and did not appropriately document current or planned protecting interventions addressing the missing safety factors.

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 a safety assessment decision of safe, safe with services, or unsafe for each child. Policy also requires investigators to describe the protecting intervention(s) that has been put in place or is immediately planned for any identified safety factors and to explain how each intervention protects (or protected) each child.

- MDHHS established a safety planning policy in March 2019 and revised its safety assessment policy in February 2019; however, the new and revised policies did not align with best practice recommendations for child protection agencies or fully address our related audit recommendations. We noted:

    - The safety planning policy MDHHS established in March 2019 indicates caseworkers must ***consistently assess the safety and need*** for protection of all children during an investigation and that the safety plan must address ***immediate safety concerns***.

    - The February 2019 safety assessment policy revision significantly extended the required time frame for completing safety assessments to occur ***at or near the end of the investigation*** when sufficient evidence and information has been collected to accurately complete the tool. Prior to February 2019, MDHHS required the assessments to be completed ***as early as possible following the initial face-to-face,*** but no later than the initial investigation disposition.

  Our evaluation of these MDHHS policies noted the following deficiencies:

    (1) Neither policy requires investigators to complete a safety plan or safety assessment in conjunction with the initial contact with the family and

determination of the child's safety or document why a safety plan was not needed.

CWLA's *Standards of Excellence for Services for Abused or Neglected Children and Their Families*, indicates a child protection agency should have policies, procedures, and assessment tools to assist CPS staff that have ***initial contact with the child and family when determining if the child is safe.***

(2) MDHHS could not provide evidence of an evaluation regarding the potential impact of its policies on investigators' ability to timely address safety concerns for alleged child victims.

To help determine the impact, we assessed the timeliness of investigators' implementation of safety plans and completion of safety assessments for a sample of 99 CPS investigations completed under the revised policies. We noted investigators did not implement a safety plan *or* complete a safety assessment in conjunction with the initial face-to-face contact with the family for 27 (27%) investigations ranging from 1 day to 27 days after the initial contact, with a median of 7.5 days.

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

- Significant number of safety plans and safety assessments that did not address all immediate safety concerns for alleged child victims and the resulting potential risks to protecting their safety.

- Potential risks to alleged child victims when neither a safety plan nor safety assessment is completed in conjunction with the initial contact with families under investigation for CA/N.

FOLLOW-UP RECOMMENDATIONS

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

We also recommend CPS investigators improve the completeness and accuracy of safety plans and safety assessments.

We further recommend MDHHS evaluate the impact of policy departures from best practices recommendations.

FOLLOW-UP AGENCY PRELIMINARY RESPONSE	MDHHS disagrees with our follow-up conclusion.
AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE	The agency preliminary response and our auditor's comments to Finding 8 are presented on pages 70 and 71.

FINDING 9

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
MDHHS did not always submit a petition to the court in specified circumstances, such as, but not limited to, when MDHHS determined 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 abuse or exposure, as required by the CPL. 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.

Recommendation Reported in September 2018:
We recommended that MDHHS file court petitions when required by the CPL.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it had:

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, including supervisory verification that petitions were filed when required.
- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether the petitions were filed as required for the sampled investigations.
- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

FOLLOW-UP CONCLUSION

Complied.

In our review of 100 CPS investigations, 9 required a court petition to be filed in accordance with the CPL and MDHHS filed all 9.

FINDING 10

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
MDHHS did not always refer CPS Central Registry cases* to the applicable prosecuting attorney when it determined evidence of a child's death, serious physical injury, or sexual abuse or exploitation, as required by the CPL. Our review of 160 CPS investigations identified 6 Central Registry cases required referral to the county prosecuting attorney. In 3 (50%) instances, MDHHS did not complete the referral.

Recommendation Reported in September 2018:
We recommended 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 PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it had:

- Issued a communication to staff clarifying documentation expectations.
- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, including supervisory verification that referrals were made to the prosecuting attorney when required and sufficiently documented.
- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether the sampled investigations were properly referred and documented.
- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

MDHHS's plan also indicated it was in the process of creating a MiSACWIS mobile software application to document completion of required investigation activities in real time from the field, with planned implementation by March 31, 2019.

FOLLOW-UP CONCLUSION

Complied.

In our review of 100 CPS investigations, 5 Central Registry cases required referral to the county prosecuting attorney and MDHHS referred all 5 cases.

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

FINDING 13

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
MDHHS did not always accurately assess the risk of future harm to children for CPS investigations. We reviewed the completed risk assessment tool for 156 investigations, in conjunction with other documentation, and noted an improper risk-level assessment for 57 (37%) of the investigations:

- For 46 investigations, the assessed risk levels were too low.
- For 11 investigations, the assessed risk levels were too high.

The resulting improper risk levels led to an improper category classification for 8 (14%) of the 57 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. Based on the accumulated responses to 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.

We determined the 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.

Recommendation Reported in September 2018:
We recommended that MDHHS accurately assess the risk of future harm to children for CPS investigations.

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

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it was actively working on technology enhancements aimed at increasing the accuracy of risk assessment tool completion and improving the supervisor's ability to verify accuracy, with the first release of the enhancements scheduled to be completed in December 2018.

MDHHS's plan also indicated it had:

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, including supervisory verification that the risk assessment tool was completed accurately.

- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether risk assessments for the sampled cases are consistent with documented facts and evidence.

- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

MDHHS's plan further indicated it was in the process of creating a MiSACWIS mobile software application to document completion of required investigation activities in real time from the field, with planned implementation by March 31, 2019.

FOLLOW-UP CONCLUSION

Not complied. A material condition still exists.

Our follow-up noted:

- MDHHS implemented a MiSACWIS system change to end the automatic population of risk assessment questions based on the family's data entered into MiSACWIS. CPS investigators are now required to provide responses to all 22 questions on the risk assessment tool based on gathered evidence. Our review of the completed risk assessment tool for 97 investigations, in conjunction with other documentation, noted investigators incorrectly responded to questions contrary to collected evidence, resulting in improper risk-level assessments for 28 (29%) of the investigations as follows:

    - For 25 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.

  - For 3 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 not warranted for the circumstances.

The inaccurate risk assessments described in the preceding bullets led to an improper category classification for 8 (29%) of the 28 investigations. In these instances, MDHHS's low- or moderate-risk level conclusions led MDHHS to assign a Category III classification to the investigation, thereby allowing for some, or no, monitoring and likely lesser service provision. Our review determined the associated investigation documentation supported high- or intensive-risk levels, thus requiring a Category II classification for the investigations, and post-investigative monitoring of the family.

