

## CHILDREN'S PROTECTIVE SERVICES REVISIONS

Phone: (517) 373-8080  
<http://www.house.mi.gov/hfa>

**House Bill 4704 as reported from committee**  
**Sponsor: Rep. Kathy Crawford**

Analysis available at  
<http://www.legislature.mi.gov>

**House Bill 4705 as reported from committee**  
**Sponsor: Rep. Matt Hall**

**House Bill 4706 (H-1) as reported**  
**Sponsor: Rep. Andrea K. Schroeder**

**House Bill 4708 (H-1) as reported**  
**Sponsor: Rep. Luke Meerman**

**House Bill 4707 (H-1) as reported**  
**Sponsor: Rep. Frank Liberati**

**House Bill 4709 as reported**  
**Sponsor: Rep. David LaGrand**

**1st Committee: Families, Children and Seniors**  
**2nd Committee: Judiciary**  
**Complete to 1-14-20**

**BRIEF SUMMARY:** As a package, the bills would implement several recommendations of the House Oversight Committee that address findings in the Auditor General's report on Children's Protective Services investigations to do the following:

- HB 4704: Define *abbreviated investigation* and exempt abbreviated investigations from investigation checklist requirements.
- HB 4705: Clarify required responses to a report of child abuse or neglect.
- HB 4706: Modify a determination by the Department of Health and Human Services that community services are needed in response to a report and investigation of child abuse or neglect.
- HB 4707: Require an annual review regarding whether a county has adopted and implemented standard child abuse and neglect investigation and interview protocols and require the findings to be reported to the legislature and the Governor's Task Force on Child Abuse and Neglect.
- HB 4708: Require a license-exempt Child Development and Care Program child care provider to be listed on the Central Registry if found by a preponderance of the evidence to be the perpetrator of child abuse or neglect.
- HB 4709: Require quarterly reports to legislative oversight committees that include, among other things, whether investigations were commenced within 24 hours of receiving a report and whether a Central Registry review or clearance was performed for all required individuals.

**FISCAL IMPACT:** The legislation would have fiscal implications for the state and local units of government. Please see **Fiscal Information**, below, for a detailed discussion of each bill.

### **THE APPARENT PROBLEM:**

The Office of the Auditor General (OAG) released its performance audit report on Children's Protective Services (CPS) investigations regarding allegations of child abuse and/or neglect in

September 2018.<sup>1</sup> The audit objective was to “assess the sufficiency of MDHHS’s efforts to ensure the appropriate and consistent application of selected CPS investigation requirements.” The conclusion reached by the OAG was that those efforts were “insufficient.” The report lists 17 material conditions and 7 reportable conditions, described in the report as “findings.” Briefly, a *material condition*, considered more severe than a *reportable condition*, may impact the operation of a program in an effective and efficient manner. A reportable condition may be viewed as an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; instances of fraud; illegal acts unless an act is inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has, or is likely to have, occurred.

Multiple hearings on the CPS audit were held in the House Oversight Committee, with several recommendations by the committee adopted during the April 18, 2019, hearing. At that time, the committee referred the OAG report on the CPS audit to the House Families, Children and Seniors Committee, along with the committee’s recommendations, for further consideration as to whether legislative changes to the Child Protection Law were warranted or departmental policy and protocol changes alone could address the audit findings. Legislation has since been offered to address some of the findings by the OAG and implement the recommendations made by the Oversight Committee.

### ***THE CONTENT OF THE BILLS:***

Each bill in the package amends the Child Protection Law (CPL). Included in the summary of each bill is the specific finding by the OAG in its performance audit report on CPS investigations, or recommendation by the House Oversight Committee, that the bill seeks to address.

#### **HOUSE BILL 4704**

Currently under the CPL, the Department of Health and Human Services (DHHS) must implement an *investigation checklist* to be used in each investigation of suspected child abuse or child neglect it handles. An investigation cannot be closed until the checklist is completed and the completed checklist is reviewed by a supervisor.

House Bill 4704 would amend add a definition for *investigation checklist* (“a tool used by a supervisor to review and verify compliance with investigation requirements”).

