STATE OF MICHIGAN

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DEPARTMENT OF HEALTH & HUMAN SERVICES
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Children's Protective Services Policy Manuals

Issued: 3-4-2024

STATE OF MICHIGAN

DEPARTMENT OF HEALTH & HUMAN SERVICES

CPS OVERVIEW

The Children's Protective Services (CPS) program is committed to keeping children and families together safely, strengthening families, and preventing further harm. In collaboration with children, families, communities, and other key partners, CPS is dedicated to upholding a system rooted in prevention, family preservation, and equity.

By law, the department is responsible for investigating allegations of child abuse and child neglect. This includes 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 a child's health or welfare, a teacher, a teacher's aide, a member of clergy, or an individual 18 years of age or older who is involved with a youth program and neglect by a parent, legal guardian, or any other person responsible for the child's health or welfare.

The Michigan Department of Health and Human Services (MDHHS) embraces the following tenets in the delivery of CPS services:

- Most parents have the strength and ability to care for their children and keep them safe when adequately supported by family or other social supports.
- CPS strives to end all forms of racism and assure racial and ethnic equity and justice.
- Families who need help from CPS are diverse in family structure, culture, race, ethnicity, religion, economic status, beliefs, values, and lifestyles.
- The presence of poverty does not mean a child is unsafe or the parent lacks the ability to care for their child(ren).
- CPS services should be accessible, strength-based, culturally relevant, and delivered with compassion and respect.
- CPS proactively helps families by building protective capacities before maltreatment occurs.
- Except in the most extreme circumstances, involuntary separation of children from their families is not an acceptable solution for families in need.

- When investigation of the referral finds there is a preponderance of evidence of abuse or neglect by a person responsible for the child's health or welfare, the department must assess the needs and strengths of the family and refer the family to services commensurate with the risk level.

CPS PROCESS

Children's Protective Services (CPS) program responsibilities include:

- Intake.
- Prevention services.
- Investigation.
- Post-investigative services.

Intake

Anyone may make a report of suspected child abuse or neglect to Michigan's Centralized Intake (CI). Reports can be made:

- By phone, at 855-444-3911.
- By completing the DHS-3200, Report of Actual or Suspected Child Abuse or Neglect, following directions on the form.

Mandated reporters may make a report online using the Mandated Online Reporting System (MORS), Michigan Online Reporting.

Centralized Intake

The Michigan Department of Health and Human Services (MDHHS) has a centralized intake unit that receives reports of suspected abuse or neglect, 24 hours a day, seven days a week. The intake unit may:

- Screen in the report for investigation.
- Transfer the report to another entity such as law enforcement, a tribe, licensing agency, or another state.
- Screen out the report as not appropriate for investigation.
- Screen out and assign to a local county for prevention services.

Centralized Intake will screen in a report for investigation if all the following apply:

- The allegations constitute suspected child abuse or neglect**.**
- The alleged victim(s) is under the age of 18 at the time of the referral.

- The **abuse** alleged was committed by a parent, a legal guardian, any other person responsible for the child's health or welfare, a teacher, a teacher's aide, a member of clergy, or an individual 18 years of age or older who is involved with a youth program.
- The **neglect** alleged was committed by a parent, legal guardian, or any other person responsible for the child's health or welfare.
- The allegations include human trafficking, and the referral is received from a law enforcement agency, regardless if the allegations involve a person responsible for the child's health or welfare.

For more information on Centralized Intake, see the PSM 712 series.

SCREENING DISPUTES

Screening disputes

A local MDHHS office may contact a CI supervisor for reconsideration in the following limited circumstances:

- There is a technical error.
- The referral is on an ongoing case and the case manager has entered more information into the electronic case management system that would eliminate the need for a new investigation, such as, the case manager has entered documentation to show that the current allegations are being addressed.
- The county has new or additional information that should be added to the referral that would impact the assignment decision.

The county director or designee may contact the second-line CI manager or director to discuss screening disputes. CI is responsible for the final decision on assessment of prevention needs, and the final decision to screen in or screen out a referral.

Note: Local MDHHS offices are responsible for transferring assignments from county to county. Disputes between counties should be resolved by the involved county directors with the Business Service Center director's involvement, if necessary.

Note: If any contacts are made, in-person, by phone or any other method by which information is exchanged with the alleged perpetrator or child victim, the referral must remain assigned for investigation.

Prevention Services

The Family First Prevention Services Act (FFPSA) authorized new title IV-E funding for time-limited prevention services for mental health, substance abuse, and in-home parent skill programs for children or youth who are candidates for foster care, pregnant or parenting youth in foster care, and the parents or kin caregivers of those children and youth. FFPSA has allowed the department to expand support services to families meeting candidacy requirements for eligibility.

In most cases, CPS case managers must complete the Structured Decision Making (SDM) Safety and Risk Assessments to complete an investigation. The results of these assessments will assist CPS with determining if the child or youth is an eligible candidate for foster care. For information on the Safety and Risk Assessments, see PSM 713-11, Assessments. For more information on prevention eligibility, see SRM 108, Prevention Services: Family First Prevention Services Act.

Investigation

If a report of suspected abuse or neglect is screened in for investigation, the report is forwarded to the local county MDHHS office where the child is located and assigned to a case manager.

Investigations include the activities outlined in PSM 713-01, CPS Investigation - General Instructions, and are completed within 30 calendar days unless there is an extenuating circumstance which requires an approved extension.

The case manager will compile a written report based on the information obtained.

In some cases, case managers must notify and/or collaborate with law enforcement and the local prosecuting attorney. For more information on investigation requirements, see PSM 713-01, CPS Investigation - General Instructions.

Post-Investigative Services

CPS post-investigative services must be offered to families in category I and II cases and may be offered in category III cases. The goal is to refer families to quality community resources that are available, accessible, and culturally appropriate to help ensure child safety and family preservation. Services build on family strengths and may include referrals to community-based resources or contracted programs, such as the Family Preservation Program.

PURPOSE

Child Protection Law (CPL) details requirements around the reporting of suspected child abuse and neglect and prescribes the responsibilities and duties of the Michigan Department of Health and Human Services (MDHHS) to prevent and respond to child abuse and neglect, and to enhance the welfare of children and preserve family life. The CPL contains definitions applicable to the reporting and investigation of suspected child abuse and neglect, MCL 722.622. The definitions contained in this item are based on CPL and are relevant to application of assignment for investigation and determination of investigation outcomes.

LEGAL DEFINITIONS

Child

An individual under 18 years of age, MCL 722.622(f). Children's Protective Services (CPS) has the responsibility to investigate and respond to alleged abuse or neglect of a child until the child is age 18.

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, any other person responsible for the child's health or welfare, a teacher, a teacher's aide, a member of the clergy, or an individual 18 years of age or older who is involved with a youth program, MCL 722.622(g).

Child Neglect

Harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person responsible for the child's health or welfare that occurs through either of the following, MCL 722.622(k):

- Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care, though financially able to do so, or by the failure to seek financial or other reasonable means to provide adequate food, clothing, shelter, or medical care.

- 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.

Cruel

Brutal, inhuman, sadistic, or that which torments, MCL 750.136b(1)(b).

Imminent Risk of Harm

There is likelihood of immediate harm. This term is used in the priority response criteria and the safety assessment, see PSM 712-1, CPS Intake, and PSM 713-01, CPS Investigation - General Instructions.

Intimate Parts

Includes the primary genital area, groin, inner thigh, buttock, or breast of a human being.

Person Responsible for the Child's Health or Welfare

"Person responsible for the child's health or welfare" means a parent, legal guardian, individual 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(1)(e) or 8(8), nonparent adult; or an owner, operator, volunteer, or employee of 1 or more of the following:

- A licensed or registered child care organization.
- 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, 1979 PA 218, MCL 400.703.
- A court-operated facility as approved under section 14 of the social welfare act, 1939 PA 280, MCL 400.14.

Note: This includes licensed individuals providing respite care.

Nonparent Adult

A person who is 18 years of age or older and who, regardless of the person's domicile, meets all of the following criteria in relation to the child, MCL 722.622:

- Has substantial and regular contact with the child.
- Has a close personal relationship with the child's parent or with a person responsible for the child's health or welfare.
- Is not the child's parent or a person otherwise related to the child by blood or affinity to the third degree.

Note: Third degree relatives include parents, grandparents, great-grandparents, brothers, sisters, aunts, uncles, great-aunts, great-uncles, nieces, and nephews.

Note: Adults, other than the primary licensed caregiver(s), residing in a respite placement are considered a nonparent adult.

Note: This includes nonparent adults residing with a child when the referral involves sexual exploitation (human trafficking).

Physical Harm

Any injury to a child's physical condition (MCL 750.136b(1)(e)).

Serious Physical Harm

Any physical injury to a child that seriously impairs the child's health or physical well-being, including, but not limited to, brain damage, a skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprain, internal injury, poisoning, burn or scald, or severe cut, MCL 750.136b(1)(f).

OPERATIONAL DEFINITIONS

Battering

Chronic and repeated physical abuse that results in serious physical harm to the child.

Torture

Inflicting great bodily injury or severe mental pain or suffering upon another person within their custody or physical control with the intent to cause cruel or extreme physical or mental pain and suffering. Proof that the victim suffered pain does not need to be present to find that torture occurred.

Custody or Physical Control

The forcible restriction of a person's movements or forcible confinement of the person to interfere with that person's liberty, without that person's consent or without lawful authority.

Great Bodily Injury

Serious impairment of a body function which includes, but is not limited to, one or more of the following:

- Loss of a limb or loss of use of a limb.
- Loss of an eye or ear or loss of use of an eye or ear.
- Loss or substantial impairment of a bodily function.
- Serious visible disfigurement.
- A comatose state that lasts for more than 3 days.
- Measurable brain or mental impairment.
- A skull fracture or other serious bone fracture.
- Subdural hemorrhage or subdural hematoma.
- Loss of an organ.
- Loss of a foot, hand, finger, or thumb or loss of use of a foot, hand, finger, or thumb.

OR

One or more of the following conditions:

- Internal injury.
- Poisoning.
- Serious burns or scalding.
- Severe cuts.
- Multiple puncture wounds.

Severe/Serious Mental Pain or Suffering

A mental injury that results in a substantial alteration of mental functioning that is manifested in a visibly demonstrable manner caused by or resulting from any of the following:

- The intentional infliction or threatened infliction of great bodily injury.
- The administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt the senses or the personality.
- The threat of imminent death.
- The threat that another person will imminently be subjected to death, great bodily injury, or the administration or application of mind-altering substances or other procedures calculated to disrupt the senses or personality.

Egregious Acts

Per MCL 722.622(p-r) of Child Protection Law, the following are considered egregious acts due to confirmed serious abuse or neglect as a result of mental injury, physical injury, or neglect to a child:

- Battering, torture, or other severe physical abuse.
- Loss or serious impairment of an organ or limb.
- Life-threatening injury.
- Murder or attempted murder.
- Serious mental harm.
- Sexual abuse.
- Sexual exploitation.
- Exposure to or contact with methamphetamine production.

Reasonable

Based on sound judgement; fair and sensible. Not extreme or excessive.

Resides

To dwell permanently or continuously. It expresses an intention of a person to keep or return to a particular dwelling place as their fixed, settled, or legal abode.

ELEMENTS OF ALLEGED CHILD ABUSE OR NEGLECT

MDHHS responds to allegations meeting criteria for child abuse or child neglect to a child under the age of 18 at the time of the referral, by an alleged person responsible. The referral allegations must minimally meet the CPL definitions of child abuse and/or neglect to be assigned. Four elements must be present in the allegations to screen in a referral for investigation:

- Allegations of harm or threatened harm.
- To a child's health or welfare.
- Through non-accidental or neglectful behavior.
- By a person responsible for the child's health and welfare.

Exception: MDHHS responds to allegations of human trafficking when assistance is requested by law enforcement, regardless of the role or status of the perpetrator to the victim.

Exception: Allegations of abuse by a teacher, a teacher's aide, member of clergy, or an individual 18 years of age or older who is involved in a youth program will be transferred to the Placement Collaboration Unit for a collaborative investigation process.

MALTREATMENT TYPES

Child abuse and neglect are defined by federal and state laws. Maltreatment types provide for organization, conceptualization, and operationalization of the broader CPL definitions of child abuse and child neglect. Maltreatment types fit into two broad categories of either child abuse or child neglect based on the legal definitions of each. See *legal definitions* of child abuse/child neglect in this item.

Threatened Harm

An action, accidental or non-accidental, inaction or credible verbal threat by a person responsible and absent intervention, there is high probability that harm will occur.

A child found in a situation where harm is highly probable to occur based on a current or historical circumstance:

- A current circumstance may include, but is not limited to:
  - Allegations of threatened harm in the current referral.
  - Child left home alone.
  - Domestic violence.
  - A residence where drugs are manufactured and/or sold.
- A historical circumstance may include, but is not limited to:
  - Confirmed case that included an egregious act of child abuse and/or neglect.
  - Confirmed case that included threatened harm.
  - Prior termination of parental rights.
  - Conviction of crimes against children.

Note: See PSM 713-11, Assessments for additional guidance on assessing threatened harm.

Threatened Harm is divided into the following maltreatments:

Threatened harm of physical injury

- Is cruel, injurious, malicious, dangerous, or poses a high probability of injury to the child, but harm did not occur.
- Dangerous behavior or excessive action toward the child AND current behavior would cause serious physical harm, including unsafe use of physical restraint. Threatened harm of physical injury does not include situations where the child is not in immediate proximity.
- A person responsible has made credible threats to cause serious physical harm to the child that, if carried out, would constitute child abuse, and it is highly probable that without intervention, the person responsible will carry out these threats.
- A person responsible talks about being worried, fearful, or preoccupied with abusing or neglecting the child.
- A person responsible expresses a credible concern for what another person responsible is capable of doing or may do, and the person responsible of concern has unsupervised access to the child.

Threatened harm of mental injury

Psychological or emotional harm is, absent intervention, highly probable to lead to:

- Significant impairments to the child's emotional or behavioral functioning.
- Adverse impact on the child's development or well-being.

Threatened harm of sexual abuse

- No sexual act has occurred; however, the person responsible behaves in ways that create a substantial likelihood that the child will be sexually abused.
- Person responsible makes credible statements of intentions to sexually abuse victim or person responsible fails to eliminate the risk.

Grooming

Also includes when no sexual act has occurred; however, the behavior creates a substantial likelihood that sexual abuse will occur, such as grooming behaviors. Grooming includes verbal, written or physical behavior that may not be overtly sexual but is likely designed to prepare a child for future sexual abuse. Grooming is a process where a person intentionally builds a relationship with someone to manipulate, exploit or abuse a child. It includes a deliberate and escalating pattern of actions taken to lower a child's inhibitions.

The following are common behaviors exhibited while grooming:

- Form a relationship - They may single a child out as unique, treat the child as more special and give them extra attention or gifts.
- Test boundaries - They may often test boundaries to determine the child's comfort level.
- Touch - They may begin with non-sexual touches and then slowly progress to more inappropriate touching such as accidental grazing of an intimate part of the body. Often there is a pattern of movement from innocent touching to more sexual touching.

- Intimidation - They may begin by blaming the child for something to simply see if the child tells an adult. This progresses to threatening the child or causing the child to feel a sense of guilt. They may often use statements such as "No one will believe you," or threaten them with danger if they tell.
- Share increasingly sexually explicit material via messaging applications or text.
- Communicate and reinforce secrecy.

Indecent Exposure

A person commits indecent exposure if that person exposes their genitals for the purpose of sexual gratification, or for purposes of shaming, humiliating, shocking, or exerting control over the victim; or when the alleged perpetrator knows or should know that this conduct is likely to offend, affront, or alarm.

Threatened harm of sexual exploitation

Circumstances in which no sexual exploitation has occurred, but the person responsible behaves in ways that create a substantial likelihood that the child will be sexually exploited.

Note: In order to make a finding of threatened harm of sexual exploitation, the perpetrator must be a person responsible.

Threatened harm of labor trafficking

A trafficking event has not yet occurred, but the person responsible behaves in a way that creates a substantial likelihood that the child will be trafficked.

The alleged perpetrator of the trafficking does not need to meet criteria for person responsible to investigate when law enforcement requests assistance. The department can investigate trafficking conditions regardless of role or status of the alleged perpetrator.

Note: To make a finding, the perpetrator must be a person responsible.

Threatened harm of physical neglect

Though a parent or person responsible is financially able or able to access resources, absent intervention, harm is highly probable, by any one of the following:

- Living conditions that, absent intervention, are highly probable to cause harm to the child. Person responsible fails to act to address the child's living conditions, which are unsanitary and/or contain hazards that are highly probable to lead to the child's injury or illness if not resolved.
    - Consider the child's age and developmental status and to what extent the specific living conditions pose a danger to the child.
- Failure to provide adequate clothing or appropriate hygiene that, absent intervention, is highly probable to cause harm to the child. The child's basic needs for clothing and/or hygiene are unmet to the extent the child's daily activities will be severely impacted without intervention, and/or the child will develop or suffer worsening injury or illness.
- Absence of supervision is highly probable to cause harm to the child, absent intervention. The child is not attended to or supervised by the person responsible AND there is no other person able and willing to provide safe supervision to the extent that harm to the child is highly probable without intervention.
    - Consider the child's age, abilities, behaviors, need level, and length of time unsupervised. Time of day and other surrounding circumstances should also be considered when determining the level of supervision required to protect the child.

Threatened harm of placing a child at unreasonable risk

Neglectful behavior that, absent intervention, is highly probable to cause identifiable harm if the behavior does not cease. Occurs by failure to intervene and eliminate a risk to a child although the person is able to do so and has or should have knowledge of the risk.

Threatened harm of medical neglect

- Failure to obtain necessary medical, dental, or mental health care for a child and the failure to obtain care, absent intervention, is highly probable to result in harm, including any of following:
    - Death.

  - Disfigurement.
  - Bodily harm.
  - Impairment to the growth, development, or functioning of the child.
- Frequently missing appointments, therapies, or other necessary medical and/or mental health treatments that, absent intervention, is highly probable to cause the child harm or have a negative impact on the child.
- Taking the child out of or terminating treatment against medical advice, and the removal, absent intervention, is highly probable to cause the child harm or have a negative impact on the child.
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Identifying whether harm or threatened harm of a particular maltreatment type has occurred will need to be determined throughout the course of the investigation. Upon assignment, the maltreatment type will be selected based on completion of the Structured Decision Making Centralized Intake Assessment Tool. If it is determined that threatened harm of a particular maltreatment type exists, the corresponding threatened harm maltreatment type will need to be identified within the electronic case management system by the case manager.

The determination of how to apply threatened harm is also based upon the perpetrator's role in the action of the abuse or neglect. See table below for example:

When the threat of harm is from the **person responsible**, consider the most applicable maltreatment type.	Parent forcibly chokes the child with no visible injury: Parent → Threatened harm of physical injury.
When the threat of harm is from **other caregivers**, and the person responsible does not intervene or protect the child.	Parent knowingly allowed another caregiver to choke the child with no visible injury: Parent → Threatened harm of placing a child at unreasonable risk. Other Caregiver → Threatened harm of physical injury.

CHILD ABUSE

Child abuse is divided into the following maltreatment types:

- Physical injury.
- Mental injury.
- Sexual abuse.
- Sexual exploitation.
- Labor trafficking.
- Threatened harm of physical injury.
- Threatened harm of mental injury.
- Threatened harm of sexual abuse.
- Threatened harm of sexual exploitation.
- Threatened harm of labor trafficking.

Physical Injury

Non-accidental or purposeful action which results in physical harm. Includes situations where an injury exists and there is inconsistent explanation as to how the injury occurred. This can include situations where a child has an injury and any of the following apply:

- The injury itself suggests that it is non-accidental.
- A medical professional has concern the injury is consistent with abuse or is inconsistent with the explanations provided.

Physical injury does not include actions by a parent or guardian, person responsible, or persons authorized by a parent or guardian to reasonably discipline a child, including the use of reasonable force, MCL 750.136b(9). A parent can physically discipline their child with the intent to discipline and not cause injury. Minor injuries may sometimes accidentally occur when a parent uses physical discipline that is not excessive or overtly harmful.

Medical Child Abuse

Medical child abuse may result in risk of physical or emotional harm to a child and is encompassed in physical injury. Medical child abuse occurs when a child receives or is at risk of receiving either of the following:

- Unnecessary and harmful, or potentially harmful, medical care at the initiation of the child's parent or caregiver.

- Unnecessary medical treatment due to a parent or caretaker exaggerating, fabricating, or causing symptoms of illness.

Note: Children with known, verified diseases and disorders can also be a victim of medical child abuse.

Newborn Exposed to Substances

A newborn born exposed to substances not attributed to medical treatment, causing injury or defect as diagnosed by a medical professional, may be considered serious physical injury or serious physical harm. For more information on cases involving newborns exposed to substances, see PSM 716-7, Case Involving Substances.

Mental Injury

Psychological or emotional harm meeting any of the following criteria:

- Has led to significant impairment to the child's emotional or behavioral functioning.
- Has had adverse impact on the child's development or well-being.
- Results in serious mental harm.

Serious mental harm is an injury to a child's mental condition or welfare that is not necessarily permanent but results in visibly demonstrable manifestations of a substantial disorder of thought or mood which significantly impairs judgement, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life, MCL 750.136b(g). Mental injury must be diagnosed by a mental health professional to confirm mental injury.

Examples of child impairment/behaviors include, but are not limited to, the following:

- Fire setting, self-harm, animal maltreatment, suicidal ideation.
- Regression to wetting themselves or defecating on themselves.
- Previously verbal toddlers stop talking.
- Child expresses credible fear that they will experience abuse or neglect.
- Child may isolate themselves, may be preoccupied with their body, or may shut down.

Sexual Abuse

Pursuant to MCL 722.622, a confirmed case that involves sexual penetration, sexual contact, attempted sexual penetration, or assault with intent to penetrate as those terms are defined in section 520a of the Michigan penal code, 1931 PA 328, MCL 750.520a. The following acts are included:

- Sexual penetration means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body. Emission of semen is not required, MCL 750.520a(r).
- Sexual contact includes the intentional touching of the victim's or perpetrator's intimate parts or the intentional touching of the clothing covering the immediate area of the victim's or perpetrator's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for revenge, to inflict humiliation, or out of anger, MCL 750.520a(q).
- Attempted sexual penetration, sexual contact, or assault with intent to penetrate means any attempt to commit an act or do any act towards the commission of sexual abuse, as defined above, while failing in the perpetration due to being intercepted or prevented in the execution, MCL 750.92.

Sexual Exploitation

Allowing, permitting, or encouraging a child to engage in any of the following for the benefit of others:

- Commercial sex activity.
- The photographing, filming, or depicting of a child engaged in a listed sexual act including:
  - Sexual intercourse.
  - Erotic fondling.
  - Sadomasochistic abuse.
  - Masturbation.
  - Passive sexual involvement.
  - Sexual excitement.

- Erotic nudity.

- Sharing sexual acts over live video or phone.

- Coercing or forcing a child to participate in or be exposed to pornography and/or sexual behavior.

See MCL 722.622(r) for statutory definition of sexual exploitation, and MCL 750.145c for definitions of listed sexual acts.

Sexual exploitation also includes sex trafficking. Sex trafficking is the action of subjecting a child to the recruitment, harboring, transportation, provision, patronizing, or soliciting for the purposes of a commercial sex act through the use of force, fraud, or coercion, or in which the person induced to perform the act is under 18 years of age. Trafficking may involve an exchange of goods or psychological responses. Offenders may exchange love, friendship, protection, or attention to a child while an exchange of goods could include money, drugs, jewelry, clothing, food, shelter, or transportation.

For assignment, the alleged perpetrator of the trafficking does not need to meet criteria for person responsible. When law enforcement requests assistance, the department can investigate trafficking conditions regardless of role or status of the alleged perpetrator.

Note: In order to make a finding, the perpetrator must be found to be a person responsible.

Labor Trafficking

The recruitment, harboring, transportation, provision, or obtaining of a person for labor as a result of force, fraud, coercion, or manipulation. Labor trafficking can include, but is not limited to, domestic servitude, forced labor in restaurants or salons, forced agricultural labor or debt bondage.

The alleged perpetrator of the trafficking does not need to meet criteria for person responsible to investigate when law enforcement requests assistance. The department can investigate trafficking conditions regardless of role or status of the alleged perpetrator.

Note: In order to make a finding, the perpetrator must be found to be a person responsible.

CHILD NEGLECT

Child neglect is divided into the following maltreatment types:

- Physical neglect.
- Placing a child at unreasonable risk.
- Medical neglect.
- Threatened harm of medical neglect.
- Threatened harm of physical neglect.
- Threatened harm of placing child at unreasonable risk.

Physical Neglect

Though a parent or person responsible is financially able or able to access resources, harm has occurred to the child, by any one of the following:

- Living conditions which are unsanitary and/or contain hazards that lead to the child being injured or ill. Consider the child's age and developmental status and to what extent the living conditions pose a danger to the child.

- Failure to provide adequate clothing and/or appropriate hygiene to the extent that the child's daily activities are severely impacted.

- Deficient food and/or hydration to meet the needs of the child and the child experiences significant lack of food, unmitigated hunger and/or dehydration.

  Note: Excludes fasting for religious reasons.

- Absence of supervision causing harm to the child. Consider the child's age, cognitive abilities, behaviors, need level and length of time unsupervised. Time of day and other surrounding circumstances should also be considered.

Abandonment is considered physical neglect. Abandonment is when a person responsible willfully deserts or surrenders a child without making adequate arrangements for the child's basic needs or the continuing care of the child.

Note: Abandonment does not apply to Safe Delivery of Newborns Law.

Placing a child at unreasonable risk

Neglectful behavior that causes identifiable harm to the child by failing to intervene and eliminate a risk although the person responsible is able to do so and has or should have knowledge of the risk. Knowledge is based on common knowledge the general population would possess without additional education or information on child safety, child development, or other related areas. Does not include incidences that happen unexpectedly or accidentally.

Placing a child at unreasonable risk requires consideration of the following in context to the imminent risk of harm:

- Age, developmental, cognitive and verbal abilities of the child.
- Person responsible's knowledge they have or reasonably should have regarding the risk of danger as well as interventions to eliminate danger.
- Person responsible's ability to respond to the danger posed.
- Impact to the child's health or welfare by way of imminent risk of harm.

Examples of unreasonable risk may include, but are not limited to:

- Unable or unwilling to protect the child from others.
- Exposing, allowing, or encouraging the child to engage in illegal or life-threatening activities.
- Erratic or impaired behavior by the person responsible.
- Access to dangerous objects.

Note: All need to demonstrate the adverse impact to the child.

Medical Neglect

Failure to obtain necessary medical, dental, or mental health care for a child and the failure to obtain care has resulted in harm, including any of the following:

- Death.
- Disfigurement.

- Bodily harm.
- Impairment to the growth, development, or functioning of the child.

Includes when a person responsible fails to obtain and/or regularly administer prescribed medication to a child and the failure to provide medication results in any of the above.

Includes action or inaction by a person responsible which results in failure to thrive diagnosis by a qualified medical professional.

Failure to provide immunizations or routine well-child care or dental visits does not constitute medical neglect.

A parent or guardian legitimately practicing their religious beliefs who do not provide specified medical treatment for a child, for that reason alone is not considered to constitute medical neglect, MCL 722.634.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox (Child-welfare-policy@michigan.gov).

CATEGORIES OF DISPOSITION

After completing an investigation, each case is assigned a category. The category is determined by the absence or presence of child abuse or child neglect and the results of the safety and risk assessments. Categories are defined in the Child Protection Law (CPL) (MCL 722.628d).

Category V

A category V classification means the department determined there was no evidence of child abuse or child neglect and services are not needed. A category V case may also indicate the family cannot be located.

Category IV

A category IV classification means the department determined there was not a preponderance of evidence of child abuse or child neglect, but community services are recommended. The department must assist the child's family in locating and voluntarily participating in community-based services relevant to the needs of the family and risk to the child as identified in the risk assessment.

Category III

A category III classification means the department determined there is a preponderance of child abuse or child neglect, and the risk assessment tool indicated low or moderate risk of future harm to the child. The department must assist the child's family in receiving community-based services relevant to the needs of the family and risk to the child. If the family does not voluntarily participate in services or fails to make progress to reduce the risk level, the department must consider reclassifying the case as category II.

Category II

A category II classification means the department determined there is evidence of child abuse or child neglect, and the risk assessment tool indicated high or intensive risk of future harm to the child. The department must open a protective services case and provide the services necessary to rectify the conditions that led to a preponderance of evidence.

Category I

A category I case means the department determined there is evidence of child abuse or child neglect and 1 or more of the following is true:

- A petition is required under the Child Protection Law (MCL 722.628d, 722.637, and 722.638).
- The child is not safe and a petition for removal is needed.
- The case was previously classified as a category II and the child's family did not voluntarily participate in services.
- There is a violation, involving the child, of a crime listed or described in section 8a(1)(b), (c), (d), or (f) or of child abuse in the first or second degree as prescribed by section 136b of the Michigan penal code, 1931 PA 328, MCL 750.136b.

For more information on petition requirements, see PSM 715-3 Family Court: Petitions, Hearings and Court Orders.

In category I cases where the child remains in the home, protective services must open a case and provide services to the family. In category I cases where the child is removed and placed outside of the home, the case must be transferred to foster care for services and monitoring.