- CPL amendments effective November 1, 2022 delinked the risk assessment tool and resulting investigation category classification from Central Registry additions. See the follow-up conclusion for Finding 20.

We still 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 and investigation category classification.

FOLLOW-UP RECOMMENDATION

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

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

On May 24, 2023, MDHHS provided us with the following response:

MDHHS agrees that it must accurately assess a family's risk of future involvement with the child welfare system and recognizes there are always opportunities for improvement in this area.

MDHHS has implemented a number of strategies to increase risk assessment accuracy. MDHHS recognizes that our Children's Protective Services employees have been asked to use antiquated tools and technology to solve 2023 problems. MDHHS recently requested a $12 million appropriation from the Legislature to take another step toward implementation of our new electronic case management system, the Comprehensive

Child Welfare Information System, commonly known as CCWIS. This appropriation will allow us to revise the department's current risk assessment to improve accuracy, consistency, and equity in providing services. Additionally, after several years of working with legislative partners, MDHHS accomplished a statutory change that took effect November 1, 2022. This change removed the current risk assessment as a consideration in determining the placement of someone on the child abuse and neglect Central Registry. This legislative action was necessary to allow the department to move forward with revising the risk assessment tool to address potentially subjective and ambiguous language that could result in inconsistent interpretation of risk assessment among other opportunities. In conjunction with the above efforts, MDHHS will continue to provide interim guidance and training to staff to ensure risk is accurately assessed and addressed.

FINDING 14

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
MDHHS did not conduct impact assessments for MiSACWIS risk assessment functionality changes. Our review identified 9 MiSACWIS risk assessment functionality errors. MDHHS informed us it had made system changes to correct these errors; however, it did not evaluate the impact these errors had on completed CPS investigations.

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. Specifically, 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.

Our review determined at least 163 completed investigations with confirmed CA/N also had an inaccurate risk level of low or moderate assigned, rather than a correct risk level of high or intensive. As a result, MDHHS had neither identified the inaccurate risk levels and category classifications for these 163 investigations nor added the 205 associated perpetrators to the Central Registry.

Recommendation Reported in September 2018:
We recommended that MDHHS conduct impact assessments for MiSACWIS risk assessment functionality changes.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it had completed the risk assessment impact analysis in October 2018 and the cases that required further field validation were in the final stages of being amended, as needed. MDHHS's plan also indicated that if risk assessment functionality was changed in the future, MDHHS would determine if an impact assessment was warranted.

FOLLOW-UP CONCLUSION

Complied.

We noted:

- MDHHS conducted impact assessments for 15 MiSACWIS risk assessment functionality errors and formulated management decisions for investigations with identified inaccurate risk levels, including the addition of perpetrators to the Central Registry for some investigations.

- CPL amendments effective November 1, 2022 delinked the risk assessment tool and resulting investigation category classification from Central Registry additions. See the follow-up conclusion for Finding 20.

FINDING 16

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
CPS investigators did not always complete CPS investigations within required time frames. Our review of 160 CPS investigations noted MDHHS did not complete 47 (29%) within 30 days or within the time frame of an approved extension, when applicable.

MDHHS's policy and the Modified Settlement Agreement and Consent Order and its successor, the Implementation, Sustainability, and Exit Plan* (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 allowed supervisors to approve extensions in extenuating circumstances.

Recommendation Reported in September 2018:
We recommended that CPS investigators complete CPS investigations within required time frames.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it had:

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, including supervisory verification that the investigation was completed within the required time frame.
- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether sampled investigations were completed within 30 days, or an allowable exception was granted.
- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt an associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

FOLLOW-UP CONCLUSION

Substantially complied.

Our review of 100 CPS investigations noted 97 (97%) of the investigations were completed within 30 days or within the time frame of an approved extension, when applicable.

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

FINDING 17

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
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 its CPS investigation activities and decisions intended to protect the safety and well-being of the children are carried out appropriately. We noted:

a. CPS supervisors often did not identify and/or correct investigation deficiencies when reviewing investigations and commonly approved investigation reports with existing deficiencies.

b. CPS supervisors did not review 28 (18%) of 160 investigations within 14 days of their receipt of the investigation.

c. Documentation did not exist to support supervisors met with the investigator for a case consultation prior to the disposition for 24 (15%) of 156 investigations that required a case consultation.

MDHHS policy required supervisors to review and, after all needed corrections are made, approve investigation reports. MDHHS's policy and the ISEP required the CPS supervisor to review and approve all CPS investigation reports within 14 calendar days from receipt of the report. MDHHS policy also required the CPS supervisor meet with the investigator on every assigned complaint prior to case closure; the ISEP required CPS supervisors meet with investigators monthly to review the status and progress of each CPS investigation.

Recommendation Reported in September 2018:
We recommended that CPS supervisors improve the effectiveness and timeliness of CPS investigation reviews and the consistency of case consultations with investigators.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it had:

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements, and verify required documentation occurred. The controls required in the SCP are aimed at identifying errors as they occur and correcting them prior to investigation completion.

- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law and the effectiveness of the SCP in catching and correcting errors for sampled investigations.

- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

- Created a team of CPS supervisors to provide ongoing skill development workshops to their peers that will focus on improving local county office culture and enhancing supervisors' ability to deliver effective supervision and leadership.

FOLLOW-UP CONCLUSION

Partially complied. A material condition still exists.

Our follow-up noted:

- MDHHS did not comply with part a.

  Our review of final SCP reports compared to our sample of 100 completed CPS investigations:

  - Identified numerous deficiencies which could have been identified and/or corrected through more effective supervisory review and significantly contributed to the errors noted and reported in our follow-up conclusions for Findings 2 through 5, 8, 13, and 21.

  - Determined CPS supervisors did not complete the SCP review and approval within the required time frames.

    MDHHS policy establishes the time frames required for completion of each phase of the SCP and allows an additional three business days for completion of each phase of the SCP if the supervisor cannot meet the established time frame for the phase. We noted:

    - Phase 1 of the SCP was not completed within 7 days after receipt of the CPS complaint, as required, for 12 (12%) investigations. On average, they were 5 days late, with a range of 1 day to 27 days late.

    - Phase 2 of the SCP was not completed within the 14 calendar days of complaint receipt, as required, for 11 (11%) investigations. On average, these investigations were 6 days late, with a range of 1 day to 20 days late.

