**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

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**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**.

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**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 |

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**Audit Findings**

<table>
<thead>
<tr>
<th>Material Conditions</th>
<th>Reportable Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>7</td>
</tr>
</tbody>
</table>

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.

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**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.
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

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

### 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.