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LEGAL BASE

The following federal and state laws are the legal basis for Children's Protective Services (CPS) in Michigan:

Federal Law

Social Security Act, Title IV, Part A, Sec. 402(a)

Federal Indian Child Welfare Act, Public Law 95-608 25 USC Sub-section 1901-1952

The Preventing Sex Trafficking and Strenghtening Families Act, P.L. 113-183

Trafficking Victims Protection Act

State Social Welfare Laws

1939 PA 280 (MCL 400.115b and 400.55(h))

State Child Protection Law (CPL)

1975 PA 238 (MCL 722.621 et seq.)

State Child Care Organization Licensing Law

1973 PA 116 (MCL 722.111 - 722.128)

Juvenile Code

1939 PA 288 (MCL 712A.1 et seq.)

Public Health Code

1978 PA 368 (MCL 333.17001 et seq.)

LEGAL DEFINITIONS

Amendment

A change in case record or central registry information such as case name, address, code, case number, etc., including any change to correct inaccurate information.

Basis-in-Fact

Direct, personal knowledge on the part of the reporting person that is specific and concrete and reasonably indicates harm or threatened harm to a child's health or welfare.

Central Registry

A repository of names of individuals who are identified as perpetrators related to a central registry case in the department's statewide electronic case management system.

Central Registry Case

A central registry case means the department classified a case as confirmed serious abuse or neglect, confirmed sexual abuse, confirmed sexual exploitation, and/or confirmed methamphetamine production.

Child

An individual under 18 years of age.

Indian Child, Indian Child's tribe

Indian Child

An unmarried person who is under the age of 18 and is either of the following:

- A member of an Indian tribe.
- Eligible for membership in an Indian tribe as determined by that tribe.

Indian Child's Tribe

The Indian tribe in which an Indian child is a member or eligible for membership. In the case of an Indian child who is a member of or eligible for membership in more than one tribe, the Indian child's tribe is the tribe which the Indian child has the most significant contacts.

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, any other person responsible for the child's health or welfare or by a teacher, a teacher's aide, a member of clergy, or an individual 18 years of age or older who is involved with a youth program.

Child Care Organization

Defined in 1973 PA 116 (MCL 722.111 to 722.128) and includes child care centers, nursery schools, parent cooperative preschools, foster family homes, foster family group homes, children’s therapeutic group homes, child care homes, child caring institutions, child placing agencies, children's camps, and children’s campsites.

Child Care Provider

An owner, operator, employee, or volunteer of a child care organization or of an adult foster care location authorized to care for a child.

Child Neglect

Harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person responsible for the child's health or welfare that occurs through either of the following:

- Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care, though financially able to do so, or by the failure to seek financial or other reasonable

means to provide adequate food, clothing, shelter, or medical care.

- Placing a child at an unreasonable risk to the child's health or welfare by failure of the parent, legal guardian, or any 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.

Threatened Harm

An action, inaction or credible verbal threat by a person responsible and absent intervention, there is a high probability that harm will occur.

Children's Protective Services

Program services designed to rectify conditions which threaten the health and safety of children due to the actions or inactions of those responsible for their care. These services include investigation of a child abuse/neglect referral; determination of the facts of danger to the child and immediate steps to remove the danger; providing or arranging for needed services for the family and child; and when appropriate, initiation of legal action to protect the child.

Commencement

Any activity taken to begin an investigation.

Confirmed Case

The department has determined, by a preponderance of evidence, that child abuse or child neglect occurred by a person responsible for the child's health, welfare, or care. A confirmed case is also referred to as a substantiated case.

Confirmed Case of Methamphetamine Production

A confirmed case that involved a child's exposure or contact with methamphetamine production.

Confirmed Serious Abuse or Neglect

A confirmed case of mental injury or physical injury or neglect to a child that involves any of the following:

- Battering, torture, or other serious physical harm.
- Loss or serious impairment of an organ or limb.
- Life-threatening injury.
- Murder or attempted murder.
- Serious mental harm.

Confirmed Sexual Abuse

A confirmed case that involves sexual penetration, sexual contact, attempted sexual penetration, or assault with intent to penetrate as those terms are defined in section 520a of the Michigan penal code, 1931 PA 328, MCL 750.520a.

Confirmed Sexual Exploitation

A confirmed case that involves allowing, permitting, or encouraging a child to engage in prostitution, or allowing, permitting, encouraging, or engaging in the photographing, filming, or depicting of a child engaged in a listed sexual act as that term is defined in section 145c of the Michigan penal code, 1931 PA 328, MCL 750.145c.

Criminal History Check

A fingerprint-based criminal history check through the department of state police and the Federal Bureau of Investigation.

Criminal History Record Information

Name; date of birth; personal descriptions including identifying marks, scars, amputations, and tattoos; aliases and prior names; social security number, driver's license number, and other identifying numbers; and information on misdemeanor arrests and convictions and felony arrests and convictions.

Dating Relationship

Frequent, intimate associations primarily characterized by the expectation of affectional involvement. A dating relationship does not include a casual relationship or an ordinary fraternization between two individuals in a business or social context.

Domestic Violence

A pattern of coercive control perpetrated against one or more intimate partners. Behaviors can include sexual abuse, physical violence, threats, intimidation, financial control, possessiveness and isolation, among others. The abuse may continue after a couple has separated or is no longer living together and often directly involves, targets and impacts the children in the family.

Electronic Case Record

All information and documents related to a specific case or person that are stored in an electronic case management system.

Electronic Case Management System

The system that supports a workflow, management collaboration, storage of images and content, decision formulation, and processing of electronic files or cases.

Exploitation

Improper use of a child for one's own profit or advantage.

Expunge

To physically remove or eliminate and destroy a record or report.

False Complaint

A false allegation of child abuse or neglect made knowingly by an individual to the department. A person who knowingly makes a false report of child abuse or neglect may be charged with a misdemeanor if the false report was for an alleged misdemeanor offense. If the false report was for an alleged felony offense of child abuse and neglect, then the person may be charged with a felony.

Five Category Disposition

The five dispositions for CPS investigations are:

Category V - A category V classification means the department determined there was no evidence of child abuse or child neglect and services are not needed.

Note: A category V case may also indicate there is insufficient evidence to confirm or deny allegations for a family that cannot be located.

Category IV - A category IV classification means the department determined there was not a preponderance of evidence of child abuse or child neglect, but services are recommended. The department must assist the child's family in locating and voluntarily participating in community-based services relevant to the needs of the family and risk to the child as identified in the risk assessment.

Category III - A category III classification means that the department determined there is a preponderance of evidence of child abuse or child neglect, and the risk assessment tool indicated low or moderate risk of future harm to the child. The department must assist the child's family in receiving community-based services relevant to the needs of the family and risk to the child. If the family does not voluntarily participate in services or fails to make progress to reduce the risk level, the department must consider reclassifying the case as category II.

Category II - A category II classification means the department determined there is a preponderance of evidence of child abuse or

child neglect, and the risk assessment tool indicated high or intensive risk of future harm to the child. The department must open a protective services case and provide the services necessary to rectify the conditions that led to a preponderance of evidence.

Category I - A category I classification means the department determined there is a preponderance of evidence of child abuse or child neglect and one or more of the following is true:

- A court petition is required under the Child Protection Law (MCL 722.628d, 722.637, and 722.638).
- The child is not safe and a petition for removal is needed.
- CPS previously classified the case as category II, and the child's family did not voluntarily participate in services.
- There is a violation, involving the child, of a crime listed or described in section 8a(1)(b), (c), (d) or (f) or of child abuse in the first or second degree as prescribed in section 136b of the Michigan Penal Code, 1931 PA 328, MCL 750.136b.

  For more information on petition requirements, see PSM 715-3, Family Court: Petitions, Hearings and Court Orders.

  In category I cases where the child remains in the home, protective services must open a case and provide services to the family. In category I cases where any child is removed and placed outside of the home, the case must be transferred to foster care for services and monitoring.

Extended Family Network

Includes the nuclear family with the non-custodial parent, extended or blended family, and other adults viewed as family who have an active role in the functioning of the child's family. These adults may or may not reside in the immediate area**.**

Human Trafficking

Sex trafficking victim

An individual subject to the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the

purposes of a commercial sex act through the use of force, fraud, or coercion, or in which the person induced to perform the act is under 18 years of age. Trafficking may also involve an exchange of goods or psychological responses.

Labor trafficking victim

An individual subject to the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Intimate Partner

A spouse, a former spouse, an individual with whom the individual has a child in common, an individual with whom the individual has or had a dating relationship, or an individual residing or having resided in the same household.

Local Office CPS File

The system used to keep a record of written report, document, or photograph files with and maintained by a county or a regionally based office of the department.

Members of the Clergy

A priest, minister, rabbi, Christian Science practitioner, spiritual leader, or other religious practitioner, or similar functionary of a church, temple, spiritual community, or recognized religious body, denomination, or organization.

Medical Practitioner

A medical practitioner is one of the following:

- A physician or physician's assistant licensed or authorized to practice under part 170 or 175 of the public health code, MCL 333.17001 to 333.17088 and MCL 333.17501 to 333.17556.
- A nurse practitioner licensed or authorized to practice under section 172 of the public health code, MCL 333.17210.

Mental Health Practitioner

A psychiatrist, psychologist, or psychiatric social worker including a licensed master's social worker, licensed bachelor's social worker, or registered social work technician (under 1978 PA 368, as amended) who has successfully completed a psychiatric social service practicum.

Mental Health Professional

An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following, MCL 333.1100b(19)(a-f):

- A physician.
- A psychologist.
- A registered professional nurse licensed or otherwise authorized to engage in the practice of nursing under part 172 of the public health code, 1978 PA 368, MCL 333.17201 to 333.17242.
- A licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code, 1978 PA 368, MCL 333.18501 to 333.18518.
- A licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code, 1978 PA 368, MCL 333.18101 to 333.18117.
- A marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code, 1978 PA 368, MCL 333.16901 to 333.16915.

Non-offending Caretaker

In domestic violence cases, the non-offending caretaker/adult survivor is defined as the adult living in the home who has NOT been found to be abusive to the children. In all other CA/N cases, the non-offending caretaker is any other adult residing in the home who has not been found to be abusive or neglectful.

Perpetrator Notification

A notification to individuals whose name has been entered on central registry for a criminal conviction, confirmed case of serious abuse or neglect, confirmed sexual exploitation, confirmed sexual abuse, or confirmed methaphetamine production. This also includes notice to individuals identified as a perpetrator in a confirmed case who are not placed on central registry. All perpetrator notices inform individuals of their rights to review the record and request amendment or expungement.

Person Responsible For The Child's Health Or Welfare

"Person responsible for the child's health or welfare" means a parent, legal guardian, individual 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(1)(e) or 8(8), nonparent adult; or an owner, operator, volunteer, or employee of 1 or more of the following:

- A licensed or registered child care organization.
- 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, 1979 PA 218, MCL 400.703.
- A court-operated facility as approved under section 14 of the social welfare act, 1939 PA 280, MCL 400.14.

Non-parent Adult

A person who is 18 years of age or older and who, regardless of the person's domicile, meets all the following criteria in relation to the child (MCL 722.622):

- Has substantial and regular contact with the child.
- Has a close personal relationship with the child's parent or with a person responsible for the child's health or welfare.
- Is not the child's parent or a person otherwise related to the child by blood or affinity to the third degree.

Note: Third degree relatives include parents, grandparents, great-grandparents, brothers, sisters, aunts, uncles, great-aunts, great-uncles, nieces, and nephews.

Note: A nonparent adult who resides in any home where a child is receiving respite care.

Note: This includes nonparent adults residing with a child when the referral involves sexual exploitation (human trafficking).

Power of Attorney

A written, signed document authorizing another person to act as one's agent for specific purposes for a limited period of time. (As an example, a parent leaves a child in the care of a neighbor while the parent is on vacation and leaves a written statement that, during that vacation period, the neighbor may consent to any needed surgery or medical treatment for the child.) Court action is not necessary for a power of attorney and a power of attorney is not equivalent to an order of guardianship.

Preponderance Of Evidence

Evidence which is of greater weight or more convincing than evidence which is offered in opposition to it.

Referral

Written or verbal communication to the department of an allegation of child abuse or neglect. The term referral in the Children’s Protective Services manual (PSM) is interchangeable with the term report in the Child Protection Law.

Relative

A relative is defined as an individual who is at least 18 years of age and related to the child within the fifth degree by blood, marriage, or adoption, including the spouse of an individual related to the child within the fifth degree, even after the marriage has ended by death or divorce, the parent who shares custody of a half-sibling, and the parent of a man whom the court has found probable cause to believe is the putative father if there is no man with legally established rights to the child.

A relative is also defined as an individual who is at least 18 years of age and not related to a child within the fifth degree by blood, marriage, or adoption but who has a strong positive emotional tie or role in the child's life or the child's parent's life if the child is an infant, as determined by the department or, if the child is an Indian child, as determined solely by the Indian child's tribe. As used in this section, Indian child and Indian child's tribe mean those terms as defined in section 3 of chapter XIIB; see NAA 215, Placement/Replacement Priorities for Indian Child(ren).

Relevant Evidence

Evidence having a tendency to make the existence of a fact that is at issue more probable than it would be without the evidence.

Respite

Respite care is a licensed alternative placement providing planned relief to primary caregivers from the demands of ongoing care for an individual whose health and welfare would be jeopardized if left unattended. Respite care does not include incidental visits with an alternate caregiver such as sleep overs or incidental visits with a grandparent or other relatives, family, and friends.

Severe Physical Injury/Serious Physical Harm

Severe physical injury means serious physical harm to a child, as defined in MCL 750.136b. Serious physical harm means any physical injury that seriously impairs the child's health or physical well-being, including but not limited to, brain damage, a skull or

bone fracture, subdural hemorrhage or hematoma, dislocation, sprain, internal injury, poisoning, burn or scald, or severe cut.

Serious Mental Harm

As defined in MCL 750.136b, injury to a child's mental condition or welfare that is not necessarily permanent but results in visibly demonstrated manifestations of a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

Specified Information

Information in a CPS case record related specifically to the department's actions in responding to a referral of CA/N regulated by the CPL.

Unconfirmed Case

A case that is not substantiated.

Unrelated Caregiver

An adult who is not related to a child by blood, marriage, or adoption; who is willing and able to best meet the needs of the child, and safeguard the child from risk of harm to the child's life, physical health and/or mental well-being.

Youth Program

Events or activities designed for participation by minors and supervised by program employees or volunteers outside the presence of a parent or guardian.

REFERRAL PROCESS

Michigan Department of Health and Human Services (MDHHS) uses a statewide Centralized Intake (CI) unit for reporting child abuse and neglect.

DEFINITIONS

Person Responsible for the Child's Health or Welfare

"Person responsible for the child's health or welfare" means a parent, legal guardian, individual 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(1)(e) or 8(8), nonparent adult; or an owner, operator, volunteer, or employee of 1 or more of the following:

- A licensed or registered child care organization.
- 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, 1979 PA 218, MCL 400.703.
- A court-operated facility as approved under section 14 of the social welfare act, 1939 PA 280, MCL 400.14.

Note: This includes licensed individuals providing respite care.

Nonparent Adult

A person who is 18 years of age or older and who, regardless of the person's domicile, meets all the following criteria in relation to the child, MCL 722.622:

- Has substantial and regular contact with the child.
- Has a close personal relationship with the child's parent or with a person responsible for the child's health or welfare.
- Is not the child's parent or a person otherwise related to the child by blood or affinity to the third degree.

Note: Third degree relatives include parents, grandparents, great-grandparents, brothers, sisters, aunts, uncles, great-aunts, great-uncles, nieces, and nephews.

Note: Adults, other than the primary licensed caregiver(s), residing in a respite placement are considered a nonparent adult.

Note: This includes nonparent adults residing with a child when the referral involves sexual exploitation (human trafficking).

CPS CENTRALIZED INTAKE

CI is staffed 24 hours a day, 7 days a week and can be reached at 1-855-444-3911.

If a person comes into the local office to make a referral alleging child abuse or child neglect, the local office should offer a MDHHS phone and the CI telephone number to make the referral from the office. If the person does not want to talk on the phone, the local office must take the referral on a DHS-3550, Children's Protective Services Centralized Intake Record,form and forward to CI or complete an online report at www.michigan.gov/mandatedreporter. Any referrals received by the local office through fax or email must be sent to CI immediately.

Courts requesting MDHHS to complete a home study with children involved in guardianships, with no allegations of abuse or neglect, should be entered as a non-CPS intake by the local county. These requests should not be forwarded to CI.

CI contact information:

- Phone: 1-855-444-3911.
- Fax: 616-977-1154 and 616-977-1158.
- E-mail: DHS-CPS-CIGroup@michigan.gov.

Information on online reporting can be found at:

www.michigan.gov/mandatedreporter

INITIAL REFERRAL

Intake begins when a referral alleging child abuse and/or neglect is received by CI. The referral is usually made through a telephone contact by the reporting person, but may also occur as an in-person, written, or online contact. The intake process is focused on initial fact gathering and evaluation of information to determine the validity of the referral, whether it meets statutory criteria for investigation, and to assess the level of risk to the child. Evaluation of the referral information determines the nature and priority of the initial response.

SOURCES OF REFERRALS

Referrals of suspected child abuse and/or neglect originate from various sources, including professionals mandated by law to report, MDHHS employees, and the public. The public can make a report to CI by telephone, in-person, or in writing. Professionals who are mandated by law to report child abuse and neglect also have the option to make a report using the online reporting system.

Mandated Reporters

Mandated reporters are professionals who are mandated by law to report suspected child abuse or neglect as defined in the Child Protection Law (CPL) [MCL 722.623(1)(a)]. For MDHHS employees mandated by law to report suspected child abuse or neglect; see APR 200, Mandated Reporter- Child.

The CPL requires mandated reporters to make an immediate report to MDHHS by telephone or the online reporting system upon suspecting child abuse and/or neglect.

If a report is made by phone, mandated reporters must also make a written report within 72 hours. Mandated reporters must utilize the DHS-3200, Report of Actual or Suspected Child Abuse or Neglect, form to fulfill the written report requirement. Professional reports (for example, police reports and hospital reports) can take the place of the DHS-3200, unless critical information is missing in the professional report.

At intake, the mandated reporter should be reminded of the legal requirement to submit a written report within 72 hours to CI. The DHS-3200 is available online from the MDHHS public website Mandated Reporters. If the reporting person does not have the DHS-3200 form, CI will email the form to the mandated reporter to expedite compliance with the law.

If a report is completed online, mandated reporters are not required to complete a written report.

Due to federal laws and regulations, domestic violence providers and substance abuse agencies can only provide the information required for reporting by MCL 722.623 unless the client signs a consent for release of information to MDHHS for a CPS investigation; see SRM 131, Confidentiality, for more information.

Note: CPS investigators are not required to file a separate report of suspected child abuse and/or neglect on their own active investigations. If the CPS investigator learns of a new allegation, suspects new maltreatments, or identifies additional household victims, they **must** thoroughly investigate those allegations as part of the active investigation and document the findings in the disposition. This excludes new referrals involving a child death; see SRM 172 Child/Ward Death Alert Procedures and Timeframes.

ELICITING REFERRAL INFORMATION

The reporting person should be asked to be as specific as possible about the alleged child abuse and/or neglect, indicating what was observed or heard that caused the suspicion of child abuse and/or neglect, family demographics, and how the reporting person knows the family and the information they provided.

REQUIRED CHECKS FOR LICENSING STATUS

Inquiries must be made to verify the licensing status of individuals associated with the referral. These inquiries are to be supported by a search of the electronic case management system conducted by

CI to determine if a licensed provider is identified as a member of the CPS referral.

The reporting person must be asked if anyone affiliated with the referral is a licensed foster care provider, licensed day care provider, or a relative provider. Intake staff will document if any of the children in the home are listed within the electronic case management system as foster children. Any children in the home with an active foster care case should be listed as intake participants. These clearances must be documented in the referral source comment section in the electronic case management system.

PRELIMINARY INVESTIGATION

When information received from the reporting person is not sufficient to reach a decision to screen out, transfer, or screen in the referral for an investigation and assign a priority response, CI must conduct a preliminary investigation. Within 24 hours of receipt of the referral, a decision must be made to screen in and assign for CPS investigation, to transfer to another unit that has jurisdiction, or to screen out the referral.

The preliminary investigation for these intake situations should at minimum include one or more of the steps below. Additional steps should be completed when necessary to assist in making appropriate decisions regarding assignment.

PRELIMINARY INVESTIGATION ACTIVITIES

Activities which may be part of a preliminary investigation include but are not limited to the following:

1. An electronic case management system search on all persons listed on the referral. Review the CPS history to determine any trends between past referrals and current allegations.

2. A criminal history check on all persons potentially responsible for the child’s health and welfare.

3. Attempted contact with any collateral contacts who have pertinent information regarding the allegations or the child(ren)'s well-being.

Document all steps of the preliminary investigation that were completed in the preliminary investigation section. A summary should be completed for each step conducted in the preliminary investigation. The summary should detail how the information obtained supports the decision made to screen in, transfer, or screen out the referral.

Note: If there is already an assigned investigation or an open case, the referral must be forwarded to the assigned case manager for their awareness and any necessary follow-up regarding the allegations. A preliminary investigation is not required when there is already an assigned investigation or an open CPS or foster care case unless a preliminary investigation is necessary to make an accurate screening decision. CI must enter a social work contact in the active case to indicate the referral was received and the reason for the screen out decision.

REFERRAL DOCUMENTATION

The department is required to maintain documentation of the receipt and disposition of all CPS referrals. Any contacts made during intake must be entered into the electronic case management system in the Social Work Contacts module.

When allegations are entered into the electronic case management system, **proofread to ensure the identity of the reporting person is not revealed**. Once a determination is made to screen in, transfer, or screen out the referral, the details of the allegations cannot be changed.

When selecting allegations under the Allegations Details screen in the electronic case management system, select at least one abuse/neglect type in the Maltreatment Types tab. The maltreatments selected should be selected in accordance with the definition of those maltreatments; see, PSM 711-2, Definitions, Responsibilities and Maltreatment Types. Also, select any of the risk factors if the reporting person indicates the presence of those

factors in the home (for example, domestic violence, drug residence - methamphetamine, and substance exposed newborn).

Death of a Child

If the referral alleges the death of a child, check the child death box on the maltreatment types tab and enter the date of death in the deceased child's electronic case record; see PSM 712-06, Special Intake Cases. Details should be obtained to determine if there are any concerns of child abuse and/or neglect that led to the child's death. For more information regarding death of a child; see SRM 172, Child/Ward Death Alert Procedures And Timeframes.

DECISION TO SCREEN OUT

If, after intake and/or preliminary investigation, neither CPS intervention nor a transfer to an agency, assigned investigator, or assigned case manager is determined appropriate, the reasons for screening out the referral must be documented in the electronic case management system. Reasons to screen out a referral include:

- Referral already investigated.
- Discounted after preliminary investigation.
- Does not meet statutory criteria.
- Insufficient information to locate child or family.
-
- Out of jurisdiction.
- Safe delivery of a newborn without allegations of child abuse and/or neglect other than abandonment.

If the referral is appropriate for handling by another agency, refer the reporting person to the appropriate agency. For example, the Friend of the Court (FOC) for child support referrals or other custody issues not related to child abuse and/or neglect, community mental health for mental health services, or the school district for truancy issues, among others.

When an audit or second line supervisor reviews a screened out referral and determines the referral is appropriate for assignment, CI may use the date and time of the review to create another referral, and reference the original reporting source and intake ID.

Multiple Reporting Persons

If a subsequent referral is received while an intake is in pending status for a family, the reporting person of the subsequent referral should be added to the electronic case management system as an additional reporting person. Document the date and time of the subsequent referral and any additional information provided.

Note: A second reporting person cannot be added unless the intake is in pending status; the addition cannot be made if the intake has been screened out or screened in and assigned for investigation.

TRANSFER

Referrals may be transferred to another agency for investigation if the referral does not meet the CPL definition of child abuse and/or neglect. The following are examples of allegations in which a referral should be transferred and the entity for the transfer:

- Allegations of child abuse and/or neglect by a person not responsible for the child's health and welfare must be transferred to law enforcement and the prosecuting attorney.
- Alleged licensing violations should be transferred to MDHHS or private agency certification staff, Division of Child Welfare Licensing (DCWL), or Licensing and Regulatory Affairs (LARA).
- Children residing on lands within exclusive jurisdiction of a Native American tribe that does not have a special written agreement with the department must be transferred to that tribe's child welfare agency. For more information on assigning cases with Native American children; see NAA 233, Children's Protective Services Investigations.
- Incidents of child abuse and/or neglect that occurred outside the state of Michigan may be transferred to the appropriate state's child welfare agency.
- Allegations that are already being addressed in a current, open investigation or that does not meet assignment criteria should

be transferred to the active MDHHS case manager. CI must enter a social work contact in the active case to indicate the referral was received and the reason for the screen out. An auto notification will be sent to all active staff in the electronic case management system.

- Incidents of child abuse and/or neglect that occurred on a military base. Military Base Law, Federal Army Regulation 608-18, prohibits investigation of CPS referrals on military bases, unless a special written agreement exists.

- Referrals that list the alleged perpetrator as a member of the clergy, a teacher, a teacher's aide, or an individual 18 years of age or older who is involved in a youth program, must be referred to the prosecuting attorney/law enforcement within 24 hours of receipt of the referral. Referrals pertaining to these individuals will be automatically sent to the MIC/PCU intake coordinator in the electronic case management system and assigned to a PCU specialist for follow up.

Division of Child Welfare Licensing (DCWL)

There will be an auto notification sent to DCWL when referrals involve:

- Licensed foster homes.
- Licensed relative foster care placements.
- Child Caring Institutions (CCIs).
- Court operated facilities (COFs).
- Child placing agencies (CPAs).
- Children in foster care who were in any setting other than a parental home or daycare when the alleged maltreatment occurred.

Information on referral participants and allegations must be sent to DCWL and will be included on the auto notification. Contact information for the DCWL area managers can be found on the Child Welfare Licensing - Field Services Contact Information.

Licensing and Regulatory Affairs (LARA)

There will be an auto notification sent to LARA when referrals involve:

- Children's camps.
- Child care centers.
- Licensed family and group childcare homes.
- Adult foster care homes.

Screened out referrals will be manually sent to LARA-CCLB-Complaints@michigan.gov by Centralized Intake when involving:

- Unlicensed child care programs.

Note: Child care programs that do not require licensing are those that fall within the exemption found under MCL 722.111(h)(i) -(v) and MCL 722.111(o)(iii) only if they fall within the providing babysitting services.

The CI specialist must also complete and send the law enforcement notification (LEN) whenever there is a crime against a child and the referral involves a child care program not required to be licensed. The LEN, located within the electronic case management system, must be sent to the appropriate law enforcement jurisdiction.

CI must notify LARA and email referral information to the Bureau of Community Health Systems Health Facility Complaint Mailbox for referrals involving:

- Hospitals.
- State psychiatric facilities.
- Nursing homes.

The name and phone number of the reporting person should be included in the written referral transferred to the other agency, if the other agency is authorized to investigate allegations of abuse and neglect. The reporting person should be advised that the agency responsible for the investigation might contact them.

New Referrals on Assigned CPS Investigations or Open CPS Cases

Careful attention must be given to documenting the intake dispositions of new referrals received during a pending investigation or an open case. When a new referral is received on a pending investigation or open case, the new allegations must be

evaluated by the same standards as other referrals to determine assignment of the new referral.

If there is an open case or pending investigation, contact should be made with the assigned case manager to identify if the new allegations are known or being addressed with the family. If the new allegations are being addressed with the family or do not meet criteria for assignment, the referral should be transferred to the assigned case manager for any necessary follow-up. A social work contact must be entered into the active investigation or case for each intake ID, documenting review of the new allegations, and that the information was transferred to the assigned case manager.

If the new referral contains allegations not already addressed in the active investigation, the allegations meet criteria for assignment, and it is within fifteen days of receipt of the intake for the active investigation, the new referral should be screened in as an accept and link investigation; see PSM 713-08, Special Investigative Situations in the accept and link section. If the new referral is received after fifteen days of receipt of the intake for the active investigation, it should be screened in as an accept and assign investigation.

SCREEN IN FOR CPS INVESTIGATION

The referral allegations must minimally meet the CPL definitions of child abuse and/or neglect to be assigned. Four elements must be present in the allegations to screen in a referral for investigation:

- Allegations of harm or threatened harm.
- To a child's health or welfare.
- Through non-accidental or neglectful behavior.
- By a person responsible for the child's health and welfare.

Exception: Human trafficking referrals made by law enforcement that involve children must be assigned regardless of whether the alleged perpetrator meets the criteria of a person responsible for the child's health and welfare or not.

PRIORITY RESPONSE CRITERIA

The CPS Minimal Priority Response Criteria determines:

- Response time for commencement of the investigation.
- Response time for face-to-face contact with each alleged child victim.

When CI receives a referral of suspected child abuse and/or neglect, the CI specialist completes the priority response tool. The priority response tool assists with determining if the referral is screened in as a priority one or priority two response. CI has the discretion to extend a priority response time to 24/72 hours or reduce a priority response time to 12/24 hours based on specific exceptions. A rationale must be provided.

Exception: In referrals alleging an infant was born exposed to substances, but no other immediate safety concerns are reported, CI may reduce the priority response time to 24/72.

Exception: First responders (e.g., medical personnel, law enforcement, FBI) are requesting CPS on scene, and the response is appropriate given the immediate circumstances.

A case manager must commence the investigation and make face-to-face contact with each alleged child victim(s) within the corresponding timeframes.

Priority One Response:12/24

- A priority one response investigation must be commenced within 12 hours after receipt of the referral by CI.
- Face-to-face contact must occur with each alleged child victim within 24 hours after receipt of the referral by CI.

Priority Two Response:24/72

- A priority two response investigation must be commenced within 24 hours after receipt of the referral by CI.

- Face-to-face contact must occur with each alleged child victim within 72 hours after receipt of the referral by CI.