- Phase 3 of the SCP was not completed within 7 days after the investigator submitted it to the supervisor, as required, for 9 (9%) investigations. On average, these investigations were 3 days late, with a range of 1 day to 8 days late.

- MDHHS partially complied with part b.

  We determined CPS supervisors did not complete their final review and approval of 6 (6%) of the 100 sampled CPS investigations within 14 days of receipt of the investigation, as required by MDHHS policy. This was an improvement from the 18% error rate we previously reported; however, further improvement is needed. On average, the supervisory review and approval of these 6 investigations was 11 days late, with a range of 3 to 27 days late.

- MDHHS substantially complied with part c.

  We determined casefile documentation supported CPS supervisors met with the investigator for a case consultation prior to disposition for 98 (98%) of the 100 CPS investigations reviewed.

We still consider this finding to be a material condition because supervisory oversight is MDHHS's primary control to effectively detect and correct investigation deficiencies, yet frequent and pervasive errors persist as evidenced by our follow-up conclusions for Findings 2 through 5, 8, and 13.

FOLLOW-UP RECOMMENDATION

We recommend CPS supervisors improve the effectiveness and timeliness of CPS investigation reviews.

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with our follow-up conclusion.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The agency preliminary response and our auditor's comments to Finding 17 are presented on pages 72 and 73.

FINDING 18

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
MDHHS did not monitor families' participation in post-investigative services for all Category III CPS investigations. 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. We determined MDHHS closed 74% of these investigations without monitoring the families' participation in post investigative-services or considering whether the investigation should be reclassified to a Category II CPS investigation.

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 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 asserted legal discretion existed and the CPL did not intend nor require MDHHS to monitor all Category III CPS investigations, and its 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.

Recommendations Reported in September 2018:
We recommended that MDHHS monitor families' participation in post-investigative services to determine whether the families are receiving and participating in services intended to alleviate the child's risk level for abuse and/or neglect, when applicable.

We also recommended 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 PLAN TO COMPLY

MDHHS's December 5, 2018 agency plan to comply indicated disagreement with our recommendations to address this finding and did not set forth plans to seek legislative clarification to validate its interpretation of, and compliance with, Section 8d(1)(c) of the CPL for Category III investigations. MDHHS stated in the plan that it was continuing to explore a change in policy requirements for service provision in Category III investigations 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.

FOLLOW-UP CONCLUSION

Not complied. A material condition still exists.

At the time of our follow-up review, Section 8d(1)(c) of the CPL for Category III investigations remained unchanged. Also, MDHHS's policy allowing 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, without further monitoring, remained in effect.

We determined that during our 12-month review period, MDHHS closed 4,449 (65%) of the 6,862 Category III classified CPS investigations without monitoring the families' participation in post-investigative services or considering whether the investigation should be reclassified to a Category II CPS investigation.

We still consider this finding to be a material condition because MDHHS's policy continues to not correspond to CPL requirements and because of the high percentage of Category III investigations MDHHS closed.

FOLLOW-UP RECOMMENDATIONS

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

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

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with our follow-up conclusion.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The agency preliminary response and our auditor's comments to Finding 18 are presented on pages 74 and 75.

FINDING 20

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
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 the 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 required 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.

Our review noted MDHHS did not add 257 confirmed perpetrators of CA/N to the Central Registry, as required by the CPL, as follows:

- 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 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 for 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).

Recommendation Reported in September 2018:
We recommended MDHHS ensure it adds confirmed perpetrators of CA/N to the Central Registry when required by the CPL.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it had:

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, including additional supervisory controls to verify all individuals are placed on the Central Registry when necessary.
- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether names were properly added to the Central Registry.
- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

FOLLOW-UP CONCLUSION

Complied.

We noted:

- MDHHS added confirmed perpetrators of CA/N to the Central Registry, according to its investigation category classification, for the 26 applicable investigations we reviewed.
- MiSACWIS generated an investigation category classification value based on information entered by the investigator for the approximately 61,000 investigations closed during our review period.

Effective November 1, 2022, Public Acts 64, 65, 66, 67, and 72 of 2022 amended the CPL's Central Registry requirements and no longer links Central Registry addition to the CPS investigation category classification. Therefore, the impacts previously reported in Findings 13 and 14 related to the Central Registry are no longer applicable.

FINDING 21

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
MDHHS needs to improve its process for notifying individuals that their names have been added to the Central Registry as perpetrators of CA/N. Our review of 37 investigations requiring MDHHS to add the perpetrator(s) to the Central Registry noted MDHHS did not have documentation to support it had appropriately provided written notification to 24 perpetrators associated with 16 (43%) of the investigations. The CPL states if MDHHS classifies a report of suspected CA/N 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. Without improvements, MDHHS cannot ensure individuals are always made aware they are named in the Central Registry as a perpetrator of CA/N, notified of their right to request MDHHS to expunge* their record from the Central Registry, and informed of their right to a hearing if MDHHS refuses the expungement request.

CPS investigators provided us with differing responses to explain why documentation of written notification was absent, and MDHHS's supervisory oversight intended to ensure compliance with investigation requirements was not sufficient to identify and correct instances when documentation of notification was deficient.

Recommendation Reported in September 2018:
We recommended that MDHHS improve its process for notifying individuals that their names have been added to the Central Registry as perpetrators of CA/N.

AGENCY PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it had:

- Issued a communication to CPS staff clarifying documentation expectations.
- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, including additional supervisory controls to verify notifications of due process were sent and documented.
- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether documentation reflects that notifications of due process were sent.
- Developed the PCR process to provide independent oversight of CPS investigation practices at local county

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

offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

MDHHS's plan also indicated it was in the process of creating a MiSACWIS mobile software application to document completion of required investigation activities in real time from the field, with planned implementation by March 31, 2019.

FOLLOW-UP CONCLUSION

Partially complied. A reportable condition exists.

According to Section 7(4) of the CPL, written notification to perpetrators added to the Central Registry "*shall be sent by registered or certified mail, return receipt requested, and delivery restricted to the addressee*." [Emphasis added.] To improve CPS investigation documentation and demonstrate compliance with this requirement, MDHHS issued program guidance instructing CPS staff to document the certified mail return receipt within the casefile when mailing the perpetrator notification letter; however, MDHHS policy conversely required CPS staff to document the certified mail return receipt only when the notification was refused or otherwise undeliverable.