The bill would also define *abbreviated investigation* to mean an investigation in which a full investigation with all investigative policy requirements is not conducted and the department has determined that the case will result in a departmental determination, following a field investigation, that there is no evidence of child abuse or child neglect and that departmental services are not needed (i.e., a Category V disposition).

Under the bill, a caseworker would have to document why an investigation was an abbreviated investigation. An investigation checklist would not be required for an abbreviated

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<sup>1</sup> Report highlights: <https://audgen.michigan.gov/wp-content/uploads/2018/09/CPS-REPORT-HIGHLIGHTS.pdf>  
Full report: <https://audgen.michigan.gov/wp-content/uploads/2018/09/r431128516-0011.pdf>

investigation. However, before an abbreviated investigation could be closed, the investigation would have to be approved by the county director or his or her designee. If this review and approval did not occur, the caseworker would have to conduct a full investigation.

MCL 722.622 and 722.628a

**NOTE:** House Bill 4704 addresses in Finding #23 (a reportable finding) the practice of CPS to conduct an abbreviated investigation in a case in which the investigator determines early in the investigation that there is no evidence of child abuse and/or neglect. Such a determination results in a Category V classification (no evidence of child abuse or neglect), and no services are required. Despite the CPL's requirement that investigators complete an investigation checklist for every investigation, and that a CPS investigation be closed only after a supervisory review, the OAG audit found that this was not being done for abbreviated investigations. See pages 70 and 71 of the report for a fuller discussion of Finding #23,<sup>2</sup> including a preliminary response from DHHS to the finding.

### HOUSE BILL 4705

Currently, DHHS, within 24 hours after receiving a report of child abuse or neglect, must do either of the following:

- If the report involves certain enumerated factors (e.g., child abuse resulting in the child's death or severe physical injury or suspected sexual abuse or exploitation), refer the report to the prosecuting attorney and local law enforcement.
- Commence an investigation of the child suspected of being abused or neglected.

House Bill 4705 would clarify required responses to a report of child abuse or neglect by stipulating that, for purposes of the second required action above, an investigation could not be considered to have been commenced until DHHS had made contact that provided information on the well-being of each child in the household where a child is suspected of being abused or neglected.

MCL 722.628

**NOTE:** The OAG report summarizes Finding #1 (a material finding) as follows: "MDHHS did not appropriately commence 17% of reviewed investigations within the CPL-required 24-hour time frame. MDHHS cited differences in interpretation of the law with the OAG regarding the requirement and application of MDHHS policy for over one-third of the exceptions noted." See pages 14 to 17 of the report for a fuller discussion of Finding #1,<sup>3</sup> including a preliminary response from DHHS to the finding.

### HOUSE BILL 4706

Currently, if a determination is made by DHHS that community services are needed in response to a report and investigation of child abuse or neglect, the department must assist the child's family in receiving community-based services commensurate with the risk to the child. If the family does not voluntarily participate in community services or its participation does not

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<sup>2</sup> <https://audgen.michigan.gov/wp-content/uploads/2018/09/r431128516-0011.pdf#page=72>

<sup>3</sup> <https://audgen.michigan.gov/wp-content/uploads/2018/09/r431128516-0011.pdf#page=16>

alleviate the child's level of risk, DHHS must consider reclassifying the case as requiring child protective services.

Under the bill, DHHS would determine whether its *safety assessment* determined the child to be safe, safe with services, or unsafe.

*Safety assessment* would mean a statistically validated structured decision-making tool designed to classify whether a child is safe, safe with services, or unsafe and to identify the following:

- Safety factors present.
- Protecting safety interventions initiated or planned.
- Overall *safety decisions*.

*Safety decision* would mean a decision based on the assessment of all safety factors, protecting interventions, and any other information known about the case. A safety decision would include one of the following determinations:

- Safe—The child is safe. No safety factor exists.
- Safe with services—At least one safety factor is indicated and at least one protecting intervention has been put into place.
- Unsafe—At least one safety factor is indicated and placement is the only protecting intervention possible for the child.