Note: If an alleged child victim is identified after the investigation has been assigned, face-to-face contact with the newly identified alleged child victim must occur within 24 hours if the allegations have not already been addressed per policy requirements with the newly identified alleged child victim, as demonstrated in a social work contact.

ESTABLISHING INTAKE CASE NAME

For all CPS referrals screened in for investigation, CI must complete a search of the electronic case management system to ensure the accurate person is added to the investigation.

If more than one family is residing in a home and there are allegations of abuse and/or neglect regarding multiple families, a separate referral should be generated for each family.

In most instances, CPS cases should be established in the parent's or legal guardian's name if the child **resides** with the parent or legal guardian. CPS cases should also be established in the parent's or legal guardian's name in situations where child abuse and/or neglect may have occurred when the child previously resided with the parent or legal guardian, regardless of who is alleged to have perpetrated abuse or neglect. There are certain instances in which this will not occur, such as an offending parent who has victim children residing in multiple counties and Maltreatment in Care (MIC) cases that involve day care facilities and Child Caring Institutions; see *Intake* PSM 714-05, Maltreatment in Care.

WHEN A CHILD IS IN OUT-OF-HOME PLACEMENT

When CI receives allegations of child abuse and/or neglect against a child’s parent (or other previous caretakers) and the alleged child victim is currently residing in a court ordered out-of-home placement, the following steps must be taken:

- If the alleged incident occurred at a parent's (or other caretaker's) home or during a visit, enter the alleged perpetrator as the primary caregiver in the electronic case management system with that person's address as the case address.
- List the alleged child victim as a non-household member.
- List the non-household address as the address where the alleged child victim is currently residing.

If the alleged perpetrator of the child abuse and/or neglect is the foster parent or current caregiver, the case must be registered in the name of the foster parent or current caregiver.

For more information on out of home placement and how these cases should be assigned; see PSM 714-5, Maltreatment In Care.

NON-HOUSEHOLD MEMBERS

Non-household members should only be added to a case when the non-household member is a person responsible for the health and welfare of the child and does not reside in the household. Persons who should be listed as a non-household member include, but are not limited to:

- Legal parents, and putative parents involved in the care of the alleged child victim(s), involved in the allegations.
- Legal guardians of the alleged child victim(s) who are involved in the allegations.
- Alleged perpetrators.

Other persons important to the case, but who are not persons responsible for the health and welfare of the child, should not be listed as non-household members. These persons may be grand-parents, other relatives, etc. These persons may be resources/sup-port for the family and/or possible placements for a child if out-of-home placement if necessary. Names and contact information may be documented in the intake narrative.

CONFIDENTIAL REFERRALS

A referral involving, but not limited to the following, may need to be marked confidential:

- MDHHS employee.
- Relative of a MDHHS employee.
- A high-profile media case.
- Prominent member of the community (judge, chief of police, etc.).

If a CPS referral needs to be marked confidential select the Confidential Complaint box.

CPS CASE RECORD RETENTION

The Child Protection Law (MCL 722.628(11)) requires each report alleging child abuse and/or neglect be entered into a data system. MDHHS uses the electronic case management system as the data system of record. The department is required to maintain the information until the child is 18 years old or until 10 years after the investigation is commenced, whichever is later. If the case is classified as a central registry case, case information shall be retained until the department receives reasonable information that the perpetrator of abuse is dead.

RESOURCES

Michigan's Centralized Intake Procedures & Best Practices Manual.

SDM Centralized Intake Assessment Policy & Procedures Manual.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox (child-welfare-policy@michigan.gov).

OVERVIEW

Centralized Intake (CI) may receive referrals that require additional information or guidance in addition to standard intake steps outlined in PSM 712-1, CPS Intake, in order to appropriately screen in, screen out, or transfer an intake. This item provides information for those special cases.

DEFINITIONS

Domestic Violence **(DV)**

A pattern of coercive control perpetrated against one or more intimate partners. Behaviors can include sexual abuse, physical violence, threats, intimidation, financial control, possessiveness, and isolation, among others. This includes situations where one of the partners does not live in the home but has substantial contact in the home or has lived in the home but continues to behave in threatening ways.

Intimate Partner

A spouse, a former spouse, an individual with whom the individual has a child in common, an individual with whom the individual has or had a dating relationship, or an individual residing or having resided in the same household.

Dating Relationship

Frequent, intimate associations primarily characterized by the expectation of affectional involvement. A dating relationship does not include a casual relationship or an ordinary fraternization between two individuals in a business or social context.

CPS - MALTREATMENT IN CARE (MIC)

The Children's Protective Services Maltreatment in Care Unit (CPS-MIC) was developed to ensure safety and well-being of children under the care and supervision of the Michigan Department of Health and Human Services (MDHHS) and for children being cared for in a facility or home licensed by MDHHS. The CPS-MIC Unit investigates:

- Licensed foster homes.

- Licensed adult foster homes (for minor foster children placed in an adult foster home only).
- Licensed or unlicensed relative placements.
- Independent living.
- Child Caring Institutions (CCI).
- Child Care Licensing Programs (CCLP).
- Parental homes still under foster care and court supervision, after the children return home. Not applicable when children go from a respondent parent's home directly to a non-respondent parent's home. This is assigned to CPS in the local office.

The Intake Decision Table for CPS and CPS-MIC Investigations specifies the responsibilities of CPS and CPS-MIC for investigation of CA/N referrals received by MDHHS.

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
Licensed foster home or licensed/unlicensed relative caregiver when allegations involve:	**CPS**	**CPS-MIC**
A foster parent or relative caregiver, and the alleged child victim is in foster care residing in the foster home or relative placement.		X
A foster parent or relative caregiver, biological/adoptive children, and children in foster care residing in the foster home or relative placement, regardless of which child(ren) in the home is/are the alleged victim.		X
A legal parent, and the child victim is in foster care, regardless of placement type.		X
A foster parent, and the alleged child victim has returned to the parent's care.		X

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
A foster parent with biological/adoptive children and there are not or were not any foster children placed in the home at the time of the alleged abuse/neglect.	X	

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
Legal parents (including in-home placement or following return home from foster care with court jurisdiction), when allegations involve:	**CPS**	**CPS-MIC**
A child in their care, under in-home court jurisdiction, who does not have an open foster care case.	X	
A child in their care, **not** under court jurisdiction.	X	
A child in their care who has returned home from foster care and the court maintains jurisdiction.		X
Alleged abuse or neglect occurred prior to their child going into out of home care.	X	
Adding a non-respondent parent to active court cases.	X	
A child goes from one parent directly to another parent (no out of home placement).	X	

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
CCIs (such as, detention centers, youth homes, shelter homes, residential care facilities (long- and short-term), halfway homes, court operated facilities) when allegations involve:	**CPS**	**CPS-MIC**
An employee of a CCI and an alleged child victim residing in a CCI.		X
A legal parent and an alleged child victim under MDHHS supervision; for example, allegations occurred during visit.		X
An employee or volunteer of a CCI and an alleged child victim who was returned home to a parent's care, if the abuse or neglect was alleged to have occurred during the child's placement in the CCI.		X
A licensed provider or an employee of a CCI and the alleged victim is the alleged perpetrator's own child.	X	
An employee or volunteer of a CCI and a child placed in the CCI who is not under supervision of MDHHS.		X

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
CCLPs (referrals involving children, regardless of court jurisdiction) when allegations involve:	**CPS**	**CPS-MIC**
A child in a licensed facility.		**X**
A legal parent, licensed to operate a child care facility, and the alleged victim is their biological/adopted child.	X	

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
Unlicensed facilities.	N/A	N/A

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
Licensed camp facility when allegations involve:	**CPS**	**CPS-MIC**
Children at a licensed camp facility.		X
A legal parent at a licensed camp facility, and the victim is the alleged perpetrator's own child.	X	

COUNTY ASSIGNMENT

CPS-MIC investigations are assigned to the county of the perpetrator's current residence and where the child abuse and neglect occurred, regardless of the victim's current residence.

Note: CI may assign referrals received after-hours to the county where the child victim is located to ensure contact is made. See *Inter-County Referrals* section in this item.

MULTIPLE FAMILIES IN SAME HOUSEHOLD

When CI receives allegations meeting assignment criteria on multiple families residing in the same household, and one of the

families meets criteria for assignment to CPS-MIC, CI will assign all the referrals within that household to CPS-MIC.

NEW REFERRALS ON FOSTER CHILDREN

Refer to FOM 722-13A, Maltreatment In Care - Foster Care Responsibilities, for guidance regarding referrals of abuse or neglect on a foster child.

When a referral alleges abuse or neglect of a child with an open foster care or adoption program type, or when a child with an open foster care or adoption program type is placed in a home with an alleged perpetrator, CI must send an intake decision notification to all active case managers and supervisors on the child's case. When a provider is linked to the intake, CI will also send a notification to the licensing specialist and supervisor assigned to the provider record.

CONFLICTS OF INTEREST

If at the time of intake, a CPS referral is reported to involve an MDHHS employee or a relative of an MDHHS employee, the referral must be transferred to the nearest adjacent county. These cases must also be marked confidential. See SRM 131, Confidentiality, *Making Cases Confidential in the Electronic Case Management System*, section for further information on marking a case confidential.

Disputes between counties must be referred to the appropriate Business Service Center director(s) for resolution.

INTER-COUNTY REFERRALS

CI may receive a referral that involves a child whose residence is in another county (such as when a child is brought to a hospital located in a county other than the child’s residence, or the child is visiting the non-custodial parent). The responsibility for initiating the investigation for these types of referrals depends on the nature of the allegations and the priority response. The county responsible for handling the referral is as follows:

- The county where the child is found is responsible for the referral if the priority response is Immediate Response,12-hour commencement and 24-hour face-to-face (12/24).

- The county of residence is responsible for handling the referral if the priority response requires a 24-hour commencement and 72-hour face-to-face (24/72).

Exception: If the child attends school in an adjacent county, the county of residence should handle the referral.

Inter-County Disputes and Coordination

Additional referrals should not be assigned solely for the purpose of verifying the well-being of other children/siblings on a current investigation. Courtesy requests can be made between counties to assist in the verification of well-being and filing petitions.

Counties should work together to ensure child safety and to ensure timeframes are met for commencement and face to face. Disputes between the assigned county and the county in which the request for assistance is being made must be immediately referred to the appropriate Business Service Center director(s) for resolution.

INTERSTATE REFERRALS

When CI receives a referral from an out-of-state department involving a Michigan child, and the referral is assigned, the county where the referral is assigned must proceed with standard procedures for evaluating and investigating referrals of child abuse and/or neglect. Michigan CPS staff may communicate with the referring out-of-state department to obtain necessary information.

If a referral is received regarding child abuse and/or neglect that occurred in another state and there are no current concerns that a child in Michigan is being abused or neglected, the referral should be transferred to the state in which the child abuse and/or neglect occurred.

CPS referrals to or from another state are not governed by the Interstate Compact on the Placement of Children (ICPC). Contact may be made directly with the other state department. For contact information for other states, go to https://aphsa.org/AAICPC/Resources.aspx.

PROSECUTING ATTORNEY/LAW ENFORCEMENT RESPONSIBILITY

Prosecuting attorney/law enforcement agencies are responsible for the investigation of child abuse and neglect by certain individuals and in unregulated institutional settings such as:

- Schools (both public and private), including boarding schools.
- Incidental out-of-home or in-home childcare (baby-sitting).
- Mental health facilities not subject to PA 116.
- Clergy.
- Teachers.
- Teacher's aides.
- An individual 18 years of age or older, involved with a youth program.
- Unregulated (unlicensed or unregistered) child care group and family homes.
- Persons not responsible for the child’s health or welfare.

CI must transfer these referrals and refer to the prosecuting attorney/law enforcement agency within 24 hours of receipt of the referral. When the alleged perpetrator's role has been coded by CI as a member of the clergy, a teacher, a teacher's aide, or an individual 18 years of age or older who is involved in a youth program, the referrals are automatically sent to the MIC/PCU intake coordinator in the electronic case management system and assigned to a PCU specialist for follow up.

ADDITIONAL CPS-MIC POLICY

See PSM 714-5, Maltreatment In Care, when a CPS-MIC referral is assigned for investigation.

DEATH OF A CHILD

Allegations involving death of a child will be assigned for investigation if the allegations meet the definition of child abuse

and/or neglect. If the incident that led to the child's death appears accidental, the referral may not need to be assigned. CI should obtain and review information gathered from the reporting person to determine if assignment is appropriate. If the cause of death is unknown, CI will assign for investigation. When screening out child death referrals consultation with a second line manager must occur and be documented in the electronic case record.

Document the referral is regarding a child death in the electronic case management system. For more information on child death cases, see PSM 713-08, Special Investigative Situations. Select the child is deceased and enter the date and place of death in the Person Profile Section in the child's electronic case record. The death of a child must be reported as outlined in SRM 172, Child/Ward Death Alert Procedures and Timeframes.

See PSM 715-3, Family Court: Petitions, Hearings, and Court Orders, Death of a Child Under the Court's Jurisdiction section, if the child who died is under the court's jurisdiction.

DOMESTIC VIOLENCE

A CPS referral in which the only allegation is domestic violence is not a sufficient basis for assigning the referral for investigation. To be assigned for investigation, the referral must also include information indicating the domestic violence has resulted in harm, likely harm, or threatened harm to the child(ren). Consider the potential adverse impacts, including trauma or mental harm, when making an assignment decision. Assignment should also be considered if the alleged perpetrator has engaged in any activity that would cause a reasonable person to feel terrorized, intimidated, threatened, or harassed, or has caused or threatened to cause physical or mental harm.

Issues that may assist in determining whether there is threatened harm in cases involving DV are:

- A weapon was used or threatened to be used in the DV incident.
- An animal has been tortured, deliberately injured, or killed by the perpetrator.
- A parent or other adult is found in the home in violation of a child protection court order or personal protection order.

- There are reported behavioral changes in the child (for example, a child's teacher describes how the child used to be an involved and highly functioning student, and now is withdrawn, doing poorly in coursework, or acting out with violence).
- Reported increase in frequency or severity of DV.
- Threats of violence against the child.
- Proximity and intensity of the incident in relation to the child.

For information on domestic violence cases; see, the Domestic Violence sections in PSM 713-08, Special Investigative Situations, and PSM 714-1, Post Investigative Services.

DRIVING UNDER THE INFLUENCE

When CI receives a referral in which the reporting person alleges a child is at imminent risk because the child is riding in a vehicle with an intoxicated driver, CI must direct the reporting person to contact law enforcement with a description of the vehicle, its last known location, license plate number, and identity of the driver, if known.

CI must assign referrals received from law enforcement or the prosecuting attorney when the referral alleges a person responsible for the health or welfare of a child has been arrested, charged, or convicted of operation of a motor vehicle while under the influence, and the child was in the vehicle.

INSECT INFESTATIONS

An allegation of neglect based solely on a child having head lice, or a home having an insect infestation in and of itself, is not an indicator of neglect and is not appropriate for assignment. Consider the child's age, cognitive abilities, verbal ability, and developmental level and the impact the infestation could have on the child when making the decision.

SUBSTANCE USE BY CARETAKER

Allegations only involving substance use by a parent, guardian, or person responsible, is not sufficient for CPS investigation. To assign for investigation, referrals containing allegations of

substance use must meet Child Protection Law (CPL) definitions of suspected child abuse and/or neglect.

Infants Exposed to Alcohol or Substances

CPS will investigate referrals alleging an infant was born exposed to substances not attributed to medical treatment when exposure is indicated by any of the following:

- Positive urine screen of the newborn.
- Positive result from meconium testing.
- Positive result from umbilical cord tissue testing.
- Confirmation by a medical professional of withdrawal symptoms in a newborn that are not the result of medical treatment.

Note: Medical marijuana and medication assisted treatment are considered medical treatment.

See PSM 716-7, Cases Involving Substances, for information on infants exposed to substances and alcohol.

PROPER CUSTODY OR GUARDIANSHIP

Referrals that only allege improper custody (a child residing with a person without legal guardianship or power of attorney) do not meet criteria for assignment. To be assigned, the referral must include allegations the person is unwilling or unable to meet the child's basic needs. See Guardianship/Power of Attorney in PSM 713-08, Special Investigative Situations, for more information on investigating these referrals.

SCHOOL ATTENDANCE AND HOME SCHOOLING

A referral in which the **only** allegation involves a child failing to attend school and/or alternate educational programming (educational neglect) is not sufficient basis for assignment. If the referral is initiated by non-school personnel, the person should be referred to the school district's attendance officer. If the referral is initiated by school personnel, they must be informed this issue falls under the provisions of the Compulsory School Attendance section of the School Code of 1976 (MCL 380.1561-380.1599), not Child Protection Law.

SIBLING-ON-SIBLING OR CHILD-ON-CHILD VIOLENCE

Referrals involving sibling or child-on-child violence should be evaluated to determine if the person responsible for the child's health or welfare was neglectful. If the referral is based **solely** on violence (physical abuse or sexual abuse) among siblings or other children in the home and includes no issue of parental neglect (or other child abuse and/or neglect allegations), transfer the referral to law enforcement. The referral to law enforcement must be made within 24 hours of CI receiving the referral.

See PSM 713-08, Special Investigative Situations, *Sibling-on-Sibling* Or *Child-on-Child Violence* section for more information on investigating these referrals. A minor child must never be investigated as an alleged perpetrator of child abuse and/or neglect unless they are the minor parent of an alleged child victim.

MEDICAL NEGLECT

CPS is responsible for responding to referrals that parents/legal guardians are neglecting their child's health and welfare by withholding medically indicated treatment. For more information when a referral is received regarding medical neglect of a disabled infant or medical neglect based on religious beliefs, see PSM 716-8, Medical Neglect of Disabled Children & Medical Neglect Based on Religious Beliefs.

VACCINATIONS

The Michigan Public Health Code (MCL 333.9215) provides exceptions to the immunization requirements. CPS does not investigate referrals involving parents who have chosen not to immunize their children.

NEWBORNS

CPS must conduct a full investigation if an infant is born to parents, identified as a perpetrator, who currently have a child(ren) in out-of-home care, or who are/were permanent wards because of a child abuse and/or neglect court action.

INTENT TO ADOPT

CPS must conduct a full investigation, if an infant is born to parents who currently have a child(ren) in out-of-home care or is/was a permanent ward because of a child abuse and/or neglect court action and the parents' intent is to have the newborn adopted. If it is later determined the infant was exposed to alcohol or substances not attributed to medical treatment, the referral must be assigned for investigation.

Note: This does not apply to ***Safe Delivery Act***, see below in this policy item.

BIRTH MATCH

Birth Match is an automated system that notifies CI when a new child is born to a parent who has previously had parental rights terminated in a child protective proceeding, caused the death of a child due to abuse and/or neglect or has committed a serious act of child abuse and/or neglect.

When a birth match occurs, the electronic case management system automatically generates a referral as an unassigned referral and the CI director receives an email alert that the referral has been generated. When CI receives the birth match referral, they must verify the match is accurate.

Inaccurate Match

If the match is inaccurate (the parent listed in the referral does not have history that would lead to Birth Match placement), the referral must be screened out.

Accurate Match

If the match is accurate and there is not an already pending investigation or open investigation regarding the new birth, the referral must be screened in and assigned for investigation.

See PSM 713-08, Special Investigative Situations, for information on investigating Birth Match.

SAFE DELIVERY ACT

Michigan law (MCL 712.1 et. Seq., 750.135, and 722.628) allows a parent(s) to surrender an unharmed newborn up to 72 hours old to

an emergency service provider (ESP). An ESP is a uniformed, or otherwise identified, inside-the-premises, on-duty employee, or contractor of a fire department, hospital or police station or a paramedic or an emergency medical technician when responding to a 911 call.

In situations where CI is contacted by an ESP and there is no evidence of child abuse and/or neglect, local offices and/or CI should direct the ESP to contact a public or private child-placing agency in that area directly responsible for placing a child in these situations.

The Safe Delivery website has a listing of private adoption agencies that will provide placement for an abandoned newborn. If there is no evidence of child abuse and/or neglect, the newborn is less than 72 hours old, and is voluntarily surrendered by a parent, CI must screen out the referral for investigation.

See NAA 255, Termination of Parental Rights, Voluntary Proceedings for Termination of Parental Rights section for information on the Safe Delivery Act as it pertains to American Indian children.

PREGNANCY AND SEXUALLY TRANSMITTED DISEASE

A referral involving a child under the age of 12 who is pregnant, or a child who is under the age of 12 and over the age of 1 month who has a sexually transmitted disease, must be screened in for investigation.

RUNAWAY AND MISSING CHILDREN

Routine referrals on runaway and missing children are not appropriate for investigation by MDHHS; however, careful consideration should be given to determine whether there are allegations of abuse and/or neglect. There are known risk factors that contribute to a child running away, including family dynamics, family violence, bullying, sexual abuse, and neglect. Some children are asked by their parents to leave home. If these children end up in the streets, without a place to stay, without support, and limited options to meet their basic needs, they are at greater risk of being trafficked.

HUMAN TRAFFICKING

The MDHHS Human Trafficking of Children Protocol was developed to guide case managers and other child welfare staff in assisting children who are victims of human trafficking. Human trafficking includes sex trafficking and labor trafficking.

Human trafficking referrals made by law enforcement that involve children must be screened in and assigned regardless of the alleged perpetrator meeting the criteria of a person responsible. The department can investigate trafficking conditions regardless of the role or status of the alleged perpetrator when law enforcement requests assistance to respond to help with the youth's trauma.

Human trafficking referrals made by individuals other than law enforcement must include information the alleged perpetrator meets the criteria for person responsible to be assigned for investigation. If the alleged perpetrator does not meet the criteria of a person responsible, the referral must be transferred to law enforcement.

Sex Trafficking

The act of subjecting a child to the recruitment, harboring, transportation, provision, patronizing, or soliciting for the purpose of a commercial sex act.

Sex trafficking is any incident that involves:

- Recruitment, harboring, transportation, provision, or patronizing of a child.
- Soliciting a child for a commercial sex act.
- Trafficking a child for a commercial sex act induced by force, fraud, or coercion.
- Any sex act of or with a minor in exchange for anything of value. This includes cash, drugs, jewelry, clothing, food, shelter, protection, or transportation.

Labor Trafficking

The recruitment, harboring, transportation, provision, or obtaining of a person for labor as a result of force, fraud, coercion, or manipulation. Labor trafficking can include, but is not limited to,

domestic servitude, forced labor in restaurants or salons, forced agricultural labor, or debt bondage.

RESOURCES

SDM Centralized Intake Assessment Policy & Procedures Manual.

POLICY CONTACT

Questions about this policy item may be directed to the Child-Welfare-Policy@michigan.gov.

OVERVIEW

This policy item details procedures for coordination with the local prosecuting attorney and law enforcement as required by Child Protection Law (CPL).

DEFINITIONS

Serious Mental Harm

An injury to a child's mental condition or welfare that is not necessarily permanent but results in visibly demonstrable manifestations of a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. MCL 750.136b(g).

Serious Physical Harm/Severe Physical Injury

Severe physical injury means serious physical harm to a child, as defined in MCL 750.136b(1)(f). Serious physical harm means any physical injury that seriously impairs the child's health or physical well-being, including but not limited to, brain damage, a skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprain, internal injury, poisoning, burn or scald, or severe cut.

PROCEDURE

Referral to Law Enforcement and Prosecuting Attorney

MCL 722.623(6) and MCL 722.628, Sec 8(1) require that within 24 hours of initial receipt of the referral, the department must notify local law enforcement and the prosecuting attorney about referrals involving the following allegations:

- Acts which would constitute 1st, 2nd, 3rd, or 4th degree child abuse (MCL 750.136b). Potential acts include:
  - Intentionally causing serious mental or physical harm.
  - Intentionally committing an act likely to cause serious mental of physical harm.

- A person's omission causes serious physical or mental harm.

- Possession of child sexually abusive material (MCL 750.145c).
- Sexual abuse or sexual exploitation including acts which would constitute 1st, 2nd, 3rd, or 4th degree criminal sexual conduct of a child and assault with intent to commit criminal sexual conduct (MCL 750.520b-750.520g).
- Manufacture (the production, preparation, propagation, compounding, conversion, or processing) of methamphetamine (MCL 333.7401c).
- Abuse or neglect is the suspected cause of a child's death MCL 722.628(3)(a).
- Child abuse or child neglect resulting in serious physical harm to the child (MCL 722.628(3)(c).
- The abuse or neglect was committed by a person **not** responsible for the child's health or welfare (for example, a teacher, teacher's aide, member of the clergy, or an individual 18 years of age or older who is involved in a youth program, etc.).
- Sex and labor trafficking includes recruiting, harboring, transporting, patronizing, soliciting, and making provisions for a child, knowing that a child will be subjected to forced labor or sex trafficking services. (MCL 750.462a - 750.462h)

MDHHS-2164, Law Enforcement and Prosecuting Attorney Notification Form

Case managers must generate and send the MDHHS-2164, Law Enforcement and Prosecuting Attorney Notification Form, to law enforcement and the prosecuting attorney's office of jurisdiction within 24 hours of receipt of the referral. This action must be documented in a social work contact and the form must be saved or scanned and uploaded within the electronic case record.

Note: Centralized Intake (CI) is responsible for forwarding the referral to the prosecuting attorney and law enforcement in referrals not assigned for investigation by Children's Protective Services (CPS).

Coordination with Prosecutors Office and Law Enforcement

The prosecuting attorney and the department in each county are required to adopt and implement a standard child abuse and neglect investigation and interview protocol. The DHS PUB 794, A Model Child Abuse And Neglect Protocol Utilizing a Multidisciplinary Team Approach, should be used as the model.

In addition to the situations requiring a referral to law enforcement and the prosecuting attorney in this policy item, the **case manager must also seek assistance from law enforcement for any referral in which it is necessary for the protection of the child(ren), a department employee, or another person involved in the investigation**; MCL 722.628(3).

Case managers must make efforts to coordinate and communicate with law enforcement in mutually conducted investigations.

Request for Delay of Investigation

If law enforcement requests a delay in starting an investigation, **communication and coordination must still occur to assess child safety as well as maintain standard of promptness for face-to-face contact.** The case manager should discuss these department requirements with law enforcement to determine the best approach to accomplish these objectives and maintain integrity of both investigations.

If law enforcement and/or the prosecuting attorney requests a delay in initiating an investigation, the case manager must contact their supervisor and county director (or designee) to determine how to proceed.

Reports

Case managers must request law enforcement reports for cases involving coordination with law enforcement. Document a summary of any reports of completed law enforcement investigations received, in a social work contact, and upload the document into the electronic case record.

Report to Prosecuting Attorney

A redacted DHS 154, CPS Investigation Report, must be sent to the prosecuting attorney within seven calendar days of supervisory approval for central registry cases involving:

- Death of a child.
- Serious physical harm/severe physical injury; see *definitions* in this policy item.
- Confirmed sexual abuse.
- Confirmed sexual exploitation.
- Confirmed exposure to or contact with methamphetamine production.

For proper redaction, see SRM 131, Confidentiality.

A social work contact must be added to document the redacted report was sent to the prosecuting attorney.

Law Enforcement Replacement Interviews

Use of replacement interviews by law enforcement for alleged perpetrators, other adults, and children are allowed when meeting specific criteria indicated in this item. The use of law enforcement interviews does not relieve the case manager from conducting interviews needed to accurately complete case assessments and a thorough CPS investigation. If the replacement interview fails to address all allegations and obtain necessary information for completion of case assessments for a thorough CPS investigation, the case manager must coordinate with law enforcement for subsequent interviews in cases with an ongoing criminal investigation.

Law Enforcement Contact with Children

Face-to-face contact with all alleged child victims must be made by a case manager. If a case manager cannot locate a child or is unable to access a child, law enforcement may make the initial face-to-face contact. The case manager's efforts to locate and/or

access the child prior to requesting law enforcement assistance must be documented in a social work contact. If law enforcement makes the initial face to face contact, a case manager must make face-to-face contact with all alleged child victims seen by law enforcement within 24 hours of law enforcement contact, to assess safety and well-being and coordinate any necessary safety planning.

See Face to Face Contacts by Law Enforcement in PSM 713-01, CPS Investigation - General Instructions, for more information.

If law enforcement has conducted an interview with a child during an investigation, the case manager may use the interview to satisfy policy requirements for the interview if the following factors are met. Interviews with a child may only be used if the law enforcement officer is trained in forensic interviewing techniques and is able to verify that forensic interviewing techniques were used to conduct the interview. The interview must also contain proper inquiry into all allegations.

Documentation of Law Enforcement Interviews

Case managers should use the date and time at which law enforcement conducted the interview and should indicate the interview was completed by law enforcement.

The social work contact must document the law enforcement officer is trained in the forensic interviewing protocol and forensic interviewing protocol techniques were used.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox (Child-welfare-policy@michigan.gov).

OVERVIEW

This policy provides a general overview of required activities and guidance case managers must consider in a Children's Protective Services (CPS) investigation.

DEFINITIONS

Mandated Reporter

An individual required to report suspected concerns of child abuse or neglect under MCL 722.623.

Person Responsible

"Person responsible for the child's health or welfare" means a parent, legal guardian, individual 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(1)(e) or 8(8), nonparent adult; or an owner, operator, volunteer, or employee of 1 or more of the following:

- A licensed or registered child care organization.
- 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, 1979 PA 218, MCL 400.14.
- A court-operated facility.

Note: This includes licensed individuals providing respite care.

- ***Non-parent adult***: A person who is 18 years of age or older and who, regardless of the person's domicile, meets all of the following criteria in relation to the child, MCL 722.622:
  - Has substantial and regular contact with the child(ren).
  - Has a close personal relationship with the child(ren)'s parent(s) or with a person(s) responsible for the child(ren)'s health or welfare.