Our review of 26 investigations requiring MDHHS to add the perpetrator(s) to the Central Registry, noted CPS investigators documented within a social work contact that MDHHS provided a notification letter via certified mail to each of the perpetrators added to the Central Registry. However, the corresponding certified mail return receipt was not documented for 17 notification letters associated with 11 (42%) of the investigations.

MDHHS needs to further clarify and strengthen its program guidance and policy to ensure its perpetrator notification process consistently includes documentation to support whether MDHHS carried out the perpetrator notification actions required by the CPL.

We considered this a reportable condition because of the noncompliance with CPL requirements and needed improvements to program guidance.

FOLLOW-UP RECOMMENDATION

We recommend MDHHS improve its policy to ensure appropriate documentation of written notification to perpetrators that their names have been added to the Central Registry.

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS disagrees with our follow-up conclusion.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The agency preliminary response and our auditor's comments to Finding 21 are presented on page 76.

FINDING 24

Audit Finding Classification: Material condition.

Summary of the September 2018 Finding:
MDHHS needs to strengthen its controls over MiSACWIS commencement data to help ensure it captures complete, accurate, and valid information consistent with established commencement policy. Capturing this data in this fashion is necessary to help MDHHS ensure 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.

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

b. Investigators failed to check a MiSACWIS "investigation commencement" checkbox for any contact for 7 investigations.

c. Investigators entered a commencement date preceding the complaint date for 6 investigations.

d. Investigators captured investigation commencement contact data in MiSACWIS differed from their written narrative for 6 investigations.

Recommendation Reported in September 2018:
We recommended 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 PLAN TO COMPLY

MDHHS's December 5, 2018 plan to comply indicated it:

- Developed SCP to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements, and verify required documentation occurred, including supervisory verification of the quality of CPS commencement data.

- Created CRT to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including reviewing commencement data for compliance in each sampled investigation.

- Developed the PCR process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.

FOLLOW-UP CONCLUSION

Complied.

Our follow-up noted:

- The "investigation commencement" information MDHHS captured in MiSACWIS for 100 CPS investigations we reviewed was consistent with MDHHS's established commencement policy at the time of this follow-up. However, deficiencies exist in MDHHS's commencement policy stemming from revisions which removed the requirement to assess child safety within the CPL's 24-hour required investigation commencement time frame that could impact MDHHS's ability to accurately assess and report its compliance with the CPL's commencement mandate (see follow-up conclusion for Finding 1, part b.(1)).

- We reviewed 61,171 closed CPS investigations and noted investigators checked the "investigation commencement" checkbox for at least one contact for 61,101 (99.89%).

- We reviewed the 61,101 closed CPS investigations where the investigator checked the "investigation commencement" checkbox and noted the commencement date did not precede the complaint date for 60,758 (99.44%).

- We reviewed a sample of 100 CPS investigations and noted investigators captured commencement contact data in MiSACWIS in accordance with their written narrative for all 100 (100%).

AUDITOR'S NOTE

Observation 2 is not directly related to a specific follow-up conclusion but provides an important issue for MDHHS's consideration. Therefore, we presented it separately from the findings.

OBSERVATION 2

Further guidance may be needed to investigate allegations of physical abuse.

MDHHS may need to provide further guidance to CPS investigators related to allegations of physical abuse. Our review of some investigations containing allegations of physical abuse disclosed CPS investigators concluded that a preponderance of evidence did not exist to support the allegations because no marks appeared on the alleged child victim and/or the allegations occurred in the past.

Section 722.622(g) of the CPL defines child abuse as "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, any other person responsible for the child's health or welfare."

MDHHS policy defines physical abuse as the nonaccidental occurrence of various injuries including bone fractures, internal injuries, bruises, loss of consciousness, and open wounds. MDHHS policy also defines nonaccidental as expected, intentional, incidental, and/or planned behavior on the part of the parent, caretaker, or person responsible for the child's health or welfare, which results in physical or mental injury to a child or an action which a reasonable person would expect to be a proximate cause of an injury.

HHS's *Child Protective Services: A Guide for Caseworkers* recommends CPS agencies consider various signs when investigating allegations of physical abuse, including:

- The child has unexplained burns, bites, bruises, broken bones, or black eyes.
- The child seems frightened of the parents and protests or cries when it is time to go home.
- The child reports injury by a parent or other adult caregivers.
- The parent or other adult caregivers use harsh physical discipline with the child.

MDHHS's Forensic Interviewing Protocol provides CPS investigators with questions to ask when investigating allegations of physical abuse, including many of the areas recommended by HHS. However, further guidance for considering these factors could be beneficial for CPS investigators when reaching investigative conclusions. For example, Kentucky provides its CPS investigators with a physical abuse rating scale to assist in

determining whether a preponderance of evidence exists to support the allegations. The scale includes assessing not only physical evidence of the injury but also the explanations and response to the injury by the parent or caretaker, impact of the injury on the child's behavior, and pain reported by the child. The scale allows the investigator to rank each of these factors by severity to support a conclusion of whether a preponderance of evidence of physical abuse exists.

We encourage MDHHS to consider whether the current guidance provided to CPS investigators is sufficient to produce desired outcomes and appropriate CPS investigation conclusions that protect children and are in accordance with the intent of MDHHS's policy and the CPL.

Finding 1 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 1 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 1: Improvement needed to ensure that investigations are commenced in a timely manner.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.	We clearly indicate within our follow-up conclusion the reasons supporting our determination MDHHS only partially complied with the 2018 audit recommendation. Also, materiality is based on the auditor's judgment and evaluation of test results, and we clearly indicate within our follow-up conclusion the reasons why we conclude a material condition remains.
MDHHS has exceeded the department's Modified Implementation, Sustainability, and Exit Plan (MISEP) commencement performance standards (section 5.2) that were approved by the U.S. District Court for the Eastern District of Michigan. MDHHS was required to commence all investigations of a report of child abuse or neglect within the time frames required by state law. The designated performance standard was 95% and MDHHS achieved and exceeded that metric.	MDHHS's claim that it has exceeded MISEP commencement performance standards based on its new policy may be technically correct. However, it is also misleading because, based on our testing, MDHHS did not complete any investigative activities to assess child safety for nearly 40% of sampled investigations, and even when it identified alleged child victims were in imminent danger, did not meet its own established time frame to check on child safety 8% of the time.
MDHHS is an agency devoted to an important and challenging mission: Keeping kids safe and families together. Our caseworkers balance these goals 24/7, sometimes in difficult conditions, as they investigate nearly 70,000 child abuse allegations per year. The department promised and delivered significant reforms and progress. In the last five years, MDHHS enacted these changes: • *Updated its commencement policy in December 2017 to align with practice and further clarified the policy in August 2018.* • *Developed a Supervisory Control Protocol (SCP) to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements and verify that required documentation occurred, including supervisory verification of the timeliness of commencement.*	MDHHS indicates it delivered significant reforms and progress since our 2018 audit including updating its commencement policy and enacting the SCP, CRT, and PCR processes to improve compliance with CPS investigation requirements. However, we identified shortcomings in MDHHS's updated commencement policy, as delineated in our follow-up conclusion for this Finding. In addition, our follow-up results for several Findings throughout this report demonstrate MDHHS's SCP, CRT, and PCR processes were not always effective to ensure compliance with investigation requirements (see follow-up conclusions for Findings 2 through 5, 8, 13, and 17).