If the safety assessment determined the child to be safe with services, DHHS would have to assist the child's family in receiving community-based services commensurate with the risk to the child. If the family did not voluntarily participate in community services or its participation did not alleviate the child's level of risk, DHHS would have to consider reclassifying the case as requiring child protective services. DHHS could not close the case until it had confirmed and documented the family's participation in community services and the child's well-being.

If the safety assessment determined the child to be safe, DHHS would have to assist the child's family in receiving community-based services commensurate with the risk to the child. After doing so, DHHS could close the case. If the case remained open and it was determined that the family did not voluntarily participate in community services or that its participation did not alleviate the child's level of risk, DHHS would have to consider reclassifying the case as requiring child protective services.

MCL 722.628d

**NOTE:** According to Finding #18 (a material finding), "MDHHS did not monitor families' participation in post-investigative services for nearly 22,000 investigations and therefore could not determine whether these families received and participated in the services intended to alleviate the child's risk level for [child abuse or child neglect]." See pages 59 to 61 of the report for a fuller discussion of Finding #18,<sup>4</sup> including a preliminary response from DHHS to the finding.

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<sup>4</sup> <https://audgen.michigan.gov/wp-content/uploads/2018/09/r431128516-0011.pdf#page=61>

## HOUSE BILL 4707

Currently, the CPL requires—in each county—the prosecuting attorney and the department to adopt and implement standard child abuse and child neglect investigation and interview protocols using as a model the protocols developed by the Governor’s Task Force on Children’s Justice.

House Bill 4707 would amend the CPL to require the department to conduct an annual review in each county to determine whether the county has adopted and implemented the standard child abuse and child neglect investigation and interview protocols required to be implemented under the act. The department would have to report its findings to the legislature and to the Governor’s Task Force on Child Abuse and Neglect.

MCL 722.628

**NOTE:** The report summarizes its Observation #2 as follows: “No statutory requirement exists for centralized oversight to ensure that an appropriate [child abuse or child neglect] investigation protocol has been implemented in all Michigan counties.” See page 73 of the report for a fuller discussion of Observation #2.<sup>5</sup>

## HOUSE BILL 4708

Under current law, in investigating a report of child abuse or child neglect, DHHS does not have to use its structured decision-making tool to determine the risk of future harm to a child for any of the following:

- A nonparent adult who lives outside the child’s home.
- An owner, operator, volunteer, or employee of a licensed child care organization.
- An owner, operator, volunteer, or employee of a licensed or license-exempt child development and care program child care provider, adult foster care family home or adult foster care small group home.

If an individual listed above is found, by a preponderance of the evidence, to be the perpetrator of child abuse or neglect, DHHS must list them on the Central Registry.

The bill would add to the above list a license-exempt Child Development and Care Program child care provider.

MCL 722.628d

**NOTE:** Finding #22 (a reportable condition) is described in the report as follows: “Amendatory legislation is needed to add unlicensed Child Development and Care (CDC) Program child care providers to Section 8d(3) of the CPL to provide DHHS with the statutory authority to include unlicensed CDC providers in the Central Registry when DHHS identifies these individuals as perpetrators of [child abuse or child neglect] in Category III CPS investigations.” See pages 68 to 69 of the report for a fuller discussion of Finding #22,<sup>6</sup> including a preliminary response from DHHS to the finding.

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<sup>5</sup> <https://audgen.michigan.gov/wp-content/uploads/2018/09/r431128516-0011.pdf#page=75>

<sup>6</sup> <https://audgen.michigan.gov/wp-content/uploads/2018/09/r431128516-0011.pdf#page=70>

## HOUSE BILL 4709

House Bill 4709 would add a new section to the CPL to require the agency within the department responsible for administering and providing services under the act to make a comprehensive quarterly report to the chairs of the standing House and Senate Oversight Committees by every January 31, April 30, July 31, and October 31.

The report would have to include data from CPS investigatory staff to provide a measurement for each of the following:

- Was the investigation started within 24 hours after receiving a report?
- Was a central registry review or clearance performed for all individuals?
- Was a face-to-face contact made within the established time frame required by DHHS?
- Was a sibling placement evaluation completed when one or more children remained in the home after a child had been removed?
- Were the family needs and strengths assessments completed?
- Was the supervisory review performed in a timely manner?
- How many child protective services investigators were concerned for their own personal safety?
- How many investigators used the mobile application or other tools to document compliance?