- Is not the child(ren)'s parent(s) or a person(s) otherwise related to the child by blood or affinity to the third degree.

Note: Third degree relatives include parents, grandparents, great-grandparents, brothers, sisters, aunts, uncles, great-aunts, great-uncles, nieces, and nephews.

Note: Adults, other than the primary licensed caregiver(s), residing in a respite placement are considered a nonparent adult.

Note: This includes nonparent adults residing with a child when the referral involves sexual exploitation (human trafficking).

COMMENCEMENT

Commencement must occur within 24 hours following report to Centralized Intake (CI), MCL 722.628(1). The *priority response criteria* determines whether the commencement must occur within 12 or 24 hours; see PSM 712-1, CPS Intake.

Commencement means to begin the investigation with any activity including, but not limited to:

- Review of case history.
- Gathering of evidence.
- Case planning with supervisor.
- Making successful investigation contacts.

Note: If using review of case history, information gained must be documented in the history/trends section, as well as a social work contact in the electronic case management system, indicating commencement was completed by a review of case history.

Only one social work contact should be selected as commencement within an investigation unless there is an *accept and link* assignment to the case; see PSM 713-08, Special Investigative Situations.

CONTACT WITH CHILDREN

Alleged Child Victims

The case manager must make face-to-face contact to assess child(ren) safety and well-being with each alleged child victim within designated timeframes (24 or 72 hours), as determined by the Priority Response Criteria; see PSM 712-1, CPS Intake.

Case managers must make face-to-face contact with all alleged child victims even when the alleged child victims have been seen by law enforcement as outlined below in *Face-to-Face Contacts by Law Enforcement* in this policy item.

If an alleged child victim is identified after the investigation has been assigned, face-to-face contact with the newly identified alleged child victim must occur within 24 hours if the allegations have not already been addressed per policy requirements with the newly identified alleged child victim as demonstrated in a social work contact.

Note: The newly identified alleged child victim must be added to the investigation as an alleged child victim within 24 hours of identification and all policy requirements must be completed.

Other Children

During an investigation, case managers must attempt **face-to-face contact** with the following other (non-victim) children:

- Minor children of the alleged perpetrator(s).
- Children who reside in the alleged perpetrator(s) home or who visit the home as part of a court ordered custody arrangement or other visitation agreement.

Exception: For other (non-victim) children who are in a legal guardianship, it is sufficient to verify their well-being via a telephone call to the guardian.

When **face-to-face contact** cannot occur, document:

- The barriers to making contact.

- Contact with a person able to provide reliable information concerning the child's well-being.

All children requiring contact in an investigation must be added as investigative persons to the case within the electronic case management system.

When a Parent or Adult is Not Home

Case managers must not enter a home when an adult is not present to provide permission to enter the home and speak with the child(ren). If an adult is not present at the home, case managers may not request the child(ren) step outside to interview them, even if the child(ren) agrees or suggests this solution.

If a referral alleges that a young child is home alone or a child is at imminent risk of harm and no adult is present in the home, the case manager should contact law enforcement for assistance; see PSM 713-08, Special Investigative Situations.

Face-to-Face Contacts by Law Enforcement

Face-to-face contact with all alleged child victims must be made by a case manager. If a case manager cannot locate a child or is unable to access a child, law enforcement may make the initial face-to-face contact. The case manager's efforts to locate and/or access the child prior to requesting law enforcement assistance must be documented in a social work contact. If law enforcement makes the initial face-to-face contact, a case manager must make face-to-face contact with all alleged child victims seen by law enforcement within 24 hours of law enforcement contact to assess safety and well-being and coordinate any necessary safety planning.

Case managers must still commence an investigation within the required priority response timeframe when law enforcement makes the initial face-to-face contact.

For more information on application and documentation of replacement contacts by law enforcement; see PSM 712-3, Coordination with Prosecuting Attorney and Law Enforcement.

Even in situations where contact requirements are met by law enforcement, case managers must take steps to ensure the safety of the child(ren) involved.

Interviews

If able, interviews with the child(ren) must occur to determine if the child(ren) is/are being abused and/or neglected and if safety planning, supports, or services are needed for the child.

Legal Parent/Legal Guardian Consent

Case managers do not need consent from a legal parent or legal guardian prior to contact with a child if:

- The child is an alleged victim of child abuse or neglect.

AND/OR

- The case manager has reason to believe the alleged abuse or neglect occurred.

Note: If during the investigation, information is obtained that gives reason to believe a child who was originally identified as a non-victim is an alleged victim of abuse or neglect, consent from a legal parent or legal guardian is not needed.

Note: A putative parent cannot consent to contact with the child.

If legal parent or legal guardian consent is not obtained, documentation in a social work contact must demonstrate why consent from a legal parent or legal guardian was not required if contact was made with a child.

If at any time during an investigation, a case manager no longer suspects abuse or neglect, further contact with any child requires prior consent of a parent or legal guardian. *Schulkers, et al. v Kammer, et al., 955 F3d 520 (CA 6, 2020)*

Reasonable suspicion of abuse and/or neglect exists when under the current known facts and/or circumstances, there are indicators to demonstrate abuse and/or neglect may have occurred. Reasonable suspicion no longer exists when based on the known facts and circumstances, the report of suspected child abuse or neglect cannot be confirmed.

Legal Parent/Legal Guardian Notification After Interview

If the child(ren) are contacted at school, regardless of whether prior parental consent occurred, the case manager must notify the child(ren)'s legal parent or legal guardian the case manager contacted the child at school. This notification must occur as soon as possible after the interview. A temporary delay in notification is permitted, if the notice would compromise the safety of the child or the child's siblings, or the integrity of the investigation (MCL 722.628(8)).

Forensic Interviewing Protocol

The DHS Pub 779, Forensic Interviewing Protocol, should be used to interview all age and developmentally appropriate children. Case managers must document use of the protocol for the interview as well as qualitative steps outlined within the protocol. If the protocol is not used, the reason must be documented. Children must not be interviewed in the presence of an alleged perpetrator, MCL 722.628c.

If an interview is conducted at a children's assessment center or child advocacy center, Michigan Department of Health and Human Services (MDHHS) must not maintain copies of video/audio recording and should not video tape interviews. Case managers should observe and document interviews occurring at a children's assessment center or a child advocacy center.

Contact at Schools and Other Institutions

Schools and other institutions are required to cooperate with the department during an investigation. Case managers must review the following with the designated school staff person, MCL 722.628(8) and (9):

- Prior to the interview, discuss the department's responsibilities and the investigation procedure.
- Following the interview, discuss the response the department will take as a result of contact with the child. Sharing of information is subject to confidentiality provisions; see SRM 131, Confidentiality.

NOTE: If the school does not cooperate, this does not relieve or prevent the department from proceeding with the investigation.

If access to the child occurs within a hospital, the investigation must be conducted so as not to interfere with the medical treatment of the child(ren) or other patients, MCL 722.628(10).

Assessment of Alleged Injuries

When allegations include injury on the child(ren)'s body, case managers are required to make efforts to view alleged marks, bruises, or other injuries. No child(ren) shall be subjected to a search which requires the child to remove their clothing to expose buttocks, genitalia, or breasts of child(ren), at any age.

If the area of injury includes the child(ren)'s buttocks or genitalia, case managers may view the buttocks or genitalia of the child(ren) up to the age of 6 with parent or legal guardian consent and in the presence of another adult (which may be the child's consenting parent or legal guardian). If the child(ren) is age 6 or older, case managers must request the parent/caregiver take the child(ren) for a medical examination. See PSM 713-04, Medical Examination and Assessment.

Vulnerable Children

Children may be at greater risk of abuse and/or neglect based on several identified factors. A child is considered a vulnerable child if at least one of the following factors are true:

- **Age 0 to 5 years**. Any child in the household five years of age or younger. Children in this age range are considered more

vulnerable because they are less verbal and less able to protect themselves from harm. For example, these children have less capacity to retain memory of events. Infants are particularly vulnerable because they are nonverbal and completely dependent on others for care and protection. Their normal developmental stages (for example, crying to communicate, toilet training) also make them more vulnerable due to increased caregiver stress.

- **Significant diagnosed or suspected medical or mental health concern**. Any child in the household has a diagnosed or suspected medical or mental health concern that significantly impairs the child's ability to protect themselves from harm, or a diagnosis may not yet be confirmed, but preliminary indications are present, and testing/evaluation is in process OR the child is on a waitlist for evaluation. Examples include, but are not limited to, severe asthma, severe depression, and medically fragile (for example, requires assistive devices to sustain life).

- **Not readily visible in the community**. The child is isolated or less visible within the community (for example, the child may not have routine contact with people outside the household, and/or the child may not attend a public or private school and/or is not routinely involved in other activities within the community). Children who are less visible in their community are more likely to have signs of abuse/neglect go unnoticed or unreported, and they are less able to reach out to others for assistance.

- **Diminished developmental/cognitive capacity**. Any child in the household has diminished developmental/cognitive capacity that affects their ability to communicate verbally or to care for and protect themself from harm (for example, cannot communicate or defend themself, cannot get out of the house in an emergency situation if left unattended).

- **Diminished physical capacity**. Any child in the household has a physical condition/disability that affects their ability to protect themselves from harm (for example, cannot run away or defend themselves, cannot get out of the house in an emergency situation if left unattended).

When a child has been identified as vulnerable based on the above factors, the case manager must contact one or more individuals, excluding the perpetrator, with knowledge of the child's needs. Case managers should also obtain and document the following information in a social work contact:

- Concerns regarding potential child abuse and/or neglect.
- The caregiver's ability to meet the needs of the child.
- If the child has any unmet medical, mental health, or safety needs.

Note: Vulnerable child policy applies to any child(ren) who requires a face-to-face contact; see *Contact with Children* section above.

CONTACT WITH ADULTS

During an investigation, **face-to-face contact** must be attempted with the following:

- Legal and putative parents, guardians, or caretaker(s) of the alleged child victim(s).
- Alleged perpetrators.

At minimum, a **telephone contact** must be attempted with the following:

- Other adults residing in the home with the alleged child victim(s).
- Legal parents of children not identified as victims but associated with the case.
- Legal parent(s) of children who reside in the alleged perpetrator(s) home or who visit the home as part of a court ordered custody arrangement or other visitation agreement.

When required face-to-face or telephone contact cannot be made, case managers must document the barriers that prevented contact in a social work contact.

All adults with whom face-to-face contact is required, must be added as investigative persons to the case in the electronic case

management system. Other adults may be added as associated persons.

Interview Requirements

Engagement with all adults, parents, and alleged perpetrators must be professional, respectful, culturally sensitive, non-judgmental, and non-threatening.

Case managers must display their MDHHS identification, clearly identify themselves as representing CPS, and inform the individuals being interviewed of the referral and identified concerns.

Interviews with the alleged victim's parents, guardians, and alleged perpetrator(s) should focus on the specific referral and any other concerns observed or reported that may impact child safety and/or future risk.

Case managers must attempt to obtain the following information from the child's parents, guardians, and the alleged perpetrator:

- Verification of identity and previous names.
- If the person is a licensed foster care or day care provider.
- Native American heritage for self and child(ren).
- Names and dates of birth of their children.
- Friend of the Court involvement.

Case managers must also inquire of any out of state history within the previous 10 years for all alleged perpetrators.

If the person being interviewed is the non-custodial parent of the alleged child victim, and there is a Friend of the Court order, the DHS-1450, How to Change a Parenting Time Custody Order, must be offered to the parent.

The primary objectives of the contact with the child(ren)'s parent(s), guardian(s), and the alleged perpetrator(s) is to gather information to:

- Assess the referral allegations and identify the child(ren) who may have been involved/impacted.

- Assess the caregiver's ability to meet the needs of the child(ren).
- Identify any immediate child(ren) safety concerns and help the family develop a safety plan, if warranted.
- Identify strengths and needs of the family and to coordinate access to resources.
- Gather information to accurately complete risk and safety assessments.

Support Persons

An adult may request a support person be present while being interviewed. Prior to an interview with a support person(s) present, the case manager must:

- Ensure the request or use of a support person(s) does not delay or impede any necessary safety planning.
- Inform the support person(s) at the beginning of the interview that information obtained during the interview is confidential and release of this information has civil and criminal penalties.
- Obtain consent and necessary signatures on the DHS-860, CPS Support Person Letter.

Absent Parents

Case managers must document efforts to identify and locate parents. The case manager should use the Absent Parent Protocol to identify and locate parents in an investigation, if needed.

Parents Who Are Incarcerated

To locate a parent(s) who is incarcerated, the following resources may be used:

- Michigan Department of Corrections.
- Federal prisons.
- Out-of-state facilities.
- County jails.

- VINELink.
- Contact the facility.

DIFFICULTY MAKING CONTACT/UNABLE TO LOCATE

If a case manager is unable to contact or locate an adult or family, documentation of efforts to contact the adult, family, and/or child(ren) must be documented on the DHS-991, Diligent Search Checklist. All efforts must be clearly documented in social work contacts in the electronic case management system. Case managers may also contact the MDHHS assistance case manager for assistance in locating a family; see BAM 220, Case Actions.

Imminent Risk of Harm to the Child(ren)

If the whereabouts of a child(ren) cannot be verified, and evidence indicates the child(ren) is at imminent risk of harm, the case manager must contact local law enforcement in the jurisdiction where the child is alleged to reside. The case manager must explain why the child(ren) is at imminent risk and request law enforcement attempt to verify the child(ren)'s safety. The case manager must provide law enforcement with the last known details of the whereabouts of the child(ren).

Alleged Perpetrator(s) - Refuses to Cooperate/Unable to Locate

Case managers must make attempts to interview the alleged perpetrator(s). When a child(ren) is at imminent risk of harm and the case manager is unable to locate the alleged perpetrator(s), or the alleged perpetrator(s) is not willing to cooperate, the case manager must take steps to ensure the alleged perpetrator(s) does not have contact with the child(ren). Case managers must safety plan with a non-offending parent or caregiver to ensure child safety, when able to do so. If there is imminent risk of harm to the child(ren), consider filing a petition asking the court to remove the perpetrator(s) from the home.

For information on filing a petition, see PSM 715-3, Family Court: Petitions, Hearings and Court Orders.

Child Found in Another State

In instances where it is indicated an alleged child victim or non-victim household child is visiting or residing in another state, country, territory, etc., the following steps must be taken and documented in social work contacts:

- Verbally confirm with the adult providing care for the child, that the child is with them.
- If the child is an alleged victim, request assistance from CPS in the other state or jurisdiction to conduct an interview with the child or request law enforcement verify the well-being of the child, if the CPS agency is unable to respond timely.

CASES INVOLVING MULTIPLE COUNTIES

In cases in which parents, caregivers or children are in other counties, **requests for courtesy contacts must be honored.** Courtesy case managers and supervisors must be assigned within the electronic case management system. All activities completed by the courtesy case manager must be documented in social work contacts.

Disputes between counties must be referred to the appropriate Business Service Center director(s) for resolution.

When Families Move or Visit Out of County

When a family with an active CPS investigation moves or is temporarily visiting outside of the assigned county of responsibility, case managers in the assigned county and the county where the family now resides or is temporarily visiting, should communicate to discuss the nature of the active CPS investigation. Case managers should coordinate to ensure child safety and timely completion of investigation requirements.

- If the family is living in another county **temporarily**, the assigned county of responsibility should outline the need for courtesy interviews and referral of services, and request these be completed by the county of temporary residence. The county of responsibility must provide primary case management until there is confirmation the family has moved permanently.
- If the family has **moved** to a new county, the supervisor must transfer the active CPS investigation in the electronic case management system to the new county of residence for the family.

Disputes between counties must be referred to the appropriate Business Service Center director(s) for resolution.

FIREARM ASSESSMENT

The following assessment is intended to be used when a case manager becomes aware of a firearm in a home; for example, when completing a case contact during an open case. The goal of this assessment is to evaluate the safety of the child, assist with ensuring child safety, and guide caregivers through the safe storage of firearms.

Note: Child welfare staff must continue to utilize licensing rules for licensed foster homes. Case managers must also follow criteria regarding weapons, firearms, and/or ammunition outlined in the MDHHS-5770, Relative Placement Safety Screen, and MDHHS-3130-A, Relative Placement Home Study.

ASSESSING THE SAFETY OF THE CHILD

Storage of the firearm(s) and ammunition.

- Is the firearm locked by a cable lock, trigger lock, in a gun safe, in a solid metal gun case, or in a solid wood gun case?
    - If answered *Yes*:
        - Is the key to the cable/trigger locks, gun safe, etc. accessible to youth?

If yes, consider the following caregiver and child factors collectively when assessing the safety of the child and whether there are concerns of child abuse or child neglect.

- If answered *No*:
  - Is the firearm inaccessible to the child?
  - Is the firearm unloaded?
  - Is the firearm separate from the ammunition?
  - Is the ammunition stored in a locked location?
  - Is the ammunition inaccessible to the children?

If there are any *No* responses to questions 1-5, consider the following caregiver and child factors collectively when assessing the safety of the child and whether there are concerns of child abuse or child neglect.

CAREGIVER FACTORS

- Caregiver's response to the child's access to a firearm.
- Caregiver's child welfare history as it relates to inadequate supervision or other findings that may elevate concerns of child's access to a firearm.
- Familial safety plans related to firearms.
  - Do you believe your children know there are guns in your home?

CHILD FACTORS

- Child's knowledge of where firearm is located based on child's report.
  - Have you ever seen a real gun?
    - If yes, where?
    - If yes, assess factors below.
- Are there any guns in your home?

- If no, do not imply or confirm there are guns in the home.
- If yes, assess factors below.

- Likelihood child could gain access to firearm or child did gain access to firearm.
- Child's age.
- Child's developmental and maturity level.
- Special needs of the child, including unruly or delinquent behavior and/or mental health needs. Assess any statements made by the child to use a firearm to harm self or others.
- Child's awareness of firearm safety, including formal or informal firearm education, hunter's safety, or similar training or education.

Upon review of the factors above and all evidence gathered, assess if harm has occurred, or is likely to occur, without intervention. For any case where a safety concern is identified, a safety plan must be completed and documented in the electronic case management system. The assigned case manager should verify child safety in relation to firearms in the home following implementation of a safety plan.

Note: When working through a safety plan, please be advised that people have the right to the possession of usable firearms in the home. District of Columbia v. Heller, 554 US 570, 572 (2008).

SAFETY PLANNING

Case managers must consistently assess the safety and need for protection of all children during an investigation. Safety plans must:

- Address immediate safety concerns (a safety plan is not a treatment plan).
- Be developed with the input and assistance of parents, family members, and tribe (if applicable).
- Include formal and informal supports and services.

- Include proactive and reactive steps.
- Be realistic, achievable, and understood by the parent/caregiver.
- Specify roles and expectations of pertinent individuals involved in the plan.
- Be modified as other safety concerns arise.
- Build on the strengths of the parent/caregiver.

Safety plans must be documented within a social work contact and uploaded into the electronic case management system.

Temporary Voluntary Arrangements

As part of a safety plan during CPS involvement, **a parent or a legal guardian may decide to allow** their child(ren) to temporarily stay with the other parent, a relative, or a friend, as the parent determines appropriate and/or as part of the parent's safety plan.

In such circumstances, **discussions of a temporary voluntary arrangement must be led by a parent or legal guardian; and the decision to change, extend, or stop the arrangement rests with the parent.** During a temporary voluntary arrangement, case managers and/or temporary caregivers may not restrict a parent's physical custody or access to their child(ren). Temporary voluntary arrangements are meant to be short-term and should not be used in lieu of court involvement or removal.

A parent’s right to care and custody of their children must not be restricted without the parent’s consent or court involvement. Restricting these parental rights would be a violation of that parent’s 14th Amendment rights. Restricting a parent's clearly established right to the companionship and care of their children without arbitrary government interference is a violation of the Due Process Clause of the Fourteenth Amendment.

When safety concerns exist that do not necessitate court involvement, and the parent secures a temporary voluntary arrangement for their child(ren), the case manager must ask the

parent to sign the MDHHS-5433, Temporary Voluntary Arrangement, and upload the form into the documents section within the electronic case management system.

Like any other safety plan established during CPS involvement, case managers must continuously monitor the effectiveness of the safety plan, verify the child(ren)'s continued safety, and assist the family with any additional services and supports needed. When there is no longer a need for the temporary voluntary arrangement, the case manager must notify the family, and document this in a social work contact. If there is a need to extend the timeframe of the temporary voluntary arrangement, a Family Team Meeting (FTM) must be held to determine next steps. For information on FTMs, see PSM 714-1, Post-Investigative Services.

NOTE: The parent(s) has the right to end a temporary voluntary arrangement. If this occurs, the case manager must immediately assess the safety of the child(ren) and request an FTM to determine next steps.

Screened Out Referrals

The case manager must review screened out referrals to determine if any new or additional safety planning may be needed based on screened out allegations.

The case manager must document in a social work contact the following:

- Intake ID(s) of screened out allegations.
- Acknowledgement that new allegations have been reviewed.
- Whether additional safety planning is needed.

SERVICE PROVISION

When a child(ren) can remain safely in their own home with services, include caregivers in coordinating services that build on caregiver strengths. Identify and implement services that will adequately prevent harm to the child(ren) by supporting the family. Intensive home-based services should be made available to families within 24 hours to alleviate risk and stabilize the family.

Services may be continued without initiating legal action if a child(ren) can remain in their own home safely, and the caregivers are willing and able to voluntarily participate in services to improve conditions for the child(ren).

Relative care and/or other family resources may provide support to parents as they improve their skills and work with services; see PSM 714-1, Post-Investigative Services, *Servicing Engagement* section.

COLLATERAL CONTACTS

Collateral contacts should be made to thoroughly assess referral allegations regarding the child(ren)'s safety. Examples of individuals who may be able to provide pertinent information are:

- Witnesses to the alleged abuse/neglect.
- Relatives and friends.
- Non-parent adults.
- Teachers/other school staff.
- Medical provider(s).
- Mental health provider(s).
- Neighbors.
- Reporting person(s).
- Service providers.

Case managers should request reports from law enforcement, mental health providers, physicians, emergency medical services (EMS), and other entities, when applicable, to the investigation. Reports should be summarized in a social work contact and uploaded into the document section within the electronic case management system.

Requesting Medical and Mental Health Record Information

The Child Protection Law, the Public Health Code (MCL 333.2640 & 333.16281) and the Mental Health Code (MCL 330.1748a) provide the legal authority and obligation for medical and mental health providers to share their records with CPS during an

investigation of suspected child abuse or neglect, even without the client's consent.

CPS must request the records in writing, using the DHS-1163-M, Children's Protective Services Request for Medical Information, or DHS-1163-P, Children's Protective Services Request for Mental Health Information. The DHS-1555, Authorization to Release Confidential Information, can also be utilized to request medical information that is not pertinent to the CPS investigation.

Note: The DHS-1163-M, Children's Protective Services Request for Medical Information, may only be used to obtain a child's medical information. To obtain medical information for an adult, the DHS-1555 must be utilized.

Medical and mental health providers shall release pertinent medical and mental health records to CPS case managers involved in an investigation within 14 days after receipt of the request for such records.

If the medical provider denies the written request, the local CPS office must send a copy of the denied request to the Child Welfare policy mailbox(Child-Welfare-Policy@michigan.gov). Include in the subject line of the email: denied medical records request.

In an emergency, the local CPS office may request assistance in obtaining records from the local prosecuting attorney and Family Division of Circuit Court.

OBSERVATION OF HOME ENVIRONMENT

Case managers must view the primary residence of the alleged victim child(ren), as well as the location where the alleged abuse and/or neglect occurred, if applicable. If the allegations are about the conditions of the home, case managers must document home observations in a social work contact in the electronic case record.

Safe Sleep

The sleep environment of child(ren) under 12 months of age must be observed and documented. Infants under 12 months should not sleep on couches, inflatable mattresses, or in a bed with adults or

other children. Infants should sleep alone in a crib, portable crib, bassinet or pack ‘n play (play yard) with only a firm mattress and tightly fitted sheet for every sleep time. No pillows, blankets, comforters, stuffed animals, or other objects should be in the infant's sleep area. Car seats, swings and other sitting devices are not recommended for routine sleep.

Case managers must discuss safe sleep practice with the parent/caregiver. If items needed for safe sleep are not available in the home, case managers should assist the family with obtaining needed items. This should be documented in a social work contact in the electronic case record.

HISTORY/TRENDS

Case managers must document a thorough search of history/trends, on all the following investigation persons for every investigation:

- Legal parent(s) of the alleged child(ren) victim(s) where they were an alleged or confirmed perpetrator or child victim.
- Putative parent(s) of the alleged child(ren) victim(s) where they were an alleged or confirmed perpetrator or child victim.
- Legal guardian(s) of the alleged child(ren) victim(s) where they were an alleged or confirmed perpetrator or child victim.
- Alleged or confirmed perpetrators(s).
- Alleged or confirmed child(ren) victim(s).

Note: Documentation of history/trends must clearly state each individual that a search was completed on, including prior legal names, maiden names, and aliases.

Assessment of history/trends must address the following areas:

- Number of previous investigations, categories, and timeframes.
- Previous court involvement and out of home placements.
- Broad trends/patterns for all previous child welfare cases.
- Previous service referrals and participation in services.
- Overall strengths and barriers for the family.

- Relationship between previous cases and current case.
    - This includes an assessment of history of the legal/putative parent/legal guardian as both an alleged or confirmed perpetrator and/or child victim.
- Central registry information for the following:
    - Legal and putative parent(s) of the alleged child(ren) victims.
    - Legal guardian(s) of the alleged child(ren) victim(s).
    - Alleged or confirmed perpetrators(s).

Note: If a central registry clearance was completed as part of a preliminary investigation, case managers may use these results for history/trends. For information on preliminary investigations; see PSM 712-1, CPS Intake.

If applicable, out of state history must also be assessed for all alleged perpetrators in any state in which residency is reported within the previous 10 years. All results for the above areas must be documented and detailed in the *history/trends tab* of the electronic case record.

New Investigations with Prior Central Registry (No due process date) Listing

If the central registry inquiry reveals that a perpetrator listed on the registry does not have a due process date (a date appropriate notice provided) in the electronic case management system, the current investigator must provide notice. See PSM 713-13, Central Registry and Confirmed Perpetrator Notification, *New CPS Investigation* subsection for investigative persons notification process.

CASE CONFERENCE

Case conferences between the case manager and supervisor must occur at least once within 30 days of the date of the referral. When an extension is requested, a case conference must be held during each extension period. Case conferences must occur as often as necessary to ensure child safety and to develop and assess safety

plans. Case conferences must be documented in a social work contact selecting supervision as the contact type and narrate only that the conference occurred.

ADDITIONAL INVESTIGATION ACTIVITIES

Additional investigation activities may be required, including:

- Criminal history check for the following; SRM 700, Law Enforcement Information Network (LEIN):
  - On all alleged perpetrators and adults residing in the home of the alleged perpetrator when there are allegations of:
    - Sexual abuse.
    - Physical injury.
    - Sex or labor trafficking.
    - Domestic violence, and/or
    - Substance use, sales, or production.
  - On all household members when considering placement with non-custodial parents and relatives; see PSM 715-2, Court Intervention and Placement of Children.
  - During any investigation when the case manager believes a LEIN clearance will provide pertinent information.
- Medical assessment; see PSM 713-04, Medical Examination and Assessment.
- Plan of Safe Care; see PSM 716-7, Cases Involving Substances.

Early On®

As a requirement of the Child Abuse Prevention and Treatment Act (CAPTA), 42 USC 5101 et. seq., case managers must refer all confirmed victims under the age of three to Early On in the following:

- Cases classified as category I and II.

- Cases in which the child(ren) was/were born affected by substances; see PSM 716-7, Cases Involving Substances for more information.

Special consideration must be given to children under the age of three who have medical conditions which could impact child development. In these situations, regardless of the category, the child(ren) with an identified condition should be referred to Early On.

The case manager must notify the family of the referral to Early On and ask the caregiver to sign the DHS-1555-CS, Authorization to Release Confidential Information. Completion of the DHS-1555-CS allows MDHHS to receive the Early On evaluation results and any plan for services, if applicable.

Case managers should identify developmental, cognitive, social, emotional, and/or medical concerns of the child(ren) when completing the referral. Information regarding the family may be included in the general information section.

TIME FRAME FOR COMPLETION OF INVESTIGATION

Investigations must be completed within 30-calendar days from the department's receipt of the referral unless an extension is granted.

Extension Request

In some situations, completing an investigation may require an extension of the 30-calendar day standard of promptness (SOP). When requesting an extension, case managers must document the reasons for the extension and submit an extension request prior to the end of the 30-calendar day SOP in the electronic case management system. **Extensions are not to be approved solely for the purpose of meeting the SOP.** Supervisory approval can only occur for the following circumstances:

- Obtaining medical records, or a second medical opinion to verify an injury or medical condition.

- Obtaining mental health evaluations, reports, or records necessary to reach an accurate case disposition.
- Coordinating interviews with law enforcement necessary to reach an accurate case disposition.
- Coordinating interviews with other states or counties necessary to complete a thorough investigation.

Extensions which do not fall under these circumstances may be allowed, if reviewed and approved by the Children's Services Administration (CSA) senior deputy director or their designee. Before requesting the CSA senior deputy director's approval, case managers must complete and document all requirements detailed in section, *Extension and Overdue Investigation Requirements* in this item.

The CSA senior deputy director or their designee's approval of an extension must be documented in the supervisor approval section in the electronic case record as well as in social work contacts, and the approval, such as an email approval, must be scanned and uploaded to the document section.

Extension and Overdue Investigation Requirements

Case managers requesting an investigation extension, or for investigations going overdue (without an extension request), must complete all the following within 30-calendar days from the date of the referral, and within every 30-days thereafter:

- Face-to face contact with each alleged child victim(s).
- Safety assessment.
- Contact with parent/caregiver(s) of each victim.