- *Created a Compliance Review Team (CRT) to review a sample of approved CPS investigations on an ongoing basis and determine compliance with MDHHS policy and law, including whether sampled investigations were commenced within the required time frame.*

- *Developed a Peer Case Review (PCR) process to provide independent oversight of CPS investigation practices at local county offices. The PCR process was designed to help identify systemic deficiencies, prompt associated corrective action, and identify and highlight areas of best practices which could be shared with other counties.*

As the OAG concluded in section b. above, the department commenced 100% of required investigations within the required time frames for the OAG's review period based on the current commencement policy. The MDHHS commencement policy requirements exceed practices in other jurisdictions such as Washington, North Carolina, and Oklahoma.

The department conducts an initial assessment of safety upon receipt of a referral of alleged child abuse and/or neglect by Centralized Intake. Upon receipt of an allegation, the department immediately assesses whether imminent harm is likely based on the reported allegations. Examples include but are not limited to:

- *Failure to respond immediately could result in death of, or serious injury to, the child within 24 hours.*

- *Child requires urgent or emergency medical or mental health care for injury or illness due to alleged child abuse and neglect within the next 24 hours.*

- *There is a sexual abuse allegation, and the alleged perpetrator will likely have access in the next 24 hours.*

The department's current policy is applied to the nearly 200 assigned child abuse and neglect referrals received on average each day. The policy is designed and implemented to keep kids safe through risk assessments, timely investigations, and compliance with the Child Protection Law.

MDHHS indicates it conducts an initial assessment of safety upon receipt of a complaint of alleged CA/N by Centralized Intake. However, the person reporting the alleged CA/N to Centralized Intake may not possess the information necessary at the time of the complaint intake to allow MDHHS to assess the current safety of the alleged child victims. MDHHS recognized and addressed this in its former commencement policy that defined commencement as ***requiring*** "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." However, as noted in the follow-up conclusion, MDHHS removed the requirement to assess child safety during the 24-hour time frame from its investigation commencement policy.

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Go to Finding 2

Finding 2 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 2 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 2: Considerable improvement needed in documentation of Central Registry clearances.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.	MDHHS contends it achieved compliance with the prior audit recommendation while simultaneously confirming the 14% error rate noted in our follow-up. MDHHS also indicates it disagrees a material condition exists; however, we clearly indicate within our follow-up conclusion the reasons why we conclude a material condition remains.
In the last five years, MDHHS enacted a number of reforms including the development of a Supervisory Control Protocol (SCP) to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements and verify that required documentation occurred.	The errors identified evidence the ineffectiveness of MDHHS's SCP to ensure worker compliance with investigation requirements, which further supports our conclusion.
MDHHS asserts that significant progress has been made in this area as demonstrated by an improvement of 28% to 86% compliance. A Central Registry clearance is only one factor case managers consider in their overall assessment of safety.	MDHHS's response does not acknowledge improvements in compliance are largely based on its reduction of Central Registry clearance requirements within current policy and is silent regarding the recommendation for it to evaluate the impact of its Central Registry policy change.

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Go to Finding 3

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

Finding 3 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 3 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 3: Considerable improvement needed in completion of required criminal history checks.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.	MDHHS contends it achieved compliance with the prior audit recommendation and a material condition no longer exists while simultaneously confirming nearly 30% of required LEIN checks did not occur. We maintain the significant error rate in conducting required LEIN checks and the additional reasons clearly indicated in our follow-up conclusion support the existence of a material condition.
The Michigan Department of Health and Human Services is an agency devoted to an important and challenging mission: Keeping kids safe and families together. Our caseworkers balance these goals 24/7, sometimes in difficult conditions, as they investigate nearly 70,000 child abuse allegations per year. Guided by Director Hertel's "Keep Kids Safe Action Agenda," MDHHS works with lawmakers, police, judges, and other child welfare system leaders to do everything in our power to make Michigan the safest place in America to raise kids and nurture families.	
In the last five years, MDHHS enacted a number of reforms including the development of a Supervisory Control Protocol (SCP) to increase the frequency and effectiveness of supervisory review and approval of CPS investigation activities, improve worker compliance with CPS investigation requirements and verify that required documentation occurred.	The identified errors evidence the ineffectiveness of MDHHS's SCP to ensure worker compliance with investigation requirements, which further supports our conclusion.
MDHHS asserts that significant progress has been made in this area as demonstrated by an improvement of 48% to 73% compliance with current policy and disagrees that the finding should remain a material condition. A criminal history check is only one factor case managers consider in their overall assessment of safety.	Although MDHHS asserts it achieved a 25% increase in its compliance rate, it does not acknowledge the identified improvements are largely based on reducing the extent of required LEIN checks within its revised policy.
The department's efforts for continuous quality improvement continue to result in progress with recent updates to the policy. Effective September 1, 2023, LEIN policy has been updated to require CPS case managers to request a LEIN clearance as early as possible in the investigation, but no later than seven calendar days after receipt of the referral by Centralized Intake, on all alleged perpetrators and all adults residing in the household of the alleged perpetrator. The case manager may also conduct a LEIN clearance during any investigation. And	MDHHS indicates after the OAG completed its follow-up procedures it updated its LEIN check policy and the revisions align with the OAG's recommendation. We disagree. According to the information provided in its response, MDHHS did not restore the ***requirement*** that investigators conduct LEIN checks for all persons responsible for the health and welfare of a child such as non-perpetrator parents, legal guardians, and adults living in the same home in which the ***child*** resides, as indicated by

finally, LEIN clearance must be requested when there are allegations of: sexual abuse, physical injury, sex or labor trafficking, domestic violence, and/or substance use, sales, or production. These revised policies reflect the attitude of continuous improvement and align with the recommendation by the OAG.

best practices and our recommendation. MDHHS only required LEIN checks on those individuals who live in the home of the alleged perpetrator, which often may not be the only home in which the child resides.