The data included in the report would have to be from the most recent 30-day period before the report was submitted.

Proposed MCL 722.629b

**NOTE:** House Bill 4709 incorporates a recommendation adopted by the House Oversight Committee. The audit report contains findings or observations concerning all of the topics that would be measured for the quarterly report proposed by House Bill 4709.

### ***BRIEF DISCUSSION OF EACH BILL AND RELATED FINDING OR RECOMMENDATION:***

#### **House Bill 4704 and Finding #23 (Reportable condition)**

The bill would address the conflict between the statutory language and practice by DHHS regarding the completion of an investigation checklist and supervisory review in *all* CPS investigations, even ones that quickly in the investigation reveal that no child abuse or neglect has occurred (referred to as *abbreviated investigations*).

Designated as a *reportable condition*, the report summarizes its Finding #23 as follows: “CPS investigators were not required to complete an investigation checklist when conducting abbreviated CPS investigations, nor did [DHHS] ensure that local county office directors always conducted a review of abbreviated investigations, when necessary, prior to closing the investigation.” See pages 70 and 71 of the report for a fuller discussion of Finding #23,<sup>7</sup> including a preliminary response from DHHS to the finding.

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<sup>7</sup> <https://audgen.michigan.gov/wp-content/uploads/2018/09/r431128516-0011.pdf#page=72>

According to the OAG report, DHHS informed the OAG that abbreviated investigations were not considered to be a CPS investigation that would trigger the statutory requirements. OAG, in pointing out the statutory requirements for both the checklist and supervisory review, recommended that CPS investigators complete an investigation checklist when conducting abbreviated investigations and that local county office directors conduct a review of an abbreviated investigation that does not have a completed checklist before such a case is closed.

However, DHHS updated its policy prior to the release of the OAG audit report (effective July 1, 2016) to require county office directors to review an abbreviated investigation before a case can be closed, thus instituting a dual review process that the department believes provides sufficient oversight and approval for an abbreviated investigation. According to the department's response in the report, the department "believes that the use of the investigation checklist for an abbreviated investigation is not an effective approach as the majority of the checklist elements are not applicable to abbreviated investigations." The bill would codify the department's current practice of the dual review process.

#### **House Bill 4705 and Finding #1 (Material condition)**

According to the OAG, the practice of the department regarding "commencement" of an investigation following receipt of a report of child abuse or neglect did not meet the statutory *intent* of accessing the safety of a child within the mandated 24-hour time frame, nor did it meet its own policy in effect during the audit period. According to the department, numerous activities, the completion of one or more of which during the first 24 hours, could satisfy the requirement for commencement. However, many of those activities do not involve face-to-face contact with the child alleged to be abused/neglected or with someone with accurate knowledge of the child's condition. Nor did the department's policy require that all of the children in a complaint be included in the activities of those first 24 hours. For example, in one investigation, though the child and three additional siblings were identified in the report, the department's single commencement activity only included follow up on one of the four children.

Specifically, the OAG interpreted the statute as requiring that contact sufficient to assess the safety of a child suspected of being abused or neglected should be commenced within the initial 24 hours of receiving a report, not that one or more activities (e.g., interviewing a neighbor or teacher) that did not necessarily address the issue of the child's safety be sufficient to meet the commencement requirement.

The department, however, expressed a concern that, with current staffing levels and caseloads, it is not always possible to make face-to-face contact with each child within the 24-hour time frame. For instance, though face-to-face contact with the child would be the "gold-standard", the child may be away visiting with other relatives at the time a report is made. Recently, the department has been assigning more serious allegations as Priority 1 cases and less serious ones (where there is the assurance that the child is safe) as Priority 2. A caseworker must make face-to-face contact within 12 hours for a Priority 1 case, and within 72 hours for a Priority 2 case. The approach has greatly reduced the time lag noted in the OAG report, and the department reports that they have reached a more than 90% compliance rate with federal standards for commencing a child abuse/neglect investigation.