Note: For extension requests, a face-to-face contact with each alleged child victim(s) must have occurred within 7 business days prior to supervisory approval of the extension.

Case managers must continually assess the need to implement or revise any safety plans to ensure child safety throughout the remainder of the investigation.

Extension Approval

If an extension of the 30-calendar day investigation is requested, the extension must be reviewed and approved by a supervisor.

PHOTOGRAPHS

Case managers may take photographs to capture evidence for an investigation. Taking photographs of injuries or conditions is a preferred practice for documenting evidence. Case managers must not take photographs of the child's genitalia, buttocks, or breasts of children, at any age. Case managers may only accept photographs from law enforcement and/or medical professionals. If photographs of injuries to these areas are needed for evidence, they must be taken by medical personnel during a medical examination. Case managers may consult with medical professionals to request that photographs of injuries to these areas be taken.

All photographs taken for the purpose of the investigation must be uploaded into the document section of the electronic case record. Supervisors must review all photographs prior to approving an investigation extension or disposition.

COMPLETION OF INVESTIGATION

The investigation must include the systematic, objective, and un-biased examination of facts and evidence which support the determination that a confirmation of child abuse and/or child neglect exists or does not exist.

No Preponderance or Evidence of Abuse/Neglect

If child abuse or child neglect is not confirmed, the case must be classified as a Category IV or V. A no evidence decision (Category V) is appropriate for investigations where all allegations were based on false or erroneous information, or the family cannot be located.

Preponderance of Evidence of Abuse/Neglect

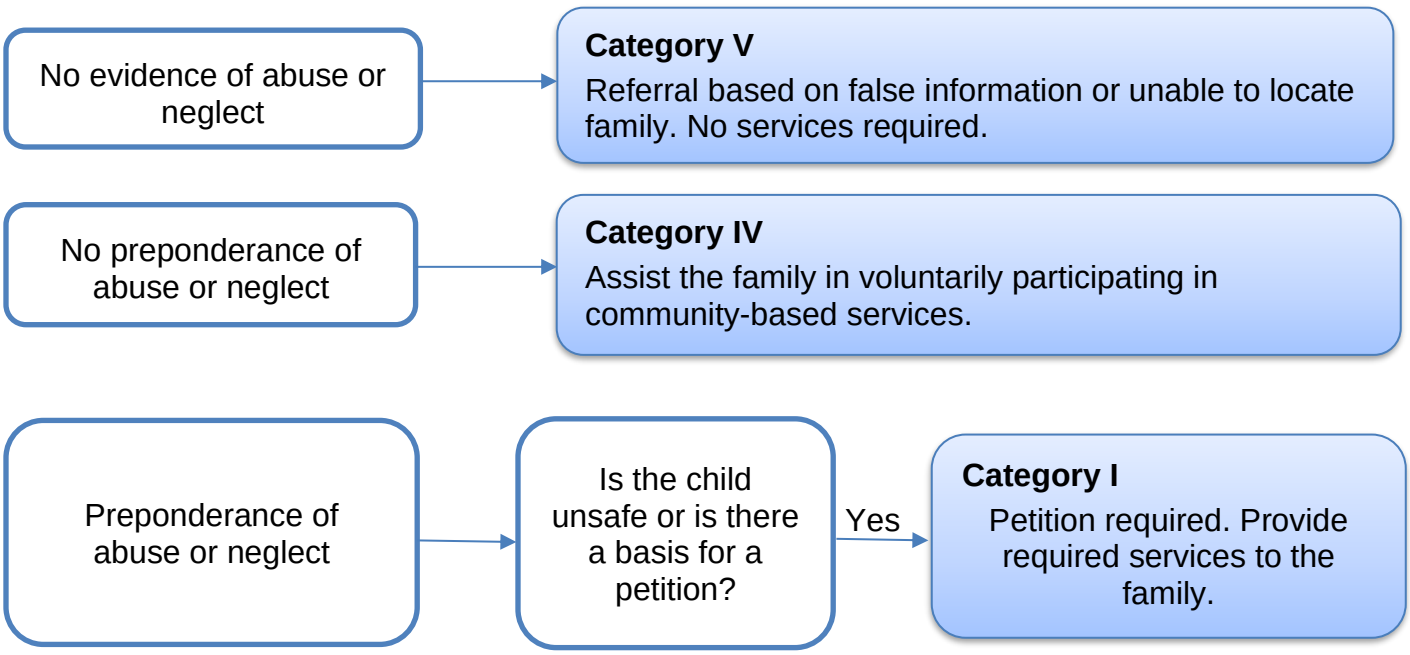
If evidence of child abuse or child neglect is confirmed, the case must be classified as a Category I, II, or III.

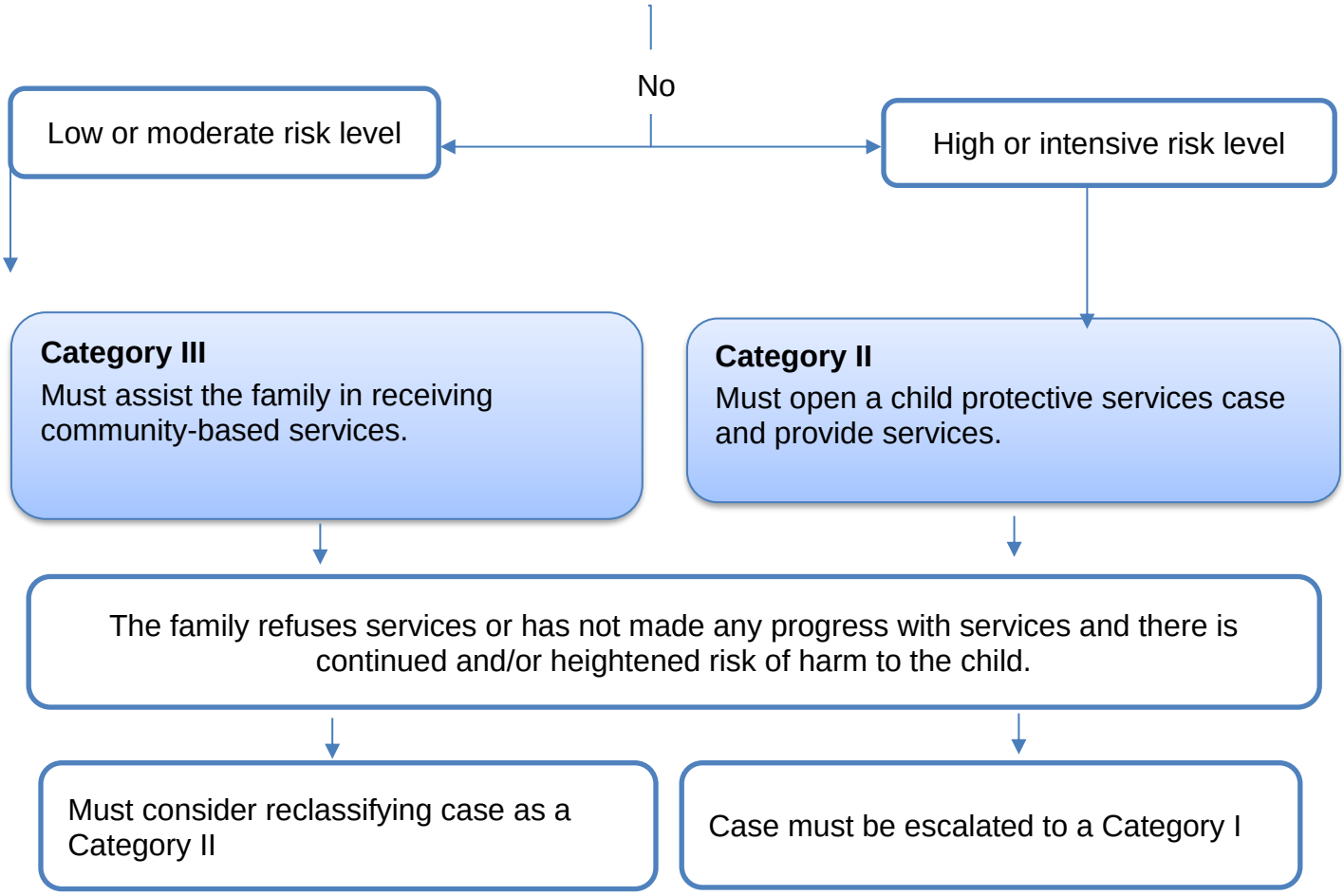
Five Category Disposition

MCL 722.628d defines the five CPS investigation categories and the department's required response for each. The decision tree below is a guide to the five category dispositions and the department's required response; see PSM 711-4, CPS Legal Requirements and Definitions.

For those cases that require the perpetrator be listed on central registry; see PSM 713-13, Central Registry and Confirmed Perpetrator Notification.

FIVE CATEGORY DISPOSITION DECISION MAKING TREE:





Perpetrator Notification

A person who has been confirmed for child abuse and/or child neglect must be appropriately notified within 30 calendar days of the investigation approval date they will be placed on central registry; or, they are a perpetrator of a confirmed case of child abuse and/or child neglect which does not warrant placement on the central registry. Some investigations may require both a DHS-847a and DHS-847c be sent to an individual perpetrator. If an individual is confirmed for multiple maltreatments, but only some result in placement on central registry, the DHS-847a must be sent for the central registry placement(s) and the DHS-847c for the confirmed maltreatment(s) that do not result in central registry placement.

For notification requirements, see Notification Requirements and Timeframes in PSM 713-13, Central Registry and Confirmed Perpetrator Notification.

Notification to Mandated Reporters

If the person who made the report to CPS is a mandated reporter, the case manager must generate and mail the DHS-1224, Complaint Source Notification Letter, to the mandated reporter within 24 hours of approval of investigation disposition (MCL 722.628(16)).

Case managers must document sending the DHS-1224 in a social work contact **without** identifying the reporting source. The DHS-1224 form must be saved in the electronic case record and uploaded to the *document* section within the *investigation tasks* screen.

ABBREVIATED INVESTIGATIONS

Case managers may consider conducting an abbreviated investigation in the following situations:

- Unable to locate family/child victim(s).
- After an interview or contact with the child victim(s) and any other information gathered confirms the referral is without any factual basis.

An abbreviated investigation means that a full investigation with all investigative policy requirements was not conducted and will result in a Category V disposition. Case managers must submit a request for supervisory approval in the electronic case record. All abbreviated investigations must also be routed for review by the local office director.

Note: If there is reason to believe the referral is without factual basis prior to completing interviews with the children, parental consent must be obtained prior to completing any interviews; see *Contact with Children* section in this item.

Required Activities

Case managers must enter all the following for an abbreviated investigation:

- Referral to law enforcement/prosecutor's office, if required; see PSM 712-3, Coordination with Prosecuting Attorney and Law Enforcement.
- Face-to-face contact with the child victim(s).
- History/trends.
- Contact with school personnel if child is interviewed at school. The parent or caregiver must be notified if the child was interviewed at school.
- Social work contacts demonstrating any case activity completed.
- All appropriate sections in the electronic case management system including disposition.
- Notification to mandated reporter, if applicable.

DOCUMENTATION IN THE ELECTRONIC CASE MANAGEMENT SYSTEM

The electronic case management system is utilized for documenting all actions taken in a CPS investigation. Case managers must complete/update all applicable tabs within the investigation module of the electronic case management system. This includes, but is not limited to, the following sections:

- Investigation persons.
- Petitions for removal.
- Allegations/findings.
- Safety Assessment.
- Risk Assessment.
- Create households.

- Social work contacts.
- Exception/Extension Requests.
- Documents.
- Disposition questions.
- Disposition summary.

Social Work Contacts

Enter all contacts, either successful or unsuccessful, into the electronic case record. Case managers must enter all social work contacts into the electronic case record within five business days.

Social work contacts should document statements, evidence, and engagement with the family as well as other actions taken by the case manager to investigate the allegations and address the safety of the child. Social work contacts must also support information provided within the disposition summary.

All social work contacts with accompanying narratives will pre-fill onto the DHS-154, Children's Protective Services Investigation Report.

Disposition Summary

Case managers must document the following in the disposition summary:

- Allegations investigated.
- Investigation disposition (preponderance/no preponderance).
- Names of the alleged and/or confirmed perpetrator(s) and alleged and/or confirmed victim(s).
- Steps taken in the investigation including:
    - Verification of the safety and whereabouts of all children listed in investigation persons.
    - Interviews with adults.

- Observations of the home and/or scene of alleged abuse/neglect.
- Any documentation obtained to support the conclusion (medical reports, police reports, etc.).

- How the relevant facts/evidence obtained during the investigation led to case outcome.
- The category disposition, the risk level, and any applicable overrides applied.
- The names of individuals added to central registry and the confirmed case type, if applicable.
- Any services recommended, offered, or referred, if applicable.
- Any safety plans developed with the family.
- If a petition was filed and rationale.

Submission for Approval of Investigation

Upon completion of an investigation meeting policy and legal requirements, the case manager must submit the case for supervisory approval. Supervisors may return the case with corrections if additional steps need to be taken. Corrections must be completed by the case manager in a timely manner to ensure the investigation is approved within 14-calendar days of initial submission for approval of the investigation.

DHS-154, Children's Protective Services Investigation Report

The DHS-154, Children's Protective Services Investigation Report, is the report used to detail the action completed in the electronic case management system for an investigation. Once approved, the DHS-154 must be generated, saved, and the signature page of the

report signed and uploaded into the document section of the electronic case record.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox (Child-welfare-policy@michigan.gov).

OVERVIEW

In cases of suspected child abuse or neglect, a medical examination assists with identifying, documenting, and interpreting injuries or potential medical conditions and helps determine the child's treatment needs.

DEFINITIONS

Medical Practitioner

A physician or physician's assistant licensed or authorized to practice under part 170 or 175 of the public health code, MCL 333.17001 to 333.17088 and MCL 333.17501 to 333.17556, **or** a nurse practitioner licensed or authorized to practice under section 172 of the public health code, MCL 333.17210.

OBJECTIVES OF A MEDICAL EXAMINATION

The objectives of a medical examination are to:

- Obtain treatment and medical care for the child.
- Obtain professional medical documentation of an injury or medical condition.
- Obtain an accurate medical diagnosis and treatment plan for an injury or medical condition.
- Obtain a medical opinion as to whether an injury appears to be intentional or accidental.
- Obtain a medical opinion as to whether an injury or medical condition is consistent with any provided explanation.
- Collect and preserve potential evidence.

PROCEDURE

Situations Requiring a Medical Exam

Case managers must request a medical examination for all alleged or suspected child victims when any of the following apply:

- Allegations of sexual abuse.
- Allegations or indication the child has been seriously or repeatedly physically injured as a result of abuse and/or neglect.
- The extent of the alleged abuse or neglect could cause unseen injuries (such as internal injuries or brain injuries).
- There is indication the child suffers from malnourishment.
- There is indication the child may need medical treatment.
- The child has been exposed to or had contact with methamphetamine production.
- An infant who is not mobile and has marks or bruises.
- The child has an injury, and the parent, child, or caregiver has provided an explanation of the injury that is not credible or is suspicious.
- The child has unusual bruises, marks, or signs of extensive or chronic physical injury.
- The child has an injury and appears to be fearful of parent(s)/caregiver(s) or exhibits characteristics, such as anxiousness or being withdrawn.
- The child has an injury alleged or suspected to be from abuse and the parent/caregiver/alleged perpetrator has previously been found to be a perpetrator of severe physical injury/serious physical harm.

In investigations involving a child fatality in which abuse and/or neglect is the suspected cause, case managers must also request

medical exams for any siblings or other child(ren) residing in or visiting the perpetrator's home.

Exception: This requirement does not apply to investigations in which the child fatality is attributed solely to unsafe sleep and there are no concerns for abuse and/or neglect of any other children.

See PSM 713-08, Special Investigative Situations, for more information on investigations involving a child fatality.

Medical Examinations for Alleged Sexual Abuse

Evaluate the following when determining whether a medical examination is needed:

- Do allegations or the information gathered indicate the child has been sexually abused and/or is at risk for a sexually transmitted infection through body fluid contact?
- Has the alleged incident occurred within 120 hours?
- Is the child experiencing physical symptoms, injury, or complaints?
- What type of incident is alleged/reported to have occurred, and will the medical evaluation provide value regarding the type of contact alleged to have occurred? For example, sexual penetration versus grabbing of breasts over clothing.

If the answer to any of these questions is yes, the case manager must seek parental agreement to take the child for a medical exam. If a medical exam is not requested in a case involving allegations of sexual abuse, the case manager must document the reason(s) why in a social work contact.

If the case manager is uncertain whether to request an examination, the case manager should contact their supervisor as well as a medical practitioner with experience in sexual abuse examinations to determine if an exam is recommended. If recommended by the medical practitioner, the case manager must request a medical exam. Contact with medical professionals and the results of any medical examinations must be documented in social work contacts.

Medical Examination for Methamphetamine Production

If a child is exhibiting symptoms suspected to be the result of exposure to methamphetamine production, the case manager must immediately request consent from the parent or legal guardian to obtain a medical exam. Symptoms may include:

- Respiratory distress/breathing difficulties.
- Red, watering, burning eye(s).
- Chemical/fire burns.
- Altered gait (staggering, falling).
- Slurred speech.

When a child is not actively displaying symptoms **but** has been found to have been exposed to methamphetamine production, a case manager must request a medical exam within four hours. Case managers should work with parents to obtain medical examinations in imminent situations. In situations when it is not feasible to obtain parental consent, case managers must seek medical assistance for the child(ren) exhibiting symptoms.

Parental Consent for Medical Examination

A parent/legal guardian has the right to withhold consent to a medical examination of their child. The case manager must engage the parent/legal guardian by taking the following steps:

- Clearly explain the basis for the recommendation for a medical examination and seek input on reservations and/or ways to address any immediate needs to ensure child safety.
- Engage the parent/legal guardian in decisions regarding the medical examination. For example:
    - Ask if they would like a support person present during the examination.
    - Ask who they prefer perform the medical examination; see who should do a medical examination.
- Assist in making transportation arrangements.
- Accompany the family to the examination.

If consent is still not granted, the case manager must contact their supervisor. If the case manager and supervisor determine a medical exam or second opinion is required to determine child safety, the case manager must seek a court order, MCL 722.626(3). The petition should explain the basis for the suspected abuse and/or neglect and the need for a medical examination. For information on filing a petition; see PSM 715-3, Family Court: Petitions, Hearings and Court Orders.

To seek a court order during regular court hours, the case manager must file a petition setting forth the basis for suspected abuse and/or neglect and need for a medical examination.

During after-hours (nights, weekends, and/or holidays), the case manager must contact the judge or other designated court official to request the order.

Note: If the court refuses to authorize an after-hours medical examination, the case manager must continue the investigation without the medical examination **and** follow-up by filing a petition seeking a court order on the next business day.

Medical Examination Without Court Order

In accordance with MCL 722.626(3)(a) and (b), a case manager must obtain a medical examination without a court order in the following situations:

- The child's health is seriously endangered, and a court order cannot be obtained.
- The child is displaying symptoms suspected to be the result of exposure to or contact with methamphetamine production.

If a medical examination without a court order is required and the child needs to be transported to receive the examination, and there is no parent or legal guardian who is available to accompany the child, the case manager must have law enforcement or an ambulance transport the child.

Who Should Conduct a Medical Examination

Whenever possible, a medical examination should be performed by a medical practitioner who:

- Has experience and expertise in interviewing and examining child victims of abuse/neglect.
- Specializes in child-sexual-abuse medical examinations, when available (for sexual abuse allegations).
- Is able to provide opinion as to whether an injury is consistent with any provided explanation.
- Is willing to collect all relevant medical evidence and document medical facts.
- Is willing to provide court testimony.

Initial Consultation with Medical Professional

Case managers must consult with a medical practitioner immediately when an examination is needed. Consultation should include the child's parent whenever feasible. When contacting the medical practitioner, case managers should request an examination of the child and provide the following information:

- The reason the medical examination is being requested.
- The reason(s) for suspicion of abuse and/or neglect.
- All known health/medical information regarding the child and family.
- Any additional pertinent case information including:
  - History of alleged and confirmed abuse/neglect.
  - Household/family makeup.
  - Home environmental factors.
  - Parent's behavior toward the child.
  - Explanations provided for an injury.

Case managers must make efforts to speak directly with the examining medical practitioner; however, if the medical practitioner is not available, the case manager may provide the information to a professional at the medical facility and provide case manager contact information for any questions the medical practitioner may have. Attempts must be made throughout the duration of the

investigation to speak to the examining medical practitioner. Efforts must be documented in social work contacts.

If there are bruises, marks, or injuries present that have not been photographed due to visual assessment restrictions, the case manager must request the practitioner take photographs during the exam; see PSM 713-01, CPS General Instructions and Checklist.

Results of a Medical Examination

A case manager must contact the medical practitioner or other medical professional familiar with the medical exam, to have them interpret the medical-examination findings. Case managers should ask the medical practitioner if the medical examination findings are consistent with the caregiver's explanation. If the findings or implications are unclear, the case manager must seek clarification.

See PSM 713-01, CPS Investigation - General Instructions, for more information on requesting medical records.

Payment for the Medical Examination

Payment for the medical examination is presumed to be the parent's responsibility. Case managers should request the parent use their private health insurance plan, pay out of pocket, or apply for Medicaid Assistance (MA), if eligible. If MA eligibility exists, the provider should bill the MA program.

If the department initiated a diagnostic medical examination and payment is not available from a third-party, and the parent is unable to pay, the case manager must make arrangements with the hospital, clinic or physician and add a DHS-93, Examination Authorization/Invoice for Service, under the Case Services tab of the ongoing module in the electronic case record to obtain payment by the department. For more information on payment; see SRF 800, DHS-93 Medical Service Authorization, or SRF 801, DHS-93 Medical Service Authorization Fee Schedule.

Note: Payment for inpatient hospitalization or treatment may not be authorized using the DHS-93. Costs for these services are paid by MA or are the parent's responsibility.

Second Opinion

Case managers have the discretion to seek a second medical opinion during a children's protective services (CPS) investigation. If an exam has not already been completed by a pediatric child abuse specialist, case managers should seek a second medical opinion in the following situations when initial medical findings are inconclusive:

- Medical findings conflict with other information or evidence, such as statements by the child or a witness or evidence of injuries.
- An immobile child was injured.
- Occurrence of bruising in uncommon locations, such as the abdomen, ears, neck, away from bony prominences or protuberances.
- Burns on children under 3 years of age.

Referral Requirements

The referral for a second medical opinion must include the following information:

- A statement informing the medical practitioner they are being asked to re-examine and evaluate the child or review medical records.
- The reason for the second opinion.
- All the information required in the Consultation with Medical Professionals for a Medical Examination section, in this item.
- All medical information/records obtained through the investigation.

If a second opinion is required but not obtained, the case manager must document in a social work contact and in the disposition questions, the reason a second opinion was not obtained.

Process

Michigan Department of Health and Human Services (MDHHS) county offices must reach out to local and regional medical professionals with appropriate qualifications for medical

examination of child abuse and neglect to determine a process of obtaining a second opinion.

If a Child Abuse Medical Expert Resource list is needed to identify qualified medical professionals; see Medical Resources for Child Protection.

For payment of a second opinion, see *payment of medical examination* section in this item.

Conflicting Opinions

When conflicting medical opinions exist, case managers may consult with a pediatric specialist or physician in their region who has experience assessing child abuse/neglect.

CASE RECORD DOCUMENTATION

Contact with medical professionals and any requests for medical records must be documented in social work contacts. In investigations where a medical examination is requested, case managers must also provide a summary of the details of the request and outcome of the medical examination within the disposition question on medical examinations.

Any forms requesting medical records, as well as any medical reports or photographs obtained during the investigation, must be scanned and uploaded to the case record. Supervisors must review all medical reports and photographs prior to extension request or approval of disposition.

POLICY CONTACT

Questions about this policy item may be directed to the Child-Welfare-Policy@michigan.gov.

OVERVIEW

The Michigan Department of Health and Human Services (MDHHS) requires case action, engagement or assessment for situations which may require additional or special investigative steps, in addition to standard investigation steps outlined in PSM 713-01, CPS Investigation - General Instructions and Checklist. Among others, special investigative situations include investigations involving domestic violence, child fatalities, and human trafficking.

NEW CHILD BORN TO PARENT WITH CHILDREN IN OUT OF HOME PLACEMENT

Case managers must assess the safety and risk to new children in a home where siblings have been removed and are in out of home placement. Specific facts and evidence should demonstrate if the safety and risk factors that resulted in the previous court action(s) have been resolved.

Case managers must also complete a DHS-3, Sibling Placement Evaluation, when a new child is born to a parent who currently has children in foster care as a result of child abuse/neglect court action.

DHS-3, Sibling Placement Evaluation

The following situations require completion of the DHS-3, Sibling Placement Evaluation:

- When a case manager files a petition with the Family Division of Circuit Court requesting the removal of one or more child(ren), but one or more child(ren) will remain in the home.
- A new child is born into a home where one or more of the siblings are currently in foster care and the new child will remain in the home.

The DHS-3 must be approved by the Children's Protective Services (CPS) supervisor, foster care supervisor and second line supervisor. The DHS-3 must document how the children remaining in the home are safe and any service provision and/or safety

planning to ensure the continued safety of the child(ren) in the home.

GUARDIANSHIPS/ POWER OF ATTORNEY

During a CPS investigation, another caregiver may obtain a guardianship for a child under investigation as a victim of abuse and/or neglect. A parent may also arrange a Power of Attorney (POA) for care of their child during an investigation. If a preponderance of evidence of abuse and/or neglect exists, appropriate services should still be referred/recommended to address the needs of the family.

A guardianship or POA does not replace a thorough and complete CPS investigation.

Intent to Adopt

When a case manager is informed of a parents' intent to have a new child adopted, the case manager must verify and document:

- The adoption process has commenced.
- The child's prospective adoptive placement.

WHEN A CHILD IS HOME ALONE

When an investigation involves allegations that a child was inappropriately left home alone, case managers should assess and consider the following:

- The child’s level of functioning.
    - What is the child’s maturity level?
    - Does the child exhibit developmentally appropriate decision making?
    - Does the child have special needs?
    - Does the child have physical, emotional, or mental limitations that place them at risk when home alone?

- Is the child involved with the juvenile justice system or does the child display behavior that may lead to involvement in the juvenile justice system?

- The situation in which the child is left alone.
  - Is the child vulnerable because of the time of day they are left alone?
  - Is the length of time a factor?
  - Is the child left alone often, every day or occasionally?
  - Have the persons responsible for the child's health and welfare developed a safety plan and appropriate procedures for emergency situations the child understands and can carry out?
  - Is the child responsible for caring for other children? If so, can the child do so appropriately?
  - Does the child have access to an adult, and is that adult aware of this and able to assist as necessary?
  - Has the child been given responsibilities that will compromise their safety or the safety of others?
- The child's emotional response to being left alone.
  - Is the child fearful, anxious, or emotionally distressed?

Case managers cannot enter a home without an adult present. See PSM 713-01, CPS Investigation - General Instructions, for more information.

SIBLING-ON-SIBLING OR CHILD-ON-CHILD VIOLENCE

For investigations involving sibling-on-sibling or child-on-child violence or sexual activity, case managers must determine:

- If the parent/caregiver is aware the alleged violence or sexual activity is occurring.

- If the parent/caregiver is responding appropriately to protect all children.

It is not appropriate to confirm child abuse and/or neglect when the parent/caregiver is aware and is acting to protect or is willing to act but does not know what resources are available.

Case managers must document steps the parents/caregiver have agreed to take to ensure the safety of the children in the home, including but not limited to:

- Assuring appropriate sleeping arrangements for all household members.
- Parental understanding of the situation and willingness to believe that protection is needed.
- Adequacy of alternative care.
- Parental plans to respond to further incidents.
- Other community agency involvement, treatment, or informal/formal supports.
- Assessment of whether clinical intervention is needed for the family.
- Determination of whether the victim child can protect themselves.
- Determination of whether the victim child is aware of what to do if threatened again.
- Assessment of family dynamics or prior trauma that needs to be professionally addressed.

Note: Children may not be confirmed as the perpetrator of abuse or neglect unless they are the parent to a child victim.

CHILD DEATH

Case managers must seek the assistance of and cooperate with law enforcement when a referral includes allegations that abuse and/or neglect may be the cause of the child's death or in referrals involving a sudden and unexplained infant death; see PSM 712-3, Coordination With Prosecuting Attorney and Law Enforcement.

The DHS 2096, Child Death Investigation Checklist, is an optional but useful tool for case managers to use when investigating a child fatality.

In conjunction with law enforcement, case managers must observe the scene (at the home or the location other than the home) where the alleged abuse/neglect occurred or where the child was found unresponsive/deceased. Objects alleged to have been involved should also be observed and photographed.

Case managers should be aware of services or supports the family may need including:

- Burial/financial assistance.
- Grief counseling.

See SRM 172, Child/Ward Death Alert Procedures and Timeframes, for proper reporting of the death of a child who is subject to a current CPS case or is a court ward.

Sudden and Unexplained Infant Death Investigation

A parent(s)/caregiver's knowledge of the tenants of infant safe sleep and lack of following them does not, in and of itself, constitute child abuse and/or neglect. When an investigation involves a sudden and unexplained infant death, evidence of the following should be considered and may affect the case disposition:

- **Substance use -** the parent/caregiver was under the influence of alcohol or substances, and their behavior or judgment was severely impaired and adversely affected their ability to safely care for the infant. Decision making for investigations involving substances is outlined in PSM 716-7, Case Involving Substances.