MDHHS does not provide information related to the impact of its policy departures from best practices recommendations.

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Go to Finding 4

Finding 4 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 4 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 4: Documentation of a complete review of CPS history for family and household members needed.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.	MDHHS contends it achieved compliance with the prior audit recommendation while simultaneously confirming error rates of up to 46%. MDHHS also indicates it disagrees a material condition exists; however, we clearly indicate within our follow-up conclusion the reasons why we conclude a material condition remains.
In the last five years, MDHHS enacted a number of reforms including the development of a Supervisory Control Protocol (SCP), Compliance Review Team (CRT), and Peer Case Review (PCR) to improve required documentation that supports investigators conducted a complete review of CPS history on all required investigation persons.	The errors identified demonstrate MDHHS's SCP, CRT, and PCR processes were not effective to ensure worker compliance with CPS investigation and documentation requirements.
MDHHS asserts that significant progress has been made in two of the three areas identified by the OAG as demonstrated by an improvement from 59% to 80% and 76% to 88%, respectively. MDHHS agrees that documentation should demonstrate CPS investigators conducted a complete review of CPS history on all required investigation persons. MDHHS consistently reviews internal policies and procedures to determine if changes are needed to strengthen policy, practice, and documentation and will consider the OAG's observations in any future policy enhancements.	MDHHS asserts it agrees documentation should demonstrate CPS investigators conducted a complete review of CPS history on all required investigation persons and acknowledges progress has not been made in all areas of conducting CPS history reviews, further supporting our conclusions. MDHHS's response does not address our follow-up recommendation regarding an evaluation of the impact of MDHHS's CPS history policy change on its ability to identify and appropriately address potential safety concerns for alleged child victims and promote CPS program objectives.

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Go to Finding 5

Finding 5 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 5 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 5: Significant improvement needed in the documentation of communication with mandated reporters.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition.	MDHHS contends it achieved compliance with the prior audit recommendation while simultaneously confirming the 10% error rate noted in our follow-up. MDHHS also indicates it disagrees a material condition exists; however, we clearly indicate within our follow-up conclusion the reasons why we conclude a material condition remains.
In the last five years, MDHHS enacted a number of reforms including the development of a Supervisory Control Protocol (SCP), Peer Case Review (PCR), and Compliance Review Team (CRT) to improve documentation that it provided the mandated reporter with written notification of its disposition of the investigation that resulted from the reporter's complaint.	
CPS investigators followed policy for the period under review in relation to contacting the mandated reporter. The department promised and delivered significant progress in providing written notification of case disposition to mandated reporters, from 31% to 90%. Building on these gains, MDHHS is consistently reviewing and improving policies to keep children safe and families together.	MDHHS does not directly address our follow-up recommendation that MDHHS evaluate the impact of its mandated reporter contact policy change on alleged child victims and families.
The OAG's observations will help shape future reforms. MDHHS maintains accountability with its internal reviews, learning from every case and designing new strategies to improve the entire child welfare system.	Although we appreciate its acknowledgment our observations will help shape future reforms, we question how MDHHS can at the same time disagree with our follow-up conclusions.

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Finding 6 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 6 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 6: Improvement needed in completing timely face-to-face contact with alleged child victims.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding is a reportable condition.	MDHHS contends it achieved compliance with the prior audit recommendation while simultaneously confirming the 5% error rate noted in our follow-up. MDHHS also indicates that it disagrees this is a reportable condition; however, we clearly indicate within our follow-up conclusion the reason we conclude a reportable condition exists.
MDHHS agrees it needs to make face-to-face contact with all alleged child victims in a timely manner.	
MDHHS made face-to-face contact with alleged child victims within 24 to 72 hours for 95% of the cases reviewed by the OAG. At times, extenuating circumstances, such as the inability to locate youth after multiple attempts, impacted staff's ability to make timely face-to-face contact. CSA's top priority is protecting the safety and well-being of children. MDHHS leadership will continue to provide consistent oversight to ensure timely contact is made whenever possible.	We acknowledge that extenuating circumstances may arise; however, we considered any such instances documented in the sampled investigation casefiles and concluded these circumstances were not the sole contributing factor to MDHHS's untimely face-to-face contact with the alleged child victim(s) cited in our follow-up conclusion.

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Go to Finding 8

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

Finding 8 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 8 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 8: Documentation of safety planning at initial contact with family and completion, accuracy, and timeliness of safety assessments need improvement.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
MDHHS disagrees that compliance with the prior audit recommendation was not achieved and disagrees that the finding should remain a material condition. *MDHHS agrees that child safety is of utmost importance. Based on the OAG's finding, MDHHS demonstrated a 94% accurate completion rate of the department's current Structured Decision Making (SDM) safety assessment and safety plans are clearly documented in 80% of CPS investigations.*	MDHHS contends it achieved compliance with the prior audit recommendation while simultaneously confirming the 21% and 6% error rates noted in our follow-up related to completion of safety plans and safety assessments, respectively. MDHHS also indicates it disagrees a material condition exists; however, we clearly indicate within our follow-up conclusion the reasons why we conclude a material condition remains.
While MDHHS recognizes opportunities to improve documentation of safety assessments and any required safety planning within case service plans, insufficient documentation does not necessarily mean actions are not being taken to ensure child safety and family well-being. It should be emphasized that the SDM safety assessment is a tool and is not intended to supersede a case manager's investigative findings, experience, and/or judgment when it comes to assessing and ensuring child safety. *To ensure child welfare staff have the tools they need to continue assessing child safety timely and effectively, the department is actively redesigning and enhancing the current safety assessment to improve accuracy, equity, reliability, and utility.* *The department has embarked on an expansive project with a nationally recognized child welfare organization to facilitate this work. This organization has worked with over 30 jurisdictions nationwide and overseas to implement the SDM safety assessment. Various, diverse stakeholders are actively contributing to the development of the enhanced assessment, including but not limited to, tribal governments, parents and young people with lived experience, race equity experts, child welfare staff and leadership, and service providers. There is a great deal of emphasis on ensuring language and application is consistent and equitable.*	Although MDHHS indicates that it disagrees with our conclusions, it also contends it is actively pursuing a number of significant improvements that align with our recommendations related to documentation, completeness, and accuracy of safety plans and safety assessments. MDHHS's response does not address our follow-up recommendation that MDHHS evaluate the impact of its policy departures from best practices recommendations.

