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Office of the Auditor General
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Performance Audit Report on Children's Protective Services Investigations
Michigan Department of Health and Human Services

Issued: September 6, 2018
Project Number: 431-1285-16

HB 4705

REPORT HIGHLIGHTS

Keeping children safe from child abuse and/or neglect (CA/N) is the foundation on which child protective services was established and is the first goal of any child protective services response.

~ Child Welfare League of America



Audit Conclusions

- MDHHS's efforts to ensure the appropriate and consistent application of selected CPS investigation requirements were **not sufficient**.
- MDHHS's efforts to accurately capture data used to report its compliance with selected CPS investigation timeliness requirements were **moderately effective**.

Potential Statutory Improvements

Finding #1	Investigation Commencement
Finding #18	Monitoring of Participation in Post-Investigative Services
Finding #22	Central Registry Requirement for Unlicensed Child Care Providers
Observation #1	Physical Safety of CPS Investigators
Observation #2	Oversight of County CA/N Investigation Protocols



Audit Findings

17
Material Conditions

7
Reportable Conditions

Selected findings include:

Investigation commencement within 24 hours	Finding #1
Central Registry clearances	Finding #2
Criminal history checks	Finding #3
CPS history checks	Finding #4
Communication with mandated reporters	Finding #5
Safety planning	Finding #8
Filing of court petitions	Finding #9
Assessments of risk of future harm	Finding #13
Supervisory oversight	Finding #17*
Monitoring of families' participation in post-investigative services	Finding #18
Capturing of MISACWIS commencement data	Finding #24

* Finding #17 pertains to ineffective CPS supervisory review which significantly contributed to 15 findings included in the report, 11 of which are considered to be material.

Michigan's Child Protection Law (CPL) and MDHHS policy provide the framework and requirements for MDHHS to carry out its CPS investigations. CPS investigators are compelled to follow these requirements.

Survey Results

We surveyed 1,680 CPS supervisors and investigators and received 990 responses (59% response rate) that showed:

- 63% of investigators responded that their CPS *caseload negatively impacted* their ability to conduct investigations in compliance with MDHHS policy, and 55% said this happened *at least half of the time*.
- 39% of supervisors responded that the *number of staff they are supervising negatively impacts* their ability to thoroughly review and approve CPS investigations.
- 25% of investigators *feared for their physical safety* half the time or more when conducting CPS investigations.



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MDHHS concluded that a preponderance of evidence of CA/N occurred in 26% of CPS investigations. A **preponderance of evidence** means evidence that is of greater weight or more convincing than evidence offered in opposition to it; a 51% or greater likelihood that CA/N occurred.



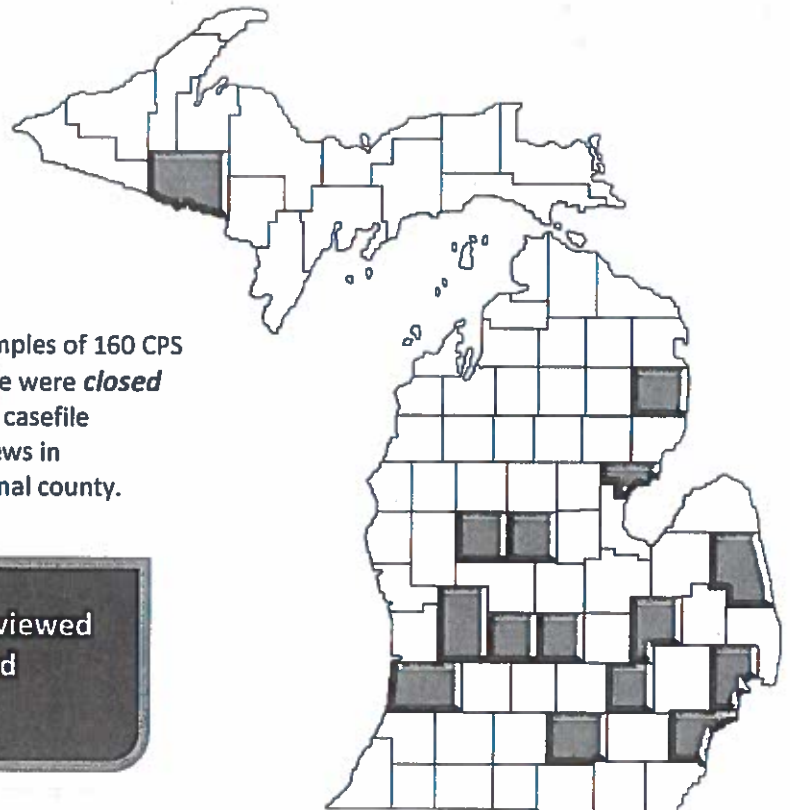
Fiscal Year 2014, 2015, and 2016 CPS Investigations and Category Disposition

	Category				
	I	II	III	IV	V
Total investigations	13,200	19,500	37,700	184,700	11,700
Preponderance of evidence?	✓	✓	✓		
Court petition must be filed by MDHHS?	✓				
Level of risk of future harm	High or Intensive	High or Intensive	Low or Moderate		
Perpetrator added to the Central Registry?	✓	✓	In limited circumstances		
Post-investigative monitoring of family?	✓	✓	See Finding #18		

Audit Sample

Audit Period: May 1, 2014 through July 31, 2016
Statewide Completed CPS Investigations: 206,000
Sampled Investigations: 160
Alleged Child Victims in Sample: 269
Counties in Sample: 15 (highlighted on map)

We judgmentally and randomly selected representative samples of 160 CPS investigations. All investigations subject to our audit sample were *closed* CPS investigations. We examined hard-copy and electronic casefile information for each sampled investigation via on-site reviews in 14 Michigan counties and an off-site review for one additional county.



We reported deficiencies in 159 (99%) of 160 reviewed CPS investigations, ranging from 1 to 13 reported deficiencies per investigation, and averaging 5.