- **Placing a child at unreasonable risk of harm -** person responsible knowingly left the child in the care of a person known to abuse and/or neglect a child, a person whose known violence, alcohol or drug use, or serious mental health concern impacted their ability to care for the child, or a person responsible allowed or failed to prevent access to the child by perpetrator(s) of crimes involving injuries against children when the person responsible knows or should have known of the crime(s).

- **Hazardous environment -** the environmental conditions in the home were hazardous or unsanitary and met criteria for neglect.

DOMESTIC VIOLENCE

The presence of domestic violence in a home does not support confirmation of abuse and/or neglect without identified harm or likely harm to the child. The factors below, in addition to all other information and evidence, must be considered prior to reaching a disposition.

For guidance regarding cases involving incidents of alleged or previously confirmed domestic violence, case managers should refer to the MiTEAM Manual Appendix A: Domestic Violence Guide for Caseworkers.

Investigation Requirements

When domestic violence is a factor, the case manager must interview the alleged domestic violence offender, the non-offending parent/partner, and alleged child victim(s) separately.

Regardless of the disposition, in all cases where domestic violence is a factor, case managers must:

- Engage and consult with the non-offending parent/partner to develop a safety plan, which may include the following and will vary based on the severity of the domestic violence incident.
  - Identifying formal and informal supports.
  - Accessing relevant services.
  - Identifying a code word with the child(ren) or support person to signal when there may be an incident of domestic violence.
  - Having a plan in place for what the child(ren) are to do when the code word is used. For example, going to the neighbor's home or calling 911.

- Suggest compiling an emergency resource bag with important documents and personal belongings to have ready in case the family needs to leave the home quickly.

- Provide the non-offending parent/partner with information about local domestic violence shelters and other local services, supports, or resources that may assist the family.

Domestic Violence Assessment

Assessment of the following applicable factors should be considered and documented throughout the investigation to determine impact on child safety as a result of domestic violence and what services should be provided to the family:

- The domestic violence offender's pattern of coercive control, including specific behaviors (violent and non-violent) and their frequency, severity, and impact on child safety.

- The domestic violence offender's history of domestic violence, including interventions or services to address and status of such interventions (such as successfully completed, did not participate, etc.).

- The role of substance use, mental health, culture, and other socio-economic factors on child safety.

- Strengths and protective strategies/interventions that the non-offending parent/partner uses to promote the safety and well-being of the child(ren).

- Adverse impacts, including trauma, on the child(ren) due to the domestic violence offender's behavior.

- Is an effective safety plan in place?

- Engagement with social supports (family, community members, neighbors, etc.).

- The extent to which the offender takes responsibility for and understands the impact of their actions on child safety and well-being.

- The ability of the non-offending parent to keep the children safe.

Reaching a Disposition

Case managers will need to determine if harm has occurred or highly probable to occur without intervention, outside of whether the child was present during the domestic violence incident. When determining the disposition in cases where domestic violence is a factor, the following can be considered:

- Was the child injured during the domestic violence incident? Or has the alleged perpetrator made any threats toward the child?
- Did the child attempt to intervene during the domestic violence incident?
- Does the child express fear or concern about the domestic violence in the home, if able to be interviewed?
- Has the child experienced any significant changes in social or emotional behavior consistent with the incidents of domestic violence? Does the child seem withdrawn or have a regression in functioning?
- Is there a consistent pattern of coercive control or physical violence in which the child(ren) are harmed or likely to be harmed? Or is the pattern of control or violence escalating?
- Is the non-offending parent able to describe or utilize strategies to keep the children safe?
- What efforts has the non-offending parent made to strengthen family functioning?
- Have any weapons been used during incidents of domestic violence or to threaten members of the household?

BIRTH MATCH

The automated birth match system that notifies Centralized Intake (CI) when a child is born to a parent who previously had parental rights terminated in a child protective proceeding, caused the death of a child due to confirmed abuse and/or neglect or had been manually added to the birth match list.

A person’s name must be manually added to the birth match list in serious child abuse/neglect cases when termination of parental

rights will not be requested or ordered. Examples of when this may occur include, but are not limited to:

- A nonparent adult is the perpetrator of child abuse/neglect, and the abuse/neglect includes any of the factors under MCL 722.638(1)(a):
  - Abandonment of a young child.
  - Criminal sexual conduct involving penetration, or assault with intent to penetrate.
  - Battering, torture, or other serious physical harm.
  - Loss or serious impairment of organ or limb.
  - Life threatening injury.
  - Murder or attempted murder.
- A parent is the perpetrator of child abuse/neglect, and the abuse/neglect includes any of the factors under MCL 722.638(1)(a) and the actions did not result in termination of parental rights.

To request manual addition of person's name to the birth match list, email the following information to Child-Welfare-Policy@michigan.gov:

- Name of individual to be placed.
- Date of birth of individual to be placed.
- Associated investigation ID.
- Specific reason for the request, including the concern for future risk to children.
- CPS policy office will review the information and determine whether the person should be added to the birth match list.

VOLUNTARY FOSTER CARE

Voluntary foster care placement may be used as a service for families when the regular caregivers must be absent on a short-term basis from the childcare role for reasons beyond their control (e.g.,

hospitalization, incarceration, residential treatment). Voluntary foster care must not be used as an alternative/substitute for court ordered foster care placement when out-of-home care is needed for protection. For more information on voluntary foster care, see FOM 722-1 Foster Care-Entry Into Foster Care, Voluntary Foster Care Placement, and NAA 230, Voluntary Placement if the child is an Indian child.

COORDINATION WITH FRIEND OF THE COURT

MCL 722.628(18-21) details required cooperation between the department and Friend of the Court in child abuse/neglect cases. Case managers must inquire with parents if there is a Friend of the Court case regarding a child who is suspected of being abused or neglected.

When it is determined there is an open Friend of the Court case, the DHS-1450, How to Change a Custody or Parenting Time Order, must be provided to the non-custodial parent of a child who is suspected of being abused or neglected. If the DHS-1450 was not provided when required, the case manager must document the reason why in the social work contacts.

Case managers must complete the DHS-729, Confidential Notice to Friend of the Court of CPS Disposition and Court Action, when there is an open Friend of the Court case regarding a child victim if an investigation of child abuse and child neglect allegations result in any of the following:

- A preponderance finding.
- Emergency removal of the child from the home due to child abuse and/or neglect, prior to completion of the investigation.
- The family court takes jurisdiction on a petition and a child is maintained in their own home under the supervision of the department.
- If one or more children residing in the home are removed and one or more children remain in the home.
- Any other circumstances that are applicable and relate to child safety.

The DHS 729 must be sent within five business days of any of the above actions.

ACCEPT AND LINK

When a new referral containing allegations meeting screen in criteria that are not essentially the same instance of child abuse or neglect already screened in for investigation, or already known to the investigator, the investigation may be screened in as accept and link. Centralized Intake staff will accept and link intakes that are received within the first fifteen days of the active investigation. **All policy requirements must be completed for both the initial investigation, and the accept and link referral.**

The following policy requirements for the accept and link referral must be completed within the designated timeframes:

- Commencement.
- Face-to-face contact with the alleged victim(s) identified in the accept and link referral.
- Contact with parent(s)/guardian(s), identified perpetrator(s) and any other adults required by policy.
- Any other policy required contacts or activities, dependent upon investigation details (for example, medical professional, medical exam, law enforcement, etc.).

See PSM 713-01, CPS - General Instructions for more information on required face-to-face contact with children and adults in an investigation.

If face-to-face contact has already been completed under the initial referral for children, parents or caregivers, case managers must complete these activities again for the accept and link referral to address the new allegations and safety plan, if necessary.

Notification and Assignment

If a referral is screened in through accept and link, the assigning case manager, the case manager assigned to the initial investigation and their supervisor will be notified by email from CI. If the assigned case manager is not available to complete commencement or face-to-face contact with the victim, the

supervisor notified of the assign and link referral must complete them or delegate these activities to an available case manager.

The on-call case manager will be notified of the assignment for completion of required case activities including commencement and face-to-face contact with the alleged child victim(s), according to priority response criteria. The on-call case manager is responsible for additional action as needed to assess and address child safety.

Accept and Link Steps

Case managers must add accept and link alleged maltreatments and findings to the allegation/finding tab in electronic case record, and include a summary of the following in the disposition narrative:

- Allegations for the initial and the accept and link referral(s).
- Findings and dispositions for each alleged maltreatment.
- A summary of investigation activities for the initial and accept and linked allegations.

ACCOMMODATION FOR DEAF/HARD OF HEARING AND NON-ENGLISH-SPEAKING CLIENTS

MDHHS is responsible for providing information and assistance to applicants and recipients of department programs who are deaf and/or hard of hearing. See the SRM 401, Effective Communication for Persons Who are Deaf, Deaf/Blind, or Hard of Hearing.

Applicants and recipients of department programs are to be informed the department will arrange and pay for the cost of a bilingual interpreter to be present at all interviews and situations where an interpreter is necessary and appropriate. See SRM 402, Limited English Proficiency and Bilingual Interpreter Services, for more information on how to arrange and pay for a bilingual interpreter.

Accommodation in Emergency Situations

When an accommodation is not readily available during an emergency situation, case managers should consider the following options:

- Seek assistance of a support person who can communicate with the individual.
- Utilize any available communication (such as writing or telephone-based interpretation).

Case managers must assess the safety of any alleged child victims and safety plan in investigations involving person(s) who need accommodation. Follow-up must occur as soon as possible utilizing an effective means of communication.

HUMAN TRAFFICKING

Definitions

Sex Trafficking

Sex trafficking is the action of subjecting a child to the recruitment, harboring, transportation, provision, patronizing, or soliciting for the purposes of a commercial sex act. Trafficking may involve an exchange of goods or psychological responses. Offenders may exchange love, friendship, protection, or attention to a child while an exchange of goods could include money, drugs, jewelry, clothing, food, shelter, or transportation.

Labor trafficking

The recruitment, harboring, transportation, provision, or obtaining of a person for labor as a result of force, fraud, coercion, or manipulation. Labor trafficking can include, but is not limited to, domestic servitude, forced labor in restaurants or salons, forced agricultural labor or debt bondage.

The alleged perpetrator of the trafficking does not need to meet criteria for person responsible for assignment. The department can investigate trafficking conditions regardless of role or status of the alleged perpetrator when law enforcement requests assistance to respond to the youth's trauma.

Note: In order to make a finding, the perpetrator must be found to be a person responsible.

Overview

The MDHHS' Human Trafficking of Children Protocol was developed to guide case managers in assisting children who are victims of human trafficking. The protocol focuses on protecting children and maintaining their safety in the community. The protocol has the following goals:

- Provide a coordinated investigative team approach while minimizing trauma to the victim.
- Provide protection and the delivery of specialized services to the child victim and family members.
- Provide cross-professional training to promote understanding of the unique dynamics and challenges of child sex trafficking and labor trafficking.
- Provide options for responding when a child has been identified as the victim of human trafficking.

Note: Whenever a referral alleging human trafficking is screened in for investigation or identified after case assignment, coordination with law enforcement is required; see PSM 712-3, Coordination With Prosecuting Attorney and Law Enforcement.

For assignment or confirmation:

- A trafficking event does not need to occur. Offenders may behave in a way that creates a substantial likelihood that the child will be sexually exploited.
- The alleged perpetrator of the trafficking does not need to meet criteria for person responsible for assignment. When law enforcement requests assistance, the department can investigate trafficking conditions regardless of role or status of the alleged perpetrator.

Authority

The Preventing Sex Trafficking and Strengthening Families Act, P.L. 113-183.

Trafficking Victims' Protection Act.

OVERVIEW

Case managers evaluate child safety, risk, strengths, and needs through use of assessment tools. These assessments assist case managers with decision making and provision of services with goals for promoting safety and well-being of children and their families.

Assessments included in this item are:

- Safety Assessment.
- Risk Assessment.
- Risk Re-assessment.
- Threatened harm assessment.
- Family Assessment of Strengths and Needs (FANS).
- Child Assessment of Strengths and Needs (CANS).

SAFETY ASSESSMENT

The Safety Assessment is a structured decision-making tool designed to identify:

- Imminent safety concerns for a child.
- Protective interventions initiated.
- An overall safety decision.

When to Complete the Safety Assessment

The Safety Assessment is completed in the electronic case record and must be completed at or near the end of the investigation when sufficient evidence and information has been collected to accurately complete the tool.

Exception: A Safety Assessment is not required in abbreviated investigations, except those in which the Family Division of Circuit Court is asked to order family cooperation in the investigation but declines, and the family still will not cooperate with Children's Protective Services (CPS).

Immediate Harm Factors

For each immediate harm factor, identify the presence or absence of each factor by checking either yes or no. If the response is yes,

an explanation is required within the narrative to provide facts from the investigation relating to the factor.

When assessing the immediate harm factors below, the word serious denotes an elevated level of concern regarding child safety.

Number 1

Caretaker(s) caused serious harm to the child and/or made a plausible threat to cause serious physical harm in the current investigation, indicated by:

- Severe injury or abuse to child other than accidental.
    - Caretaker(s) caused severe injury (defined as an injury to the child that requires medical treatment or hospitalization and that seriously impairs the child's health or physical well-being).
- Threat to cause harm or retaliate against child.
    - A threat of action which would result in serious harm (such as kill, starve, lock out of home, etc.), or plans to retaliate against child for CPS investigation.
- Excessive discipline or physical force.
    - Caretaker(s) has used torture, physical force or acted in a way which bears no resemblance to reasonable discipline, or punished child beyond the duration of the child's endurance.
- Potential harm to child as a result of domestic violence.
    - The child was previously injured in domestic violence incident.
    - The child exhibits severe anxiety (such as nightmares, insomnia) related to situations associated with domestic violence.
    - The child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of domestic violence in the home.
    - The child is at potential risk of physical injury and/or the child's behavior increases risk of injury (such as

attempting to intervene during violent dispute, participating in the violent dispute).

- Caretaker(s) use guns, knives, or other instruments in a violent, threatening and/or intimidating manner.
- There is evidence of property damage resulting from domestic violence.

- One or more caretaker(s) fear they will maltreat child.
- Alcohol/drug exposed infant.
  - Alcohol or substances found in the child's system.

Number 2

Caretaker(s) has previously maltreated a child in their care, and the severity of the maltreatment or the caretaker(s) response to the previous incident AND current circumstances suggest that child safety may be an immediate concern. There must be both current immediate threats to child safety and related previous maltreatment that was severe and/or represents an unresolved pattern of maltreatment.

- Prior death of a child.
  - As a result of maltreatment.
- Previous maltreatment that caused severe harm to any child.
  - Previous maltreatment by the caretaker(s) that was serious enough to cause severe injury (defined as an injury to the child that requires medical treatment or hospitalization and that seriously impairs the child's health or physical well-being).
- Prior termination of parental rights.
  - One or more caretaker(s) had parental rights terminated as a result of a prior CPS investigation; see PSM 715-3, Family Court: Petitions, Hearings and Court Orders, the Mandatory Petition-Request for Termination of Parental Rights section.
- Prior removal of any child.

- One or more caretaker(s) had a prior removal of any child, either formal placement by CPS staff or informal placement with friends or relatives.

- Prior confirmed CPS case.

- Prior threat of serious harm to child.

  - Previous maltreatment that could have caused severe physical injury, retaliation or threatened retaliation against a child for previous incidents, prior domestic violence which resulted in serious harm or threatened harm to a child or escalating pattern of maltreatment.

Number 3

Caretaker(s) fails to protect child(ren) from serious harm or threatened harm.

- Live-in partner found to be a perpetrator.

  - Caretaker(s) fails to protect child from serious physical harm or threatened harm as a result of physical abuse, neglect or sexual abuse by other family members, other household members or others having regular access to the child.

Number 4

Caretaker(s) explanation of any injury is unconvincing, and the nature of the injury suggests that the child's safety may be of immediate concern.

- Medical exam shows injury is result of abuse or neglect; caretaker(s) offers no explanation, denies, or attributes to accident.

- Caretaker(s) explanation for the observed injury is inconsistent with the type of injury.

- Caretaker(s) description of the causes of the injury minimizes the extent of harm to the child.

- Caretaker(s) and/or collateral contacts' explanation for injury has significant discrepancies or contradictions.

Number 5

The family refuses access to the child, or there is reason to believe that the family is about to flee, or the child's whereabouts cannot be ascertained.

- Family currently refuses access to the child and cannot or will not provide child's location.
- Family has removed child from a hospital against medical advice.
- Family has previously fled in response to a CPS investigation.
- Family has history of keeping child at home, away from peers, school, other outsiders for extended periods.
- Family refuses to cooperate or is evasive.

Number 6

Child is fearful of caretaker(s), other family members, or other people living in or having access to the home.

- Child cries, cowers, cringes, trembles, or exhibits or verbalizes fear in front of certain individuals.
- Child exhibits anxiety, nightmares, insomnia related to a situation associated with a person in the home.
- Child fears unreasonable retribution/retaliation from caretaker(s), others in home or others having access to the child.

Number 7

Caretaker(s) does not provide supervision necessary to protect child from potentially serious harm.

- Caretaker(s) present but child wanders outdoors alone, plays with dangerous objects or on window ledges, etc.
- Caretaker(s) leave(s) child alone (period of time varies with age and developmental stage).
- Caretaker(s) makes inadequate/inappropriate childcare arrangements or plans very poorly for child's care.

- Parent(s) whereabouts are unknown.

Number 8

Caretaker(s) does not meet the child's immediate need for food, clothing, shelter, and/or medical or mental health care.

- No housing/emergency shelter; child must sleep in the street, car, etc.; housing is unsafe, without heat, etc.
- No food provided or available to child, or child starved/deprived of food/drink for long periods.
- Child without minimally warm clothing in cold months.
- Caretaker(s) does not seek treatment for child's immediate medical condition(s) or follow prescribed treatments.
- Child is malnourished.
- Child has exceptional needs which parent(s) will not meet.
- Child is suicidal, and parent(s) will not take protective action.
- Child exhibits effects of maltreatment, such as emotional symptoms, lack of behavior control or physical symptoms.

Number 9

Child's physical living conditions are hazardous and immediately threatening based on the child's age and developmental stage.

- Leaking gas from stove or heating unit.
- Dangerous substances or objects left accessible.
- Lack of water, heat, plumbing, electricity, or provisions are inappropriate, such as stove/space heaters.
- Open windows; broken/missing windows.
- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food, which threatens health.

- Serious illness/significant injury due to current living conditions and these conditions still exist, such as lead poisoning, rat bites, etc.
- Evidence of human or animal waste throughout living quarters.
- Guns and other weapons are not stored in a locked or inaccessible area.

Number 10

Caretaker(s)' current substance use seriously affects their ability to supervise, protect, or care for the child.

- Caregiver(s) has abused legal or illegal substances or alcoholic beverages to the extent that control of their actions is significantly impaired. As a result, the caregiver is unable, or will likely be unable, to care for the child; has harmed the child; or is likely to harm the child.

Number 11

Caretaker(s)' behavior toward child is violent or out-of-control.

- Behavior that indicates a serious lack of self-control, such as reckless, unstable, raving, explosive, etc.
- Behavior, such as scalding, burning with cigarettes, forced feeding, killing or torturing pets, as punishment.
- Extreme action/reaction, such as physical attacks, violently shaking or choking, a verbal hostile outburst, etc.
- Use of guns, knives, or other instruments in a violent and/or out -of-control manner.

Number 12

Caretaker(s) describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations.

- Caretaker(s) describes child in a demeaning or degrading manner, such as evil, possessed, stupid, ugly, etc.
- Caretaker(s) curses and/or repeatedly puts child down.

- Actions by the caretaker(s) may occur periodically, but overall form a negative image of the child.
- Caretaker(s) scapegoats a particular child in the family.
- Caretaker(s) blames child for a particular incident or distorts child's behavior as a reason to abuse.
- The caregiver expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (for example, babies and young children expected not to cry, expected to be still for extended periods, be toilet-trained, eat neatly, expected to care for younger siblings or expected to stay alone, etc.).
- Caretaker(s) overwhelmed by a child's dysfunctional emotional, physical, or mental characteristics.
- Caretaker(s) view child as responsible for the caretaker(s) or family's problems.

Number 13

Child sexual abuse is suspected, and circumstances suggest that child safety may be an immediate concern.

- Suspicion of sexual abuse may be based on indicators such as:
    - The child discloses sexual abuse either verbally or behaviorally (for example, age-inappropriate or sexualized behavior toward self or others, etc.).
    - Medical findings consistent with sexual abuse.
    - Caregiver(s) or others in the household have been convicted, investigated, or accused of rape or sodomy, or have had other sexual contact with the child.
    - Caregiver(s) or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).

- Access to a child by possible or confirmed/known sexual abuse perpetrator exists.

Number 14

Caretaker(s)' emotional stability seriously affects current ability to supervise, protect, or care for child.

- Caregiver(s)' inability to control emotions impedes ability to parent the child.
- Caregiver(s)' refusal to follow prescribed medications impedes ability to parent the child.
- Caregiver(s)' inability to control emotions impedes ability to parent the child.
- Caregiver(s) acts out or exhibits a distorted perception that impedes their ability to parent the child.
- Caregiver(s)' depression impedes their ability to parent the child.
- Due to cognitive delay, the caregiver(s) lacks the basic knowledge related to parenting skills such as:
  - Not knowing that infants need regular feedings.
  - Proper diet.
  - Adequate supervision.
  - Failure to access and obtain basic/emergency medical care.

Number 15

Other (specify).

- Specify other factors that are present that impact the child's safety.

Safety Interventions

A protecting intervention is a safety response taken by staff or others to address the unsafe situation identified in the assessment. These interventions help protect the child from present or imminent

danger. A protecting intervention must be in place if any safety factor is indicated.

If one or more safety factors are present, it does not necessarily indicate that a child must be placed outside the home. In many cases, a temporary plan will mitigate the safety factor(s) sufficiently so that the child may remain in the home while the investigation continues. Consider the relative severity of the safety factor(s), the caregiver(s)' protective capacities and response to the investigation/situation, and the vulnerability of the child when identifying protecting interventions.

For each safety factor identified, consider the resources available in the family and the community that might help to keep the child safe. Check each protecting intervention taken to protect the child and explain in the narrative. Describe all protecting safety interventions taken and explain how each intervention protects (or protected) each child.

Number 1

Monitoring or direct services by MDHHS worker.

Number 2

Use of family resources, neighbors, or other individuals in the community as safety resources.

Number 3

Use of community agencies or services as immediate safety resources (check one).

- Intensive home-based.
- Other community services.

Number 4

Recommend that the alleged perpetrator leave the home, either voluntarily or in response to legal action.

Number 5

Recommend that the non-maltreating caretaker move to a safe environment with the child.

Number 6

Recommend that the caretaker(s) voluntarily allow the child to stay outside the home.

Number 7

Other.

Number 8

Legal action must be taken which may include a recommendation to place child outside the home.

Protecting Interventions Narrative

Case managers must explain all protecting interventions regardless of association with a safety factor. If there are safety factors present, there must be protecting interventions described within the narrative box.

Initiating Legal Action Narrative

If a case manager is initiating legal action, the case manager must explain why responses 1-7 could not be used to keep the child(ren) safe and describe the discussion with the caretaker(s) regarding placement.

Service Refusal Narrative

If services were recommended but caretakers refused to participate, describe the services that were offered.

Safety Decision

The electronic case record will compute a safety decision based on responses to the immediate harm factors.

A. **Safe** - Children are safe; no safety factors exist.

B. **Safe with Services** - At least one safety factor is indicated, and at least one protecting intervention has been put into place that has resolved the unsafe situation for the present time.

C. **Unsafe** - At least one safety factor is indicated, and placement is the only protecting intervention possible for the child. Without placement, the child will likely be in danger of imminent harm.

Injury to the Child

Within this section, responses to the following items are required:

Was any child injured in this case?

- If yes, indicate the age of youngest child with most serious injury.
- If yes, indicate what was the most serious injury to a child:
    - Death.
    - Hospitalization.
    - Medical treatment, but no hospitalization.
    - Exam only of alleged injuries. No medical treatment required.
    - Bruises, cuts, abrasions, or other minor injuries; no medical exam or treatment.

RISK ASSESSMENT

The Risk Assessment determines the level of risk of future harm to the children in the family. Interviews with the family should be structured to allow the case manager to discuss all risk and safety factors with the caretakers and complete the risk assessment following the conclusion of contacts with the family. Risk levels are intensive, high, moderate, or low, based on the scoring of the scale.

In each case in which a preponderance of evidence of child abuse and/or neglect (CA/N) has been found, the risk level determines which category (Category II or III) the case must be classified. If a petition is filed, the case must be classified as a Category I, and the risk level must be either high or intensive.

When to Complete a Risk Assessment

The Risk Assessment must be completed for all required investigations when investigation activities (gathering of evidence, interviews, etc.) are completed and prior to disposition of the case.

A Risk Assessment is required on all assigned investigations with the following exceptions:

- Supervisory approval is obtained to complete an abbreviated investigation on the referral.
- There is a preponderance of evidence of CA/N and the perpetrator is one of the following:
  - A nonparent adult who resides outside the child's home. (If there is also a perpetrator who resides in the child's home, a risk assessment must be done (for example, mom is the primary caretaker and found to be a perpetrator of failure to protect and mom's boyfriend, who is a nonparent adult who resides outside the child's home, is a perpetrator of sexual abuse).
  - A licensed foster parent. (If a licensed foster parent is also a perpetrator of CA/N on their biological or adoptive children, a risk assessment must be completed and services provided, as required.)

A Risk Assessment must be completed on the household where the alleged or confirmed perpetrator resides or for which services will be provided. If there is an alleged or confirmed perpetrator in both households **or** services will be provided to both households, a **separate** Risk Assessment must be completed on each household. Two households must **not** be combined on one Risk Assessment.

If the department is requesting removal of the child from one parent and the child will be released to the other parent, either through a voluntary placement made by the custodial parent or a court order, a Risk Assessment must be completed on the other parent's household **within 24 hours or the next business day**; see PSM 715-2, Removal and Placement of Children.

Note: If the perpetrator cannot be located, a risk assessment should instead be completed on the household receiving services or where the child resides. If a perpetrator cannot be found to ascertain the information needed to complete a risk assessment, historical information should not be used to complete the risk assessment. Social work contact documentation must support those efforts to demonstrate why a risk assessment was not completed for the perpetrator's household. If all the caregiver(s) and perpetrator(s) are uncooperative, complete the risk

assessment based on factual information ascertained from the current investigation (case contacts, collateral contacts, CPS history and trends, criminal history clearances, etc.).

Primary and Secondary Caretaker

A primary caretaker is the adult, usually the parent living in the household, who assumes the most responsibility caring for the child. When two adult caretakers are present and it is unknown which one assumes the most childcare responsibility, the adult legally responsible for the children should be selected. If this does not resolve the question, the legally responsible adult identified as a perpetrator should be selected.

The secondary caretaker is defined as an adult living in the household who has routine responsibility caring for the child but less responsibility than the primary caregiver. A living-together-partner (LTP) may be a secondary caretaker even though they have minimal responsibility for care of the child. The non-custodial parent is not a secondary caretaker unless that person is considered a member of the household.

Risk Assessment Score

The Risk Assessment calculates risk based on answers to the abuse and the neglect scales. The risk level is based on the higher score of either the abuse or neglect scales. After completion of the Risk Assessment, the case manager may determine if conditions exist for a mandatory or discretionary override; see override section in this policy item.

Select one score for each question and provide an explanation for the selection if the question is scored as a risk factor.

Neglect Scale

N1. Current complaint and/or finding includes neglect.

a. **No.**
b. **Yes, the current complaint includes allegations of neglect or a preponderance of evidence of neglect is**

found to exist, even if not alleged in the current complaint.

N2. Number of prior assigned neglect complaints and/or findings.

Count the number of prior assigned complaints for neglect (confirmed or denied) in which any adult household member identified in the current investigation was an alleged perpetrator.

a. **One or less.**
b. **Two or more.**

N3. Number of children in the household.

The number of individuals under 18 years of age **residing** in the household at the time of the current complaint. If a child was removed as a result of the investigation or is on runaway status, count the child as residing in the household. If the child was removed from the household as the result of a previous investigation and the goal is reunification, count the child as residing in the household. If the child was removed as the result of a previous investigation and parental rights to that child were terminated or the goal is termination of parental rights, do not count the child as residing in the household.

a. Three or less.
b. Four or more.

N4. Primary caretaker's social support.

Relatives, friends, or neighbors are able to help when a caretaker(s) or other adult is not functioning well and/or is in need of assistance to provide for the child's safety and well-being. Relatives, friends, or neighbors have come forward to help when the family and child needed support, and/or the child needed placement. Relatives, friends, or neighbors have followed through on commitments in the past and provide ongoing support and assistance to the caretaker.

a. The primary caretaker accesses or can access relatives, friends, or neighbors for positive social support.

b. Limited or negative social support (check all that apply):

__ **No or limited supportive relationships with relatives, friends, or neighbors.** Caretaker does not, cannot, or will not access others for assistance in care for child when needed.

__ **Relatives, friends, or neighbors have a negative impact on caretaker.** People that the caretaker uses for social support have a negative influence on the caretaker's ability to provide for, protect, or supervise the child. Examples include, but are not limited to:

- Encourages caretaker to physically discipline children when abuse has occurred, or abuse is a concern.
- Encourages caretaker not to seek services.
- Discourages the department's attempts to assist the parent in a positive manner.
- Encourages inappropriate parenting practices.