The bill would address Finding #1 by clarifying in statute that an investigation would commence when contact has been made that would provide information on the well-being of each child in the household suspected of suffering abuse or neglect.

### **House Bill 4706 and Finding #18 (Material condition)**

House Bill 4706 would address departmental follow-up in Category 3 cases. In Category 3 cases, a preponderance of the evidence has found that child abuse and/or neglect exists and the department is required to assist the child's family in receiving community-based services—for example, family counseling or parenting classes. However, a significant number of cases were closed during the audit period with no monitoring as to the family's participation in the recommended services or whether the family had benefitted from the services and either needed, or no longer needed, to continue with the services. For example, in one case, a child was determined to need dental care. However, no follow-up was carried out to see if the parents obtained the needed dental care before the case was closed. There was also no consideration as to whether a case should be reclassified as a Category II (meaning Child Protective Services are required).

The bill would address the issue by revising the CPL to allow the department to break Category III cases into two subgroups—one in which abuse and/or neglect is likely to recur and one in which abuse and/or neglect is not likely to recur and therefore the case could be closed. Using data to determine risk of recurrence, and allowing those cases to close where further abuse/neglect is unlikely, would be a more efficient use of staff time and could better target available resources to those families most needing them.

### **House Bill 4707 and Observation #2**

The OAG audit noted that, although the CPL requires each county prosecutor and the department to adopt and implement standard child abuse/neglect investigation protocols, which include forensic interviewing protocols, the statute does not currently authorize any centralized oversight to ensure that a county does so. The bill would amend the CPL to provide the statutory authority for the department to annually review whether each county has an appropriate protocol in place and also to provide flexibility to counties in implementing a protocol.

According to testimony offered by the department, some counties already have protocols in place. Reportedly, the department has recently been working with the Prosecuting Attorneys Association of Michigan to assist counties who do not yet have a protocol in place with adopting an appropriate model or developing a local one based on the statewide protocol that would fit a county's unique needs. The bill would go a bit further and require the annual review to be provided also to the legislature and Governor's Task Force on Child Abuse and Neglect.

### **House Bill 4708 and Finding #22 (Reportable condition)**

According to the OAG report, the CPL should be amended to provide DDHS with the same authority to include on the Central Registry unlicensed CDC Program child care providers who are perpetrators of child abuse and/or neglect from Category III investigations in the same manner as persons who are owners, operators, volunteers, or employees of a licensed or registered child care organization. The Michigan Department of Education enrolls unlicensed CDC Program child care providers to provide care for up to six CDC Program children in either the provider's or the child's home. The reasoning offered in the report is that these unlicensed child care providers have direct and regular contact with children in a manner similar to the licensed and registered child care providers.

Among its reasons for disagreement with the proposal, the department points to the huge volume of names currently on the Central Registry. Where some rightly should be prevented



from being a licensed or registered child care provider, others pose no risk of harm to children. This is due in part to the Registry's running the gamut from people who have murdered children to people who made a mistake that landed them on the Central Registry but do not pose a risk. Instead, the department would prefer to link placement on the Central Registry with egregious abuse or neglect rather than through an automatic process linked with the Risk Assessment outcome. Further, the department noted that unlicensed CDC Program providers do not receive the same level of training and should not be held to the same standards as the licensed and registered CDC Program providers.

The bill would implement the recommendation outlined in the OAG report and treat unlicensed CDC Program child care providers in the same manner as licensed CDC Program child care providers regarding placement on the Central Registry in Category III investigations.

#### **House Bill 4709 and House Oversight Committee Recommendation**

The members of the House Oversight Committee noted that, by the time certain information reaches them, the data are already outdated. The OAG audit report is a case in point, as the audit was performed on data from 2014 to 2016, but the report was released in late 2018. Therefore, the committee recommended that periodic reports be made by the department to an appropriate oversight authority. The bill would address the concern by requiring quarterly reports to be made to the chairs of the standing House and Senate Oversight Committees. In this way, the legislature can provide timely oversight as to whether statutory changes and the policies implemented by the department are improving the welfare of the state's most vulnerable citizens.