The design of the new safety assessment will require staff to complete the assessment within two working days of initial contact with the family, at critical decision points throughout the case, and/or prior to case closure. Additionally, a safety plan component will be built into the new assessment, designed to enhance documentation of required safety planning for any identified immediate harm factors. Prior to implementation of the new tool and practice, MDHHS policy will be updated to align accordingly.

In the interim, the department will continue to offer training, policy, and practice guidance to staff to ensure accurate completion of the SDM safety assessment and that documentation reflects the work being done to assess and ensure child safety and family well-being.

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

Finding 17 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 17 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 17: Significant improvement needed in supervisory oversight of CPS investigations.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
The OAG found MDHHS in compliance with timely review of investigations in Finding 16, which the department believes is an important step for child safety along with supervisory oversight.	This portion of MDHHS's response regarding Finding 16 is irrelevant to the follow-up conclusion for Finding 17.
MDHHS disagrees Finding 17, regarding the supervisory review of investigations, should remain a material condition and MDHHS disagrees that compliance with the prior year recommendation was not achieved. As reported by the OAG's review of Finding 17, the following improvements have been demonstrated: • *94% of investigations were reviewed by the supervisor within 14 days.* • *With the implementation of the Supervisory Control Protocol, all case files are reviewed multiple times by the supervisor within the first month of receipt.* • *98% of the case file documentation demonstrated supervisors met with the investigator prior to disposition.*	MDHHS contends it achieved compliance with the prior audit recommendation and a material condition no longer exists. However, as noted in our follow-up conclusion, our review of final SCP reports compared with the completed CPS investigations identified numerous investigation deficiencies and errors not identified and/or corrected through supervisory review. Also, the improvements described here are largely related to *timeliness* of supervisory reviews, not the effectiveness of the reviews.
Timely review and case file documentation compliance substantially increased as compared to 2018, as a result of newly implemented and ongoing remediations. The improved outcomes were achieved as the result of the following corrective actions implemented by MDHHS since the last audit: • *Assured supervisors are meeting with investigators multiple times during an investigation to discuss child safety, safety planning, and other critical items.* • *Implemented a Supervisory Control Protocol to increase the effectiveness of the review process.* • *Created a Compliance Review Team to continually evaluate processes and implement practices as needed.*	The deficiencies noted in the conclusion demonstrate the ineffectiveness of MDHHS's SCP, CRT, and PCR processes and CPS supervisor training. In addition, the errors noted significantly contributed to our conclusions that material conditions persist in the following investigation activities: • Documenting Performance of Central Registry Clearances (see Finding 2) • Completing Required Criminal History Checks (see Finding 3) • Documenting a Complete Review of CPS History (see Finding 4)

- *Developed a Peer Case Review to provide independent oversight of CPS investigation practice within each jurisdiction.*
- *Created a team of CPS supervisors to provide ongoing supervisor training.*

CPS supervisors have significantly improved the effectiveness and timeliness of CPS investigation reviews and the consistency of case consultations with investigators.

- Documenting and Implementing Safety Plans (see Finding 8)
- Assessing the Risk of Future Harm to Children (see Finding 13)

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

Finding 18 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 18 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 18: Monitoring of families' participation in post-investigative services needed for all Category III investigations.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
Five years ago, the OAG issued an audit of MDHHS's Children's Protective Services that found the department did not adequately monitor families' participation in post-investigative services.	
MDHHS disagrees with the OAG's recommendations. Following the OAG's CPS audit in 2018, the Children's Services Administration (CSA) reviewed the category III open/close practice further internally to assess the need for legislative clarification. When MCL 722.628d was enacted (1998 PA 484; analysis in 1998-SFA-0603), there was a reporting requirement by the department to the Legislature which included the number and percentage of category III cases where the person/family did not participate in services. Arguably, at that time, the department had to monitor cases to accurately report back to the Legislature. However, the 2006 amendments to MCL 722.628d (2006 PA 618; analysis 2005-SFA-1254) changed the reporting requirement to include "[t]he number of cases referred to voluntary community services and closed with no additional monitoring." Thus, by January 3, 2007, there was legislative recognition that category III cases were being closed without any additional monitoring. Further amendments did not appear to address the reporting requirement issue.	Section 8d(1)(c) of the CPL for Category III investigations remained unchanged from our 2018 audit recommendation through our follow-up period. Also, although MDHHS indicates it conducted an internal review of its Category III practice, it did not seek legislative clarification to validate its interpretation of, and compliance with, Section 8d(1)(c) of the CPL for Category III investigations. The reporting requirement language MDHHS refers to in its response related to the 2006 amendment, *was removed from the statute in 2014, with no corresponding change to Section 8d(1)(c)*. A legislative analysis conducted by the House Fiscal Agency in November 2013 indicates the 2014 amendment was to, among other things, remove obsolete language requiring MDHHS to furnish written reports from 2005 through 2008 to legislative committees.
CSA's top priority is protecting the safety and well-being of children. A category III classification means there is a preponderance of evidence of child abuse and/or neglect, and the risk of future harm is low or moderate. In all category III cases, staff are required to refer the family to services commensurate with the risk level and any identified safety factors. Prior to closure of the investigation, staff assess a family's willingness and need to voluntarily participate in services through engagement and a strength-based Family Team Meeting. If it's determined the child/ren is/are safe and ongoing CPS monitoring is not needed, the staff may open/close the category III investigation. If there is an ongoing safety matter requiring services and a family will not voluntarily	

participate, or does not appear to be making progress, the staff must consider escalating the case. Additionally, implementing the OAG's recommendation could create a situation where the department is involved in families' lives far longer than necessary. The Department believes that additional monitoring would not significantly benefit children who are identified as low to moderate risk.

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Finding 21 Agency Preliminary Response and Auditor's Comments to Agency Preliminary Response

This section contains MDHHS's preliminary response to the follow-up conclusion for Finding 21 and our auditor's comments providing further clarification and context where necessary.

Overall Auditor's Comment

MDHHS indicates in its agency preliminary response it disagrees with our conclusion and in some cases our classification of existing Findings as material or reportable. In accordance with auditing standards, we evaluated MDHHS's comments and determined the additional information provided did not warrant a change to the conclusions or classification of existing Findings as described below.

Finding 21: Improvement needed in the process to inform individuals whose names MDHHS adds to the Central Registry.