N5. Primary caretaker is unable/unwilling to control impulses.

a. No, the primary caretaker is able and willing to control impulses.

b. Yes, the primary caretaker is unable and/or unwilling to control impulses. Examples include, but are not limited to:

- **Regularly** acting without weighing alternatives or considering consequences.
- Spur-of-the-moment actions, and/or heedless, self-centered actions that **regularly** result in threatened or actual harm to the child.
- A **regular** inability to delay gratification of personal needs to assume childcare responsibility.
- Lashing out verbally (yells/screams, berates, uses hostile language, etc.) and/or physically (hits, shoves,

threatens violence, etc.) in response to (undesired or negative) actions of the child and/or others**.**

N6. Primary caretaker provides inadequate physical care and/or inadequate supervision of child.

a. **No, the primary caretaker provides adequate physical care and supervision of child.**

b. One or both of the following is true (check all that apply):

__ **Provides inadequate physical care:** The provision of physical care (the appropriate feeding, clothing, shelter, hygiene, and medical care) is inconsistent with and/or not appropriate for the child's needs. There has been harm or threatened harm to the child's health and/or well-being due to the inadequate physical care. Examples include, but are not limited to:

- Failure to obtain medical care for severe or chronic illness.
- Repeated failure to provide child with clothing appropriate for the weather.
- Poisonous substances or dangerous objects lying within reach of child.
- Child's clothing or hygiene causes negative social consequences for the child.

__ **Provides inadequate supervision:** Supervision is inconsistent with and/or not appropriate for the child's safety, resulting in threatened or actual harm to the child.

N7. Primary caretaker currently has a mental health problem.

a. No.

b. Yes, in the past year, the primary caretaker has been assessed as needing, been referred for, or participated in mental health treatment. This includes, but is not limited to:

- DSM-IV-TR diagnosis by a mental health practitioner.
- Repeated referrals for mental health/psychological evaluations.
- Recommended or actual hospitalization for mental health problems.
- Current or recommended use of psychotropic medication prescribed by mental health clinician (for example, physician, psychiatrist, etc.).

N8. Primary caretaker involved in harmful relationships.

The primary caretaker is, or has been, involved in relationships that are harmful to domestic functioning or childcare within the past year. Include only domestic violence between caretakers or between a caretaker and another adult. Do not include parent-child or child-child violence.

a. No.

b. Harmful relationship(s) or one domestic violence incident – Relationships with adults inside or outside the home that are harmful to domestic functioning. Examples include, but are not limited to:

- Criminal activities.
- Domestic discord.
- One incident of physical violence and/or intimidation/threats/harassment.

c. Multiple domestic violence incidents – Primary caretaker is currently involved in a relationship (either as a victim or as a perpetrator) in which two or more incidents of physical violence or fighting and/or intimidation/threats/harassment have occurred.

N9. Primary caretaker currently has a substance abuse problem.

a. No.

b. Yes, within the past year, the primary caretaker has, or had, a problem with alcohol and/or other drugs that interferes, or interfered, with the caretaker's or the

household's functioning. Examples include, but are not limited to:

- Substance use has negatively affected caretaker's employment, and/or marital or family relationships.
- Substance use has negatively affected caretaker's ability to provide protection, supervision, care, and nurturing of the child.
- Substance use has led to criminal involvement.

N10. Family is homeless, or children are unsafe due to housing conditions.

a. No.

b. Yes, one or more of the following is true (check all that apply):

__ **The family is homeless or about to be evicted (current eviction notice).**

__ **Current housing is physically unsafe; not meeting the health and/or safety needs of the child.** Examples include, but are not limited to:

- Structural defects or is unsound.
- Exposed wiring, inoperable heat, or plumbing.
- Human/animal waste on floors that is due to failure to consistently clean or maintain the environment.
- Rotten or rotting food due to failure to consistently clean or maintain the environment.
- Disconnection of major utilities (gas, electric or water).

N11. Primary caretaker able to put child's needs ahead of own.

a. Yes, the primary caretaker demonstrates ability to put child's needs ahead of their own.

b. No, the primary caretaker makes choices or behaves out of self-interest rather than the best interest of the child and this has a negative effect on child safety and well-being. Examples include, but are not limited to:

- Regularly does not make or keep appointments for the child that will interfere with caretaker's social activities.
- Ignores child when other adults are present.
- Leaves the child with others for extended periods of time to pursue social activities.

Abuse Scale

A1. Current complaint and/or finding includes mental injury.

a. No.
b. Yes, the current complaint includes allegations of mental injury or a preponderance of evidence of mental injury is found to exist, even if not alleged in the current complaint.

A2. Number of prior assigned abuse complaints and/or findings.

Count the number of prior assigned complaints for abuse (confirmed or denied) in which any adult household member identified in the current investigation was an alleged perpetrator.

a. None.
b. One or two.
c. Three or more.

A3. Age of youngest child.

Indicate whether one or more children **residing** in the household at the time of the current complaint is age six years or younger. If a child was removed as a result of the investigation or is on runaway status, count the child as residing in the household. If the child was removed from the household as the result of a previous investigation and the goal is reunification, count the child as residing in the household. If the child was removed as the result of a previous investigation and parental

rights to that child were terminated or the goal is termination of parental rights, do not count the child as residing in the household.

a. Seven years or older.
b. Six years or younger.

A4. Number of children in the household.

The number of individuals under 18 years of age **residing** in the household at the time of the current complaint. If a child is removed as a result of the investigation or is on runaway status, count the child as residing in the household. If the child was removed from the home as the result of a previous investigation and the goal is reunification, count the child as residing in the household. If the child was removed as the result of a previous investigation and parental rights to that child were terminated or the goal is termination of parental rights, do not count the child as residing in the household.

a. Two or less.
b. Three or more.

A5. Either caretaker was abused and/or neglected as a child.

a. No, neither caretaker was abused or neglected as a child.

b. Yes, past records (CPS, foster care, etc.), self-reporting by the caretaker, credible statements by others, or other credible information indicates that either caretaker was abused and/or neglected as a child.

A6. Secondary caretaker has low self-esteem.

a. No, secondary caretaker does not demonstrate low self-esteem or no secondary caretaker present in the household.

b. Yes, secondary caretaker's behavior and/or expressions indicate feelings of inferiority/inadequacy and/or low self-esteem. Examples may include, but are not limited to:

- Self-conscious behavior, self-doubting, or self-abasing.

- Behavior/expressions demonstrating that caretaker feels that he/she is inadequate, inferior, unlovable, or unworthy.
- Describes self as not being good enough for others, a loser, misfit, or failure.

A7. Either caretaker is domineering and/or employs excessive and/or inappropriate discipline.

Consider the circumstances of the current complaint and past practices by either caretaker.

a. No.
b. Yes (check all that apply)**:**

__ **Domineering**: Either caretaker is domineering, indicated by controlling, abusive, overly restrictive, or unfair behavior or over-reactive rules.

__ **Inappropriate discipline**: Disciplinary practices caused harm or threatened harm to child because they were excessively harsh physically, emotionally, and/or were inappropriate for child's age or development. Examples include, but are not limited to:

- Persistent berating.
- Belittling and/or demeaning the child.
- Consistent deprivation of affection or emotional support to the child**.**

A8. Either caretaker has current or a history of domestic violence.

Include only domestic violence between caretakers or between caretaker and another adult. Do not include parent-child or child-child violence.

a. No, neither caretaker has current or past domestic violence.

b. Yes, either caretaker is currently involved or has ever had involvement in relationships characterized by domestic violence (either as a victim or as a perpetrator), evidenced by two or more incidents of physical

violence or fighting and/or intimidation/threats/harassment.

A9. A child in the household has one or more of the following characteristics.

a. No child in the household has any of the below listed characteristics.

b. Yes (check all that apply to any child in the household).

__ **Diagnosed developmental disability:**

- Intellectual Developmental Disorder.
- Attention deficit disorder or ADHD.
- Learning disability or any other significant developmental problem. The child may be in a special education class(es).

__ **History of Delinquency**: Any child in the household has been referred to juvenile court for delinquent or status offenses or is an adjudicated delinquent. Include status offenses not brought to court attention, such as run-away children, habitual truants from school, and drug or alcohol problems.

__ **Mental health issue:** Any child with any diagnosed mental health problem not related to a physical or developmental disability.

__ **Behavioral issue**: Behavioral problems not related to a physical or developmental disability. Examples include, but are not limited to:

- Problems at school as reported by school or caretakers.
- Attendance in a special classroom for behavioral needs.

A10. All caretakers are motivated to improve parenting skills.

a. All caretaker(s) are motivated or parenting skills are appropriate and no improvement needed.

b. Yes, caretakers are willing to participate in parenting skills program or other services to improve parenting or initiate appropriate services for parenting without referral by the department.

c. No, one or both caretakers need to improve parenting skills but either:

- Refuse services.
- Agree to participate but indicate that parenting style will not change.
- Agree to participate but history shows a pattern of uncompleted services when working with CPS or foster care.

A11. Primary caretaker views incident less seriously than the department.

a. No, the primary caretaker views the allegations/findings of abuse or neglect **as serious or more serious** than the department and/or accepts responsibility for investigated behaviors.

b. Yes, there is evidence that the primary caretaker views the current allegations/findings **less seriously** than the department. Examples include, but are not limited to:

- Justifying abuse and/or neglect of child.
- Minimizing harm or threatened harm to child.
- Blaming the child.
- Displacing responsibility for the incident.
- Downplaying the severity of the incident.

Overrides

Overrides to risk levels have been established to ensure the level of risk for a case accurately reflects the risk level for the children. The two types of overrides to the risk level are mandatory and discretionary overrides.

Mandatory Overrides

Mandatory overrides automatically override the risk level of the case to intensive, regardless of the initial risk level. Mandatory overrides are required for the following cases:

- Sexual abuse cases in which the perpetrator is likely to have immediate access to the child victim.
- Cases with non-accidental physical injury to an infant except in situations of substance exposure to an infant.
- Severe, non-accidental, physical injury requiring medical treatment or hospitalization and that seriously impairs the child's health or physical well-being.
- Death (previous or current) of a child/sibling as a result of abuse or neglect.

Discretionary Overrides

A discretionary override may be applied by the case manager to increase the risk level in any case in which it is determined the risk level set by the risk assessment is too low. This may occur when the case manager is aware of conditions affecting risk that are not captured within the items on the Risk Assessment and/or there are unique circumstances in the family that increases risk. Discretionary overrides must have supervisory approval and may only be used to increase the risk level by one risk level.

RISK REASSESSMENT

The Risk Reassessment must be completed on ongoing protective services cases; see PSM 714-4, CPS Updated Services Plan and Case Closure.

Risk Reassessment Definitions

R1. Number of prior assigned neglect complaints and/or findings.

Count the number of prior assigned complaints for neglect (confirmed, denied, or found), in which the adult household member was an alleged perpetrator, **prior** to the complaint resulting in the current open case.

a. One or less.
b. Two or more.

R2. Number of prior assigned abuse complaints and/or findings. Count the number of prior assigned complaints for abuse of any type (sexual, physical, child maltreatment, or mental injury), confirmed, denied or found, in which the adult household member was an alleged perpetrator, **prior** to the complaint resulting in the current open case.

a. None.
b. One or two prior complaints.
c. Three or more prior complaints.

R3. Number of children in the household.

The number of individuals under 18 years of age **residing** in the household at the time the current complaint (which resulted in the current open case). If a child was removed as a result of the investigation or is on runaway status, count the child as residing in the household. If the child was removed from the household as the result of a previous investigation and the goal is reunification, count the child as residing in the household. If the child was removed as the result of a previous investigation and parental rights to that child were terminated or the goal is termination of parental rights, do not count the child as residing in the household.

a. Three or less.
b. Four or more.

R4. New confirmed complaints in the past ninety (90) days.

a. No complaints have been received, or a complaint was received and rejected or assigned for investigation but was denied.

b. Yes, a complaint was received, assigned for investigation, and was confirmed.

R5. Either caretaker has a current substance abuse problem.

a. No. No problems with substances or has successfully completed treatment and shows no evidence of a current problem.

b. Yes. Either or both caretaker(s) is (are) abusing drugs and/or alcohol. This includes caretaker(s) who is (are) currently in a drug or alcohol abuse treatment program.

c. **Yes, and refuses treatment.** Either or both caretaker(s) has(have) a current alcohol and/or drug problem; treatment has been offered or recommended and has been refused.

R6. Family is, or children are, unsafe due to housing conditions.

a. No.

b. Yes, one or more of the following is true (check all that apply)**:**

__ **The family is homeless or about to be evicted (current eviction notice).**

__ **Current housing is physically unsafe; not meeting the health and/or safety needs of the child.** Examples include, but are not limited to:

- Structural defects or is unsound.
- Exposed wiring, inoperable heat, or plumbing.
- Human/animal waste on floors that is due to failure to consistently clean or control other adults in the household, children, pets, etc.
- Rotten or rotting food due to failure to consistently clean or control other adults in the household, children, pets, etc.
- Disconnection of major utilities (gas, electric or water).

R7. Primary caretaker is unable/unwilling to control impulses.

a. No, the primary caretaker is able and willing to control impulses.

b. Yes, the primary caretaker is unable and/or unwilling to control impulses. Examples include, but are not limited to:

- **Regularly** acting without weighing alternatives or considering consequences.
- Spur-of-the-moment actions, and/or heedless, self-centered actions that **regularly** result in threatened or actual harm to the child.
- A **regular** inability to delay gratification of personal needs to assume childcare responsibility.
- Lashing out verbally (yells/screams, berates, uses hostile language, etc.) and/or physically (hits, shoves, threatens violence, etc.) in response to (undesired or negative) actions of the child and/or others.

R8. Primary caretaker provides inadequate physical care and/or inadequate supervision of child.

a. No, the primary caretaker provides adequate physical care and supervision of child.

b. One or both of the following is true (check all that apply)**:**

__ **Provides inadequate physical care:** The provision of physical care (the appropriate feeding, clothing, shelter, hygiene, and medical care) is inconsistent with and/or not appropriate for the child's needs. There has been harm or threatened harm to the child's health and/or well-being due to the inadequate physical care. Examples include, but are not limited to:

- Failure to obtain medical care for severe or chronic illness.
- Repeated failure to provide child with clothing appropriate for the weather.
- Poisonous substances or dangerous objects lying within reach of child.

•• Child's clothing or hygiene causes negative social consequences for the child.

__ **Provides inadequate supervision:** Supervision is inconsistent with and/or not appropriate for the child's safety resulting in threatened or actual harm to the child.

R9. Either caretaker is in a violent domestic relationship.

Either caretaker is involved in relationships that are harmful to domestic functioning or childcare. Include only domestic violence between caretakers or between a caretaker and another adult. Do not include parent-child or child-child domestic violence.

a. No.
b. Yes. Either caretaker is currently involved in a relationship (either as a victim or as a perpetrator), in which incidents of physical violence or fighting and/or intimidation/threats/harassment have occurred.

R10. Primary caretaker's progress in service plan and reduction of prioritized needs.

Evaluate the primary caretaker's overall effort to reduce or resolve needs identified and scored on the family assessment of needs and strengths. The evaluation is based on worker assessment of the caretaker's engagement in the plan; and the caretaker's behavior in priority needs areas, determined by observing appropriate caretaker behaviors in caring for children in the home and/or interacting with children, service providers, and others, as well as reports from collateral sources.

a. Demonstrates substantial progress in reducing all prioritized needs identified in the service plan.

The caretaker is actively engaged in services identified in the plan, and/or routinely (three-fourths or more of the time) demonstrates appropriate behaviors during interactions with children, service providers, and others in all prioritized needs areas.

b. Demonstrates at least partial progress in all prioritized needs and substantial progress in one or more prioritized needs.

The caretaker routinely (three-fourths or more of the time) demonstrates appropriate behaviors in at least one area identified as a priority need and is engaged in services identified to meet that need.

In all other priority need areas, demonstrates appropriate behavior and engagement in services or service plan objectives often (half to three-fourths of the time).

c. Demonstrates at least partial progress in two or more prioritized needs but has not shown substantial progress in any prioritized needs.

The caretaker often (half to three-fourths of the time) demonstrates appropriate behaviors in two or more areas identified as a priority need.

In addition, caretaker is, at least half the time, engaged in services or meeting service plan objectives identified to meet those needs. Caretaker's efforts may be inconsistent but occur at least half of the time.

d. Demonstrates poor progress in reducing two or more of the prioritized needs.

The caretaker rarely (less than half of the time) demonstrates or fails to demonstrate appropriate behaviors in two or more areas identified as a priority need, although partial or substantial progress may have been made in reducing one or more identified priority needs.

Caretaker is not meeting service plan objectives identified to meet prioritized needs or is not engaged in services or demonstrates service plan engagement less than half the time.

e. Refuses involvement or fails to participate in the service plan.

The caretaker refuses or does not participate in services or service plan objectives necessary to address the priority needs identified in the case plan.

R11. Secondary caretaker's progress in service plan and reduction of prioritized needs.

Evaluate the secondary caretaker's overall effort to reduce or resolve the priority needs identified and scored on the family assessment of needs and strengths. The evaluation is based on worker assessment of the caretaker's engagement in the plan; and the caretaker's behavior in priority needs areas, determined by observing appropriate caretaker behaviors in caring for children in the home and/or interacting with children, service providers, and others, as well as reports from collateral sources.

a. Not applicable; only one caretaker in the household.

b. Demonstrates substantial progress in reducing all prioritized needs identified in the service plan.

The caretaker is actively engaged in services identified in the plan, and/or routinely (three-fourths or more of the time) demonstrates appropriate behaviors during interactions with children, service providers and others in all prioritized needs areas.

c. Demonstrates at least partial progress in all prioritized needs and substantial progress in one or more prioritized needs.

The caretaker routinely (three-fourths or more of the time) demonstrates appropriate behaviors in at least one area identified as a priority need and is engaged in services identified to meet that need.

In all other priority need areas, demonstrates appropriate behavior and engagement in services or service plan objectives often (half to three-fourths of the time).

d. Demonstrates at least partial progress in two or more prioritized needs but has not shown substantial progress in any prioritized needs.

The caretaker often (half to three-fourths of the time) demonstrates appropriate behaviors in two or more areas identified as a priority need.

In addition, caretaker is, at least half the time, engaged in services or meeting service plan objectives identified to meet those needs. Caretaker's efforts may be inconsistent but occur at least half of the time.

e. Demonstrates poor progress in reducing two or more of the prioritized needs.

The caretaker rarely (less than half of the time) demonstrates or fails to demonstrate appropriate behaviors in two or more areas identified as a priority need, although partial or substantial progress may have been made in reducing one or more identified priority needs.

Caretaker is not engaged in services or is not meeting service plan objectives identified to meet those needs or demonstrates service plan engagement less than half the time. Evidence of poor progress includes a caretaker's failure or refusal to attend services or work toward service plan objectives identified to address a priority need.

f. Refuses involvement or fails to participate in the service plan.

The caretaker refuses or does not participate in services or service plan objectives necessary to address the priority needs identified in the case plan.

Overrides

For more information overrides on a risk reassessment, see PSM 714-4, CPS Updated Services Plan and Case Closure.

THREATENED HARM ASSESSMENT

In cases in which historical threatened harm is alleged, discovered, or confirmed, a threatened harm assessment must occur to demonstrate the historical information was assessed and considered in the current investigation.

The case manager must assess all five areas including:

- Severity of past behavior.
- Length of time since past incident.
- Evaluation and benefit from services (including if conditions have been rectified).
- Comparison between the past and current referrals.
- Vulnerability of child(ren).

Case managers must consider all information obtained from the assessment to comprehensively determine if threatened harm remains a factor for maltreatment, and/or to determine if legal action is needed; see PSM 715-3, Family Court: Petitions, Hearings and Court Orders for more information on potential mandatory legal action.

Severity of Past Behavior

A review of past behavior must be evaluated to assess severity. Individuals with prior criminal convictions or a prior confirmed case for the following would be concerning and considered more severe:

- Abuse and/or neglect was the cause of a child's death.
- Sexual abuse or sexual exploitation.
- Severe physical injury to a child that required medical treatment or hospitalization and that seriously impaired the health and physical well-being of the child.
- Child exposure to methamphetamine production.

Any past behavior related to a criminal conviction and/or confirmed abuse and/or neglect must be documented.

Length of Time Since Past Incident

The length of time since the historical incident(s) must be documented.

Evaluation of and Benefit from Services

Attempts must be made to obtain information on participation and benefit from past services.

Documentation must evaluate participation and benefit based on a review of historical service reports, contact with service providers, and input from the parent/caregiver.

Progress since the prior incident(s) must be documented, including whether the parent/caregiver has reoffended.

Comparison Between the Past and Current Referrals

Documentation must evaluate any historical incidences in relation to current circumstances, to determine if there is a relationship between historical concerns and current safety, or if there are trends in behavior.

Vulnerability of Child

Documentation must assess the vulnerability of the child. A child may be more vulnerable due to age, mental capacity, physical ability, etc.

STRENGTHS AND NEEDS ASSESSMENTS

In most cases where a preponderance of evidence of CA/N is found to exist, and ongoing services are provided to a family, a Family Assessment of Needs and Strengths (FANS) and a Child Assessment of Needs and Strengths (CANS) must be completed.

These assessments should be family led and are used to identify areas of focus for services to mitigate safety concerns and reduce risk to the child. These assessments are used to:

- Develop a service agreement with the family that prioritizes the needs that contributed most to the maltreatment as identified by the FANS and CANS.
    - Careful consideration should be given to any childhood trauma for the parent/caregiver that may be contributing to current circumstances. Any childhood trauma the parent/caregiver may have experienced should be assessed to assist the parent/caregiver with navigating services and support, if needed.

- Identify service provision for open cases or cases closed with a referral to a community service or another agency for services.
- Help identify gaps in service array within the community to inform opportunities for the department to explore further.
- Identify strengths to build parental and protective capacities, strengthen families, and ensure child safety.

See PSM 714-1, Post-Investigative Services, for information on service provision and service agreements.

Family Assessment of Needs and Strengths

When ongoing services are provided to a family, a FANS must be completed. When two separate households are participating on the same case, a FANS must be completed for the household in which a perpetrator resides or for which services will be provided; for example, when the non-custodial parent is found to be a perpetrator of abuse and the custodial parent is not found to be a perpetrator, a FANS is needed only on the non-custodial parent's household, unless services will also be provided to the custodial parent. A separate FANS must be completed if needed for more than one household. Two households must not be combined on one FANS.

For definitions and more detailed information and definitions on the FANS, see FOM 722-09A, Family Assessment of Needs and Strengths (FANS).

Child Assessment of Needs and Strengths

If a preponderance of evidence of CA/N is found to exist, and ongoing services are being provided to the family, the CANS must be completed for the following:

- Child identified as victims.

- Every child residing in a household in which a person identified as a perpetrator of CA/N resides.
- Every child residing in a household where services are provided for that household.

A separate CANS must be completed for each child. Children must not be combined on one CANS.

Assessment Domains, Scoring, Definitions and Milestones

For information on assessment domains, scoring, definitions and milestones see FOM 722-09, Child Assessment of Needs and Strengths (CANS).

OVERVIEW

The Child Abuse and Neglect Registry (CA/NCR) contains a list of individuals who were identified as a perpetrator in a central registry case. Confirmed cases of child abuse and/or neglect resulting in central registry placement require notification to the identified perpetrator. Confirmed cases of child abuse and/or neglect that do not result in central registry placement also require notification to the identified perpetrator.

Definitions

Confirmed Case

The department has determined, by a preponderance of evidence, that child abuse or child neglect occurred by a person responsible for the child's health, welfare, or care. If the case is not confirmed for methamphetamine production, serious abuse or serious neglect, sexual abuse, or sexual exploitation, it does not require central registry placement.

Central Registry Case

The department confirmed that a person responsible for the child's health or welfare committed serious abuse or neglect, sexual abuse, sexual exploitation of a child, or allowed a child to be exposed to or have contact with methamphetamine production.

The central registry contains a repository of names of individuals who are identified as perpetrators in a central registry case in the department's statewide electronic case management system. The registry includes:

- Individuals who have been given appropriate notification, identified by a date in the due process (DP) box, their names were placed on central registry.
- Individuals placed on central registry but who the department cannot verify the individual received appropriate notification.
- Individuals referred to the department by a convicting criminal court following an order of conviction for a violation of section 136b of the Michigan Penal Code, involving a minor victim, and any conviction involving the death of a child.

Note: Individuals that need to be placed on or removed from central registry as a result of a criminal conviction will be addressed by Children's Protective Services (CPS) program office.

ADDING A PERPETRATOR TO CENTRAL REGISTRY AND PERPETRATOR NOTIFICATION PROCEDURES

Central Registry Placement

Known perpetrators cannot be placed on central registry with an estimated birthdate. The perpetrator's proper/legal name and actual birthdate must be used. If the perpetrator is unknown and the case is kept open for services, attempts must continue to be made to identify the perpetrator. If the unknown perpetrator is identified, their name must be placed on central registry.

New Investigation Perpetrator Must Be Added on Central Registry

The perpetrator is automatically added to central registry following supervisory approval of the investigation in the electronic case management record. Once the perpetrator is added to central registry, the perpetrator notification letter must be generated and saved. The DP date must be added by the caseworker. See *Perpetrator Notification Requirements and Timeframes* section regarding detailed notification requirements.

Investigations with Prior Central Registry (No DP Date) Listing

When a new CPS investigation begins and the required central registry inquiry reveals that any member of the new CPS investigation is a perpetrator listed on central registry with no DP date, the local office conducting the new investigation must, at the completion of the investigation, provide notice to the perpetrator(s) of their placement on central registry. *See Perpetrator Notification Requirements and Timeframes* below in this policy item.

Note: If the individual has been expunged from central registry, do not add a due process date.

Perpetrator Notification Requirements and Timeframes

Placement on Central Registry Notification

Notification to the perpetrator being placed on central registry must be completed and documented by using the DHS-847a, *Perpetrator Notification* letter, in the electronic case management record. This notice must be sent by registered or certified mail, return receipt requested, and delivery restricted to the addressee within 30 calendar days after the classification of a confirmed central registry case. If the notification is returned "refused" or otherwise undeliverable, the envelope and receipt must be uploaded to the electronic case record.

Perpetrator notification of placement on central registry requires formal, documented notification to the individual, which includes the following:

- The individual has been identified as a perpetrator of confirmed serious abuse or neglect, confirmed sexual abuse, confirmed sexual exploitation, or a confirmed case of methamphetamine production.
- The right to review the file; see SRM 131, Confidentiality, for more information on what information can be released from the CPS file.
- The record may be released under MCL 722.627d.
- The right to request amendment or expunction of the report or record; see PSM 717-2, Amendment or Expunction, for more information on these requests.

These requirements are met when notice is provided to the perpetrator using the DHS-847a, *Perpetrator Notification* letter, in the electronic case management record along with confirmation of receipt.

Confirmed Cases: No Placement on Central Registry Notification

Notification to perpetrators of confirmed cases of abuse or neglect, who are not required to be placed on central registry, must be completed within 30 calendar days after the classification of a

confirmed case and documented using the DHS-847c, *Notice of a Confirmed Case* letter in the electronic case management record. This notice must be sent by first-class mail to the identified perpetrator.

The notification letter for perpetrators of confirmed cases that do not require central registry placement includes all the following:

- The individual has been identified as a perpetrator of confirmed abuse or neglect.
- The right to review the file; see SRM 131, Confidentiality, for more information on what information can be released from the CPS file.
- The right to request amendment of the record; see PSM 717-2, Amendment or Expunction, for more information on these requests.
- The record may be released under MCL 722.627d.
- Potential impact to future employment or licensing opportunities.

Minor Perpetrators

If the minor perpetrator is not emancipated, copies of the notification letter must be delivered to both the minor parent and to the minor's parent or legal guardian; see *Perpetrator Notification Requirements and Timeframes* above.

AMENDMENT AND EXPUNCTION

An individual who is the subject of a report or record made may request the department amend or expunge an inaccurate report or record from the central registry and/or local office file. See PSM 717-2, Amendment or Expunction, and PSM 717-3, Administrative Hearing Procedures, for more information on amendments and expunctions. See SRM 131, Confidentiality, for more information on what information can be released from the CPS file.

If the investigation of a report conducted under MCL 722.627j does not show serious abuse or neglect, sexual abuse, sexual exploitation, or methamphetamine production by a preponderance of the evidence, or if a court dismisses a petition based on the merits of the petition filed under section 2(b) of chapter XIIA of the

probate code of 1939, 1939 PA 288, MCL 712A.2, because the petitioner has failed to establish, or a court has failed to find, that the child comes within the jurisdiction of the court following an adjudication hearing, the information identifying the subject of the report must be expunged from the central registry after a party has exhausted all appellate remedies and an appellate review does not find that the child is within the jurisdiction of the court.

Note: This section does not apply to individuals for which the court has entered an order of conviction.

Note: A court must find and dismiss a petition on jurisdiction for the department to remove the petitioner from the Central Registry. Other reasons for the dismissal of a case that does not involve the court dismissing on the merits do not result in removal from the Central Registry.

CENTRAL REGISTRY CLEARANCES

Central registry records are accessed by completing a query in the central registry module in the electronic case management system.

Whenever department staff complete a central registry clearance and identify a perpetrator listed on central registry with no DP date, and the address of the perpetrator is known, that staff must notify the local office CPS unit where the case was last entered on central registry.

If a local office receives notice that the perpetrator is listed on central registry with no DP date, or the department staff completing the central registry clearance is the local office where the case was last entered on central registry, that local office must provide notice to the perpetrator if the perpetrator's address is known and add the DP date to central registry.

See the *Perpetrator Notification Requirements and Timeframes* section above regarding the requirements and timeframes for delivering the Perpetrator Notification letter to the perpetrator.

Note: If the central registry placement was a result of a criminal conviction and there is no DP date, please contact the Child Welfare Policy Mailbox (Child-Welfare-Policy@michigan.gov).

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox (Child-Welfare-Policy@michigan.gov).