#### ***FISCAL INFORMATION:***

**House Bill 4704** would have minimal fiscal impact on DHHS and local units of government. Any additional cost to DHHS would depend upon any increase in administrative or staff costs under the bill's provisions.

**House Bill 4705** would have a minimal to moderate fiscal impact on DHHS and on local units of government.

Within DHHS, CPS caseworkers investigate cases of child abuse or neglect. In FY 2017-18, CPS investigated 96,067 cases. Under current law, within 24 hours of receiving a report of a child being abused or neglected, DHHS must either commence an investigation or, for certain cases, refer the report to the prosecuting attorney or local law enforcement.

The DHHS Children's Protective Services Manual<sup>8</sup> requires that the department use a priority response tool when receiving a complaint of suspected child abuse or neglect. The worker receiving the complaint determines whether the case is assigned as a priority one or a priority two response case and, based on that designation, a caseworker must commence an investigation and make face-to-face contact with the alleged child victims within specific corresponding time frames dependent upon the designation.

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<sup>8</sup> Children's Protective Services Manual of the State of Michigan, PSM 712-4, <https://dhhs.michigan.gov/OLMWEB/EX/PS/Public/PSM/712-4.pdf#pagemode=bookmarks>

An investigation for a priority one response case must commence within 12 hours of receiving the complaint, and a face-to-face contact must take place within 24 hours with each alleged child victim. For a priority two response case, an investigation must commence within 24 hours and face-to-face contact must take place within 72 hours.<sup>9</sup> The Protective Services Manual lists the criteria to be used to determine which response to be assigned. Thus, under current policy, DHHS must commence an investigation within either 12 or 24 hours. In addition, a caseworker must make face-to-face contact with all alleged child victims within either 24 or 72 hours, depending upon which priority response the case has been assigned.

The bill provides that, in addition to the requirement that an investigation be commenced within 24 hours, the investigation is not considered to have commenced until contact has been made that gives information on the well-being of each child in the household in these cases. In other words, the bill requires that within 24 hours, the caseworker must make a contact to determine the safety of each child in the household. Under current policy, priority two cases do not require face-to-face contact to be completed until up to 72 hours. In some cases, the bill may require caseworkers to make contact that helps ascertain the children's safety in a shorter amount of time than under current policy. However, the bill does not require that within that 24-hour period a face-to-face contact be made in all cases or that a determination of child abuse or negligence be completed.

Any additional costs to DHHS would depend upon any increased expenditures that would be required under the bill's provisions, such as increased administrative expenses, additional staff costs, or possible caseworker training.

**House Bill 4706** would have a minimal fiscal impact on DHHS and on local units of government. Any additional cost to DHHS would depend on any increased administrative costs and staff time needed under the bill's provisions to assist families with participation in community-based services programs and to follow up to confirm and document the participation of families in these programs, as well as to confirm the well-being of the children.

**House Bill 4707** would have a moderate fiscal impact on DHHS and a minimum fiscal impact on local units of government. The bill would require DHHS to conduct an annual review in each county of the standard child abuse and child neglect investigation and interview protocols and produce a report. According to the department, conducting this annual review would require an additional department staff member as well as other resources. DHHS estimates the additional cost for 1.0 FTE position, materials, travel expenses, and the development of a tracking system to be approximately \$260,000.

**House Bill 4708** would have no fiscal impact on DHHS or local units of government.

**House Bill 4709** would increase costs for DHHS by a minimal amount. Any increased costs would be dependent upon any additional administrative costs to produce the required quarterly reports. The bill would have no fiscal impact on local units of government.

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<sup>9</sup> Children's Protective Services Manual of the State of Michigan, PSM 713-01, <https://dhhs.michigan.gov/OLMWEB/EX/PS/Public/PSM/713-01.pdf#pagemode=bookmarks>

***POSITIONS:***

Representatives of the following entities testified with no position on the bills:

Office of the Auditor General (12-3-19)

Department of Health and Human Services, Children's Service Agency (12-3-19)

Office of Children's Ombudsman (9-4-19)

UAW Local 6000 indicated opposition to HBs 4704 and 4709. (12-10-19)

Legislative Analysts: Susan Stutzky

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Fiscal Analyst: Viola Bay Wild

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■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.