MDHHS provided us with the following response:

AGENCY PRELIMINARY RESPONSE	AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE
MDHHS disagrees that the finding is a reportable condition because MDHHS fully complied with the prior audit recommendation.	MDHHS indicates that it disagrees this is a reportable condition; however, we clearly indicate within our follow-up conclusion the reasons we conclude a reportable condition exists.
MDHHS agrees that documentation demonstrates required central registry notification was provided to identified perpetrators in 100% of investigations. MDHHS consistently reviews internal processes to determine if improvements are needed to strengthen policy, practice guidance, and documentation and will continue to do so moving forward.	MDHHS's policy requirements differed from program guidance instructions provided to CPS staff. Consequently, MDHHS could not demonstrate full compliance with the CPL's requirement that it notified perpetrators by certified mail.

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FOLLOW-UP METHODOLOGY, PERIOD, AND AGENCY RESPONSES

METHODOLOGY

We reviewed MDHHS's corrective action plan and the follow-up report to our 2018 audit prepared by the Office of Internal Audit Services, State Budget Office, and interviewed MDHHS management, CPS supervisors, and CPS investigators. Also, we:

- Reviewed applicable changes to the CPL.
- Evaluated the impact of MDHHS's policy changes, including whether the revised policy was in accordance with best practices for child protection agencies.
- Judgmentally and randomly selected representative samples of 100 CPS investigations from the Statewide population of approximately 68,000 CPS investigations MDHHS assigned for investigation between June 1, 2021 and May 31, 2022; conducted on-site reviews at four MDHHS local county offices in two Michigan counties to review the hard-copy casefile information MDHHS maintained in conjunction with the electronic casefile information contained in MiSACWIS; and performed an off-site review of the selected investigation files for six additional counties. We examined each selected investigation to determine MDHHS's compliance with selected investigation requirements, including an assessment of compliance with the CPS policy in place during our September 2018 performance audit report of CPS Investigations, as applicable:
    - Compared the complaint receipt time with MDHHS's documented commencement activities to determine whether MDHHS commenced the investigation within required time frames and whether commencement included an assessment of safety of the alleged child victim(s).
    - 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 reviews to identify prior CPS involvement and assess its relevance to current conditions.

- Reviewed documentation of the investigators' contacts 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 investigators made the required face-to-face contact with the alleged child victim(s) within the required time frame.

- Verified investigators established appropriate safety plans and assessed the timeliness of safety plan establishment.

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

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

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

- 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.

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

- Evaluated whether supervisors performed effective review and approval of CPS investigation requirements 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 for 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.

- Compared the commencement data captured in MiSACWIS with the underlying casefile documentation to verify the captured data accurately reflected the investigators efforts and/or actions to comply with the commencement timeliness requirements.

- Reviewed MDHHS's impact assessments and corresponding management decisions for 15 MiSACWIS risk assessment system functionality errors.

- Performed analysis on the 6,862 Category III CPS investigations assigned between June 1, 2021 and May 31, 2022 and closed as of June 6, 2022 to identify those subject to post-investigative monitoring or consideration of whether the investigation should be reclassified to a Category II CPS investigation.

- Analyzed the population of approximately 61,000 CPS investigations assigned between June 1, 2021 and May 31, 2022 and closed as of June 6, 2022 to determine whether:

    - MiSACWIS generated an investigation category classification value based on information entered by the investigator.

    - The investigation contained a commencement contact.

    - Investigation commencement contacts occurred after MDHHS received the complaint.

- Advised MDHHS of concerns that, based on the documented investigation evidence 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 some of these children with regard to the concerns.

PERIOD

Our follow-up generally covered June 1, 2021 through May 31, 2022.

AGENCY RESPONSES

Our follow-up report contains 20 recommendations. MDHHS's preliminary response indicates it agrees with 1 of the recommendations and disagrees with 19 of the recommendations.

The agency preliminary responses to the follow-up recommendations were 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 to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, 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.

GLOSSARY OF ABBREVIATIONS AND TERMS

agency plan to comply	The response required by Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100). The audited agency is required to develop a plan to comply with Office of the Auditor General audit recommendations and to submit the plan to the State Budget Office upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, 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.
auditor's comments to agency preliminary response	Comments the OAG includes in an audit report to comply with *Government Auditing Standards*. Auditors are required to evaluate the validity of the audited entity's response when it is inconsistent or in conflict with the findings, conclusions, or recommendations. If the auditors disagree with the response, they should explain in the report their reasons for disagreement.
BSC	Business Service Center.
CA/N	child abuse and/or neglect.
Central Registry	The system MDHHS 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. Effective November 1, 2022, the CPL definition was amended to mean a repository of names of individuals who are identified as perpetrators related to a Central Registry case in MDHHS's Statewide electronic case management system. The Central Registry is not publicly searchable.
Central Registry case	A CPS case MDHHS classifies under Sections 8 and 8d of the CPL as Category I or Category II. Effective November 1, 2022, the CPL definition was amended to a case where MDHHS confirmed that a person responsible for the child's health or welfare committed serious abuse or neglect, sexual abuse, or sexual exploitation of a child or allowed a child to be exposed to or have contact with methamphetamine production.
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 of the child's health or welfare or by a teacher, a teacher's aide, or member of the clergy.

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.
CPS	Children's Protective Services.
CRT	Compliance Review Team.
CSA	Children's Services Agency.
effectiveness	Success in achieving mission and goals.
expunge	Physically remove or eliminate and destroy a record or report.
HHS	U.S. Department of Health and Human Services.
Implementation, Sustainability, and Exit Plan (ISEP)	The agreement superseding and replacing the July 18, 2011 Modified Settlement Agreement and Consent Order.
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 Implementation, Sustainability, and Exit Plan (MISEP)	The agreement that supersedes and replaces the February 2, 2016 Implementation, Sustainability, and Exit Plan (ISEP).
MSP	Michigan Department of State Police.
observation	A commentary highlighting certain details or events that may be of interest to users of the report. An observation may not include all of the attributes (condition, effect, criteria, cause, and recommendation) presented in an audit finding.
PCR	Peer Case Review.
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.
putative	Commonly believed, supposed, or claimed.
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: a deficiency in internal control; noncompliance with provisions of laws, regulations, contracts or grant agreements; opportunities to improve programs and operations; or fraud.
risk assessment	Determines the risk of future harm to a child.
SCP	Supervisory Control Protocol.
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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Report Fraud/Waste/Abuse

Online: audgen.michigan.gov/report-fraud

Hotline: (517) 334-8070