OVERVIEW

Michigan Department of Health and Human Services (MDHHS) supervisors must review and verify that Children's Protective Services (CPS) investigations comply with CPS policy and law. Supervisors must complete the Supervisory Control Protocol (SCP), which qualifies as the investigation checklist required in law.

When reviewing investigation reports, supervisors may identify and require additional casework activities, including face-to-face contacts needed for policy compliance. In instances where there are deficiencies, supervisors must return the case to the caseworker with steps for corrections outlined.

Note: All timeframes within this item are calculated based on calendar days.

Supervisory Control Protocol (SCP)

The SCP enables supervisors to review and verify compliance with investigation requirements, including the quality, quantity and documentation of a child abuse/neglect requirements. Completion of the SCP satisfies investigation checklists in MCL 722.628(e).

The SCP requires supervisors to verify that required activities were completed, that completion met policy requirements and completion of requirements were sufficiently documented.

The SCP requires supervisors to review activities at three intervals, also called check points, during a CPS investigation:

Phase 1 (Beginning the Investigation)- Supervisor review must occur within the first 7 days of the date of the complaint.

Phase 2 (Gathering Evidence)- Supervisor review must occur within the first 14 days of the date of the complaint.

Phase 3 (Completing the Investigation)- Supervisor review and verification must occur within the first 7 days of the 14-day supervisory review period.

At each phase the supervisor must review each required activity and respond with a Yes, No, or not required (N/R), as well as adding any necessary notation regarding policy compliance.

Marking Yes indicates that the supervisor verified that:

- The required activity occurred.
- The completed activity met all qualitative standards and related policy requirements.
- The activity was thoroughly documented in MiSACWIS.

Note: The SCP is not inclusive of all policy requirements. Dependent upon the investigation situation, additional policy requirements may still apply.

SCP Variance

Supervisors unable to complete a SCP check point on the due date are allowed a variance of three business days to complete and verify the SCP check point.

Each MDHHS county office must establish a written procedure to assure timely completion of the SCP in circumstances when a CPS supervisor is unavailable for more than three business days. Counties should consult with their BSC director for review and final review of developed procedures.

FINAL APPROVAL

Within 14 days of receipt of submission of the report from the caseworker, supervisors must review and approve the entire SCP prior to approval of the investigation in MiSACWIS. Final approval of the Investigation Report ensures and attests to supervisory approval of the following:

- Thoroughness and completeness.
- Accuracy of the investigation.
- Disposition of the investigation.
- Assessment of risk and safety of the children.
- Services provided to the family.

If the supervisor determines that the investigation does not comply with department policy and Child Protection Law, the investigation must not be approved until review and approval by the local office director.

OVERVIEW

The Michigan Department of Health and Human Services (MDHHS) ongoing program seeks to prevent further maltreatment and keep children safe in their own home. The ongoing program builds on family strengths and partners with families to address the needs and safety of children and families following a confirmed investigation. The goal of the department is to ensure child safety by partnering with families and providing resources that are available, accessible, and culturally appropriate.

This policy outlines requirements for engagement and contact with the family, development of a services agreement, referral to services based on family needs as identified by the family and the case manager, and completion of structured support tools.

DEFINITIONS

Family Team Meeting (FTM)

A deliberate and structured approach to involving youth, families and caregivers in case planning through a facilitated meeting of family and their identified supports; see FOM 722-06B, Family Team Meeting.

Family Assessment of Needs and Strengths (FANS)

A Structured Decision Making (SDM) tool used to evaluate the presenting needs and strengths of a family; see PSM 713-11, Assessments and FOM 722-09A, Family Assessment of Needs and Strengths.

Child Assessment of Needs and Strengths (CANS)

An SDM tool used to evaluate the presenting needs and strengths of a child; see PSM 713-11, Assessments and FOM 722-09, Child Assessment of Needs and Strengths.

ONGOING SERVICES

Following investigation, the level of department response is based on category designation; Category I, Category II, Category III, Category IV, or Category V (MCL 722.628d). For information on categories; see PSM 711-4, CPS Legal Requirements and Definitions. The category designation is based on whether child abuse and/or neglect (CA/N) is confirmed, the level of future risk,

and the safety decision as determined in the Safety and Risk Assessments. For information on Safety and Risk Assessments; see PSM 713-11, Assessments.

This item will describe ongoing case requirements and case manager responsibilities for Category I, II, and III cases where children remain in the home.

Category III Cases

Category III means there is a preponderance of evidence of CA/N, and the risk of future harm is low or moderate. The case manager must refer the family to community-based services commensurate with the risk level and safety factors identified. If the family does not voluntarily participate in services, or the family voluntarily participates in services, but does not progress toward alleviating the child(ren)'s risk level, the department must consider reclassifying the case as category II; see *Reclassification of a Case* section in this item.

If the child(ren) is/are determined to be safe and ongoing CPS services and monitoring is not warranted, the case manager must:

- Utilize the open/close option in the electronic case record in the investigation.
- Refer the family to voluntary, community-based services.
- Complete an FTM; see *Family Team Meeting* section in this item.

If the child(ren) is/are determined to be safe with services, Category III cases may be opened to assist the family with voluntarily accessing community-based services and monitoring progress.

If opening the category III case, the case manager must:

- Open the case in the electronic case management system.
- Refer the family to voluntary prevention or community-based services.
- Make contact with the family according to the risk level; see *monthly service level and contact standards chart* in this item.

Category III cases should be closed within 90 days following the date of the referral unless a case extension is needed, or the category of the case is reclassified.

Extension of Category III Case

The 90-day period may be extended up to 90 additional days in limited circumstances, such as the service provider was unable to begin services during the first 90 days. The extension request must be submitted **prior** to the end of the initial 90-day period. Complete a safety reassessment and submit the request for supervisory approval of an extension by completing the extension request in the electronic case record.

Category II Cases

Category II means CA/N was confirmed, the risk assessment result indicated a high or intensive risk of future harm, and the child(ren) can remain safe in the home with services, as determined by the safety assessment. An ongoing case must be opened, and services offered to the family.

If the child(ren)'s family does not voluntarily participate in services, a petition must be filed, and the case reclassified as a Category I; see *Reclassification of a Case* section in this item.

For Category II cases, the role of the case manager varies depending on the availability and accessibility of community resources and supports. If resources are limited, the case manager may provide direct services to the family. If community resources or contracted services are available, the case manager may coordinate the delivery of various services provided by others. Absent effective preventative services, the planned arrangement for the child(ren) is/are foster care.

Category I Cases

Category I means CA/N was confirmed, the risk level was determined to be high or intensive, the safety decision was unsafe, and a petition must be filed. There are two types of Category I cases:

- In-home placement - The child(ren) remains in the home with the parents/caregivers and court mandates services.

- Out of home placement - The child(ren) has/have been removed and placed out of the home.

CPS ongoing maintains responsibility for case management when the child(ren) remains in the home, while out of home placement cases are transferred to foster care.

RECLASSIFICATION OF THE CASE

Category III

When the family does not voluntarily participate in services or the family does not make progress toward reducing the child(ren)'s risk level, the department must consider reclassifying a Category III case as a Category II case.

Category II

A court petition is required if the department previously classified the case as Category II and the child(ren)'s family does not voluntarily participate in services.

Cases that are reclassified must be served with contact standards applicable to their new risk level.

Example: If a Category III, moderate-risk case, is reclassified to a Category II, high-risk case, adhere to the contact standards for high-risk cases.

Process for Reclassification

To reclassify the case, the case manager must take the following steps in the electronic case record:

1. Select the case for reclassification.
2. Select program type history.
3. Select escalate CPS category.
4. Select appropriate escalation category option (escalate to Category I or Category II).
5. Enter escalation case conference date.

6. Enter a narrative.
7. Select the associated risk reassessment.
8. Select approval to route the request to the supervisor.

MONTHLY CONTACT STANDARDS

Monthly contact standards for open ongoing cases are dependent upon the risk level. Case managers may use the contact standards chart to determine required contacts for each calendar month. Case managers should consider additional contacts with the family dependent upon risk factors or needs of the family.

At onset of the case, the risk level is determined from the investigation and carries over to the ongoing case. A risk reassessment cannot be completed until contact has been made with the family.

Regardless of the risk level, each primary caregiver, victim, and non-victim child(ren) in the family must be seen at least once a calendar month where the family primarily resides.

ONGOING CALENDAR MONTH CONTACT STANDARDS CHART

Opening Month	
Day One = Day following disposition by the case manager	
7 business day requirement* (Business day 1-7)	1 F/F with each primary caregiver from a participating household 1 F/F with each victim (can occur in the same contact)
1st calendar month - any risk level	1 F/F with each primary caregiver from a participating household 1 F/F with each child victim (can occur in the same contact) 2 collateral contacts
3 or less business days in the opening month	Only 7 business day requirement (may occur in current month or subsequent calendar month, but within 7 business days)

Opening Month	
	Standard contact requirements are required the following calendar month

2nd/Subsequent Calendar Month Until Closing Month						
Risk Level	Total Contacts (Face-to-face)	Contracted Agency allowed contact	Contact with each victim/non-victim child	Contact with each caregiver per participating household	Collateral contacts	Data report contact requirements (CS-1302 and CW-1302) *Requirements are per participating household*
Intensive	4	3	1	1	4	1 F/F with each primary caregiver 1 F/F with each child victim 1 F/F with each non-victim child
High	3	2	1	1	3	
Moderate	2	1	1	1	2	
Low	1	0	1	1	1	

Closing Month	
Must occur within 30 calendar days prior to closure Requirements are per participating household	1 F/F with each primary caregiver from a participating household 1 F/F with each victim 1 F/F with each non-victim child

Closing Month	
Standard calendar month contacts are not required for closing month	

Key
F/F = Face-to-face contact
Participating = Household is participating a minimum of 1 day during the period
* 7 business day requirement may meet opening month requirement in some cases

Face-to-Face Contact

A face-to-face contact is defined as an in-person contact with the perpetrator, victim, other child(ren), or other caregiver (parent, guardian, or other person responsible) for the purpose of engagement regarding substantive case issues. Contacts should allow case managers to gather information necessary for subsequent completion of the risk reassessment, reassessment of FANS and CANS, treatment planning, service agreement development and/or progress review. Each primary caregiver, victim, and non-victim child(ren) in the family must be seen at least once a calendar month where they primarily reside.

Collateral Contact

Collateral contacts refer to all other contacts the case manager may need to make, such as contacts with extended family, a relative, support persons, the school, any service providers, or other agencies. These contacts may be face-to-face, by telephone or email, among others.

Visit Requirements

Caregiver

A face-to-face contact must occur with the primary caregiver from each participating household each calendar month following

disposition. Safety planning with the family should occur during these monthly meetings and should be reviewed as needed.

When visiting with the caregiver, the case manager should allow the caregiver to lead discussions based on needs. Case managers should also engage with the caregiver to address topics such as the initial concerns from the investigation, the needs of the child(ren), and the ability of the caregiver to meet the child(ren)'s needs.

Identified Perpetrator(s)

Attempts to have at least quarterly contact with individuals confirmed as perpetrators should occur to address child(ren) safety concerns and the need for community-based services or supports.

Note: If the identified perpetrator of the child abuse and/or neglect is determined to be a caregiver, follow contact standards for a caregiver as instructed in the *Ongoing Calendar Month Contact Standards* in this item.

Children

Each child must have a face-to-face visit by the case manager a **minimum of once** every calendar month following disposition.

Note: At least once every calendar month, a private meeting must be held with the child in absence of the caregiver/perpetrator. A private meeting allows a case manager to meet individually with a child. The way a case manager conducts a private meeting will depend on the age and developmental ability of the child.

Case managers should engage with children through a child-led approach based on developmental capability. Case managers should tailor discussions to preference of the child(ren) and should include efforts to assess child(ren) safety.

Case managers must not enter a home without permission from an adult or speak to a child who is home alone. If an adult is not present at the home, case managers may not request the child(ren) step outside to speak with them, even if the child(ren) agrees or suggests this solution.

Case Manager Visit Tool

Two optional tools are available to assist case managers with gathering information during the monthly visit:

- DHS-903-A, Children's Protective Services Caseworker/Child Visit Tool. This tool may be used to take notes during the visit.
- DHS-903, Children's Protective Services Caseworker/Child Visit Quick Reference Guide. This tool contains information that should be covered in a monthly visit but is not intended for recording notes.

Social Work Contacts

All contacts must be documented in social work contacts. Social work contacts should reflect the following pertinent themes:

- Engagement with the person or family.
- Level of family engagement and progress with services.
- Safety concerns regarding the child(ren).
- Safety plans and any necessary updates.
- Any other information pertinent to the case.

Contacts by Contracted Agencies

If a family is referred to prevention services contracted by MDHHS for the purpose of reducing risk to the child(ren), face-to-face contacts by the contracted provider with the client may be counted as a face-to-face contact to replace a case manager's contact, as outlined in the *ongoing calendar month contact standards chart* in this item. Contacts the family has with other local agencies which are not under contract with MDHHS, such as a public health department or community mental health, may not be counted as face-to-face contacts to replace the case manager's contacts.

If MDHHS employs service providers such as parent aides, homemaker aides, or others to work with clients for the purpose of reducing risk to the child(ren), face-to-face contact by the MDHHS-employed service provider with the client may be counted as a face-to-face contact to replace a case manager's contact as outlined above in the *ongoing calendar month contact standards chart*.

If the case manager becomes aware the service provider(s) have not been able to meet the required number of contacts, the case manager must ensure the safety of the children by completing the required contacts. Until the issue is resolved, the case manager is responsible for meeting all required contact standards.

The initial FANS and CANS outcomes and the development of the service agreement must be discussed during the initial planning conference between the case manager, the service provider, and family. The service provider must obtain the case manager's approval of the proposed service plan prior to implementation. For more information on completion of the FANS and CANS and application of the assessment, see PSM 713-11, Assessments, FOM 722-09A, Family Assessment of Needs and Strengths, and FOM 722-09, Child Assessment of Needs and Strengths.

Families First and Families Together/Building Solutions

Families First and Families Together/Building Solutions must comply with all required service standards in referred cases. The case manager must have a minimum of one contact per month with the Families First or Families Together/Building Solutions case manager, either face-to-face, by telephone, or teleconferencing; see PSM 714-2, Supportive Services.

Scheduled and Unscheduled Home Visits

Scheduled and unscheduled visits should be considered based on the unique circumstances of the case. Scheduled home visits may be preferred to allow better coordination of visits between the case manager and family. Unscheduled visits should be considered when:

- New concerns are brought to the attention of the case manager.
- Assessment of child safety could be impacted by a scheduled visit.

SERVICING AND ENGAGEMENT

Case Manager Responsibilities

Case manager responsibilities for post-investigation cases include development of a prevention plan with the family to address safety concerns or needs identified in the risk assessment/reassessment and the FANS and CANS.

Services offered should:

- Be culturally relevant.
- Be sufficient in frequency and duration.
- Be relevant to family needs and address the top three needs identified by the FANS that contributed to the maltreatment.
- Assist parents or caregivers in identification of goals for reducing risk to the child and enhance their ability to provide adequate care of their child(ren).
- Assist parents or caregivers with identification of resources within their community and extended family support system and facilitate access to and use of those resources.
- Support parent or caregiver efforts. Help the parents or caregivers assess and be responsive to the needs of their child(ren). Support and encourage the caregivers by helping them to recognize their own strengths and encourage them to apply these strengths to reach identified goals.
- Assist parents and caregivers in learning new skills in areas including childcare, household budgeting, preparation of nutritious meals, household organization, child development, discipline, and other necessary areas.
- Facilitate linkage of family to needed resources including financial assistance, medical assistance, family planning services, housing, legal aid, or employment.
- Include engagement with the family to evaluate the need for continued services.

See PSM 714-2, CPS Supportive Services for more information on services.

Court Involvement

Every effort must be made to keep families together whenever safely possible. When engagement efforts and service provision are insufficient to achieve and maintain child(ren) safety, a petition seeking court intervention may be necessary; see PSM 715-3, Family Court: Petitions, Hearings and Court Orders. Whenever possible, case managers must request a FTM to discuss the concerns and attempt to resolve them before filing a petition; see *Family Team Meeting* section in this item.

A request for removal is not necessary in all situations. Relief requested should be the least intrusive necessary to protect the child(ren) or resolve the emergency.

The case record must demonstrate the following when filing a petition:

- Services provided and reasons for ineffectiveness.
- Imminent and substantial risk of harm to the child(ren).

The petition must state:

- The reason(s) why it is contrary to the welfare of the child(ren) to remain in the home.
- Reasonable efforts that were made to prevent the removal.

Note: Active efforts must be made to prevent removal for American Indian children; see NAA 205, Indian Child Welfare Case Management, and see NAA 235, Emergency Placement, for information on safety planning and removal of American Indian children.

Removal and placement

Non-custodial parents should always be considered first for placement of the child(ren). The case manager must work with the parents to identify relatives for placement when removal is being sought. When considering placement with the other parent, case managers should consider if a petition is necessary or if other means of engagement and safety planning would be effective for

voluntary placement with the other parent. See PSM 715-2, Court Intervention and Placement of Children, for information on placement with relatives or non-custodial parents.

Parents who are incarcerated should still be included in placement decisions for their children. Parental incarceration alone does not meet the criteria of abuse or neglect.

If a child(ren) is/are removed, but returned home within 7 days, face-to-face contact with the child(ren) is/are required within 7 days after the child(ren) is/are returned home.

Diligent Relative Search and Genograms

Diligent Relative Search

Case managers must continue to search for and identify relatives for the duration of an open case for purposes of placement and/or support. These activities should be reflected in each case service plan. Case managers must attempt to contact all known relatives and document those efforts. Relatives who are unable or unwilling to take placement may still be a source of support for the child(ren) and family.

Case managers may use the DHS-991, Relative Search Checklist, for suggestions of methods to complete a relative search.

Case managers must use the DHS-987, Relative Documentation, to document all the following when contacting relatives:

- All identified relatives.
- The relative's relationship to the child(ren).
- Contact information for the relative.
- The dates of contact by the case manager.
- The types of resources or supports the relative expresses interest in providing to the family.

Note: For an Indian child(ren), extended family members, as defined by the law or custom of the Indian child(ren)'s tribe, may be included as relatives for placement purposes. Ongoing, diligent search efforts must occur; see NAA 215, Placement/Replacement Priorities for Indian Child(ren).

Genograms

Genograms are a valuable tool that assist case managers with establishing rapport with families and gathering information on family relationships, dynamics, behavior patterns, and history. Genograms can also assist with locating, identifying, and engaging the family's relative network. For more information on genograms; see FOM 722-06, Case Planning.

A genogram must be completed during the first service period in all Category I, II, and III cases and documented in the initial updated service plan.

Case managers may hand draw genograms or use genogram software. MDHHS case managers may download the GenoPro Tool from the Software Center. Training materials and resources for genogram completion can also be found on the MDHHS Office of Workforce Development and Training (OWDT) Child Welfare Institute Student Guide, including standard symbols for genograms and a genogram example video.

Documentation

Case managers must document ongoing relative search efforts and results in the *Relative Search and Engagement* hyperlink in the electronic case record. Case managers must upload all relative search forms and genograms in the *case overview documents* hyperlink.

Early On®

The ongoing case manager must review the Early On evaluation results, recommendation for services, and ensure those services are incorporated into the case service plan. Services must be developed by engaging with the family and any service providers, to ensure services meet the family's needs.

Monthly Case Consultation

At least one case conference between the case manager and their supervisor must occur monthly for every CPS case. The case conference must be documented in the electronic case record with supervision as the contact type. The narrative should only indicate that the conference occurred.

Safe Sleep

The case manager should discuss safe sleep practices with parents of infants under 12 months of age as needed and assist parents with items they may need, for example, pack n' plays and cribs.

Family Team Meetings

FTMs should be held according to the tables within policy; see FOM 722-06B Family Team Meeting, for more information on content, structure and frequency.

The DHS-1105, Family Team Meeting Report, is used to capture the following:

- Family demographics.
- FTM logistical information.
- Strengths and needs.
- Action steps.
- Safety concerns.
- Safety plans designed to help the parent address any identified safety concerns; see PSM 713-01, CPS Investigations - General Instructions.
- Recommendations made during the FTM.

The DHS-1105 may detail safety plans designed to help the parent(s) address any identified safety concerns; see PSM 713-01, CPS Investigations - General Instructions.

The case manager should develop and document goals and detailed action steps on the DHS-1105 based on family input as well as needs identified in the FANS and CANS. The goals and action steps should be specific, realistic, and clear to identify the expected and measurable outcomes. A copy of the completed form must be provided to the family and scanned and uploaded into the *FTM documents section* of the electronic case record.

The DHS-1105 serves as the service agreement for category II and III cases.

With family input, case managers must develop a strength-based service agreement which focuses on the safety concerns and the related issues identified on the risk and needs and strengths assessments. The overall goal of the service agreement should promote a reduction in the risk to the child(ren). Goals should be developed with the family to address needs and must be identified in the service agreement.

Case managers should identify the top three prioritized needs based on the FANS and CANS to promote services for these needs. A goal must be stated for each service based on the need. Goals should be developed to demonstrate that they are:

- Developed with family input.
- Specific.
- Realistic.
- Clear to identify the expected and measurable outcomes.

The service agreement must be printed, and a copy provided to the family.

CASE CLOSURE

See PSM 714-4, CPS Updated Services Plan and Case Closure.

SPECIAL CASE SITUATIONS

Cases Involving Multiple Counties

In cases involving multiple counties, the county of residence may request that another county make a service referral, supervise services, or conduct other case manager related activities in the other county. This is referred to as a courtesy request. Courtesy requests may happen for a variety of reasons such as:

- A family will be visiting another county and while there, verification of child(ren) safety or servicing for the family is needed.
- A custodial parent resides in the county of origin and the other parent resides in another county.
- A parent places their child(ren) in another county voluntarily.

- To verify relocation of a family to another county.

Requests for courtesy supervision, service referrals, and other case management activities must be honored. Courtesy case managers and supervisors should be assigned within the electronic case record. Disputes between counties must be referred to the respective Business Service Center (BSC) director(s) for resolution.

All activities completed by the courtesy case manager must be documented in social work contacts. The assigned primary case manager and courtesy case manager should ensure a flow of communication that addresses the status of the family as well as safety concerns and needs.

Transfer of Case Due to Relocation

If the primary assessment household moves to a new county, a request may be made to the new county to transfer the case after relocation has been verified.

Disputes between counties must be referred to the respective BSC director(s) for resolution.

Domestic Violence

Interventions in cases where domestic violence is a factor should be consistent with the following three principles:

1. Safety of the child(ren) and adult victim must be the primary consideration in all phases of the intervention.

2. The domestic violence offender must be held accountable for acts of violence and coercive and controlling behavior.

3. Safety and service plans should build on the survival strategies of the adult victim to increase their likelihood of remaining safe and protecting the child(ren).

Case managers should assist and support the non-offending caregiver in recognizing and furthering all safety efforts. If the child(ren) is/are at risk of harm by the domestic violence offender, safety planning should continue to support child(ren) safety as a priority. Separation from the perpetrator sometimes places the non-offending caregiver and the child(ren) at increased risk of harm.

Information necessary to develop an intervention in cases involving domestic violence include:

- Potential adverse impacts, including trauma on the child(ren) due to the domestic violence offender's behavior.
- The offender's assaultive and coercive conduct, and the impact on child(ren) safety.
- The role of substance use, mental health, culture, and other socio-economic factors on child(ren) safety.
- Protective factors available for use by the non-offending caregiver, such as use of protective orders, police involvement, family support, or shelters.

Consideration should be made for separate service plans for the non-offending caregiver and the domestic violence offender. See *Case Manager Responsibilities* section for more information on the development of service agreements.

Domestic violence offenders may use manipulative tactics to use the child welfare system to further abuse and retaliate against the non-offending caregiver, or to gain leverage in possible custody disputes. Offenders may file allegations of CA/N against the other caregiver. This behavior may be a warning sign that the danger is increasing.

See PSM 712-6, CPS Intake-Special Situations, *Domestic Violence* section, and PSM 713-08, Special Investigative Situations, Domestic Violence section.

Firearm Assessment

A firearm assessment is intended to be used when a case manager becomes aware of a firearm in a home during an open case. The goal of this assessment is to evaluate the safety of the child, assist with ensuring child safety, and guide caregivers through the safe storage of firearms. See PSM 713-01, CPS Investigation - General Instructions for guidance on assessing firearm safety.

If an assessment was completed during the investigation, the ongoing case manager should be monitoring that all safety plans and/or steps taken to secure a weapon are being adhered to.

Note: Case managers must continue to utilize licensing rules for licensed foster homes. Case managers must also follow criteria regarding weapons, firearms, and/or ammunition outlined in the MDHHS-5770, Relative Placement Safety Screen, and MDHHS-3130-A, Relative Placement Home Study.

New Investigation During an Open Ongoing Case

If a new investigation is received during an open ongoing case, case managers should actively communicate with the assigned investigator to coordinate case requirements, visits, family progress, concerns, and case service plans. Both case managers can utilize relevant contacts from the new investigation and open ongoing case and incorporate those contacts into their respective cases. If a preponderance of evidence of child abuse and/or neglect is found on the new referral, the case manager must open or maintain the case with the higher risk level. If both cases result in Category I dispositions, the case manager must keep the case open that resulted in out of-home placement.

If there are any disputes regarding case services or case direction, insight should be sought from the program manager or director.

Screened Out Referrals

The case manager must review screened out referrals to determine if any new or additional safety planning may be needed based on screened out allegations.

The case manager must document in a social work contact the following:

- Intake ID(s) of screened out allegations.
- Acknowledgement that new allegations have been reviewed.
- Whether additional safety planning is needed.

Open Maltreatment in Care Cases

If there is a combination of confirmed victims, including biological/adoptive children of the identified perpetrator and foster children, the case must transfer to CPS ongoing in the county where services will be provided to the family.

If the identified victims are biological/adoptive children of the identified perpetrator and a foster child is not confirmed as a victim, the case must transfer to CPS ongoing in the county where services will be provided to the family.

CPS ongoing will oversee the provision of services for the family. Regular updates to the foster care agency of responsibility must occur to ensure suitability of continued placement. Preventative services must be initiated by CPS ongoing at case opening.

Note: If a foster child victim is moved to a new placement separate from the perpetrator, but the perpetrator is licensed, the case must transfer to CPS ongoing in the county where the licensee resides, to provide services that address the risks identified during the confirmation. This must occur even if no children remain in the home.

LEGAL BASE

Federal

Child Abuse Prevention and Treatment Act, 42 USC 5101 et. seq.

The Secretary of Health and Human Services may establish an office to be known as the Office on Child Abuse and Neglect.

The purpose of the Office established under subsection (a) shall be to execute and coordinate the functions and activities of this subchapter and subchapter III. In the event that such functions and activities are performed by another entity or entities within the Department of Health and Human Services, the Secretary shall ensure that such functions and activities are executed with the necessary expertise and in a fully coordinated manner involving intradepartmental and interdepartmental consultation with all agencies involved in child abuse and neglect activities.

A State plan submitted under paragraph (1) shall contain a description of activities that the State will carry out using amounts received under the grant to achieve the objectives of this subchapter, including- (xxi) provisions and procedures for referral of a child(ren) under the age of 3 who is/are involved in a confirmed case of child abuse or neglect to early intervention services funded under part C of the Individuals with Disabilities Education Act (20 U.S.C 1431 et seq.).

State

Child Protection Law, MCL 722.628d(c)-(e).

CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox Child-Welfare-Policy@michigan.gov.

OVERVIEW

A family may access supportive services to ensure the safety of the children in the home and improve family well-being. Various funding sources are available to finance service provision.

Individuals and families may be eligible for assistance payments programs, including healthcare coverage, Food Assistance Program (FAP), cash assistance, Child Development and Care (CDC), and State Emergency Relief (SER).

Purchased services are those services purchased for a family through contracts negotiated between the Michigan Department of Health and Human Services (MDHHS) and community-based service providers. The local office negotiates purchased service contracts. Within federal and/or state guidelines, local offices determine what services will be purchased with local contract funds, select service providers, negotiate, and monitor contracts, assess provider performance, evaluate the effectiveness of contract services, and determine the continuance or termination of contracts.

ASSISTANCE PAYMENTS PROGRAMS

Individuals can request assistance for healthcare coverage, food assistance, childcare, and cash assistance on the MiBridges website. Individuals are also able to apply by using the MiBridges app on their mobile device. Individuals can apply for assistance, upload documents, report changes to their current assistance case, and explore resources in the area.

State Emergency Relief (SER)

State Emergency Relief (SER) is a statewide resource to provide immediate help to families facing conditions of extreme hardship or if a family is facing an emergency which threatens their health and safety. SER may be able to help with housing or other emergent needs. SER, when applicable, is a first resource to families and is often sufficient to resolve an emergency.

Eligibility for SER is determined by MDHHS eligibility specialists. SER program information, covered services, and department policy is detailed in the State Emergency Relief Manual (ERM).

COMPREHENSIVE TRAUMA ASSESSMENTS

For information on Comprehensive Trauma Assessments; FOM 802, Mental Health, Behavioral and Developmental Needs of Children.

Comprehensive Trauma Assessments, must be completed while the case is open.

FAMILIES FIRST

Families First of Michigan (FFM) offers families home-based, intensive, short-term crisis intervention and family education services for four weeks using the FFM model. FFM services are designed to support the family unit and to protect the well-being of the child(ren) to ensure the family remains safely intact or that the child(ren) can remain safely in the home. Families First will provide a minimum of 10 hours of contact with the family per week. An extension of up to two weeks may be available.

FAMILY REUNIFICATION ACCOUNT (FRA)

The Family Reunification Account (FRA) is a flexible funds sub-account under the local office Child and Family Safety, Stability, and Permanency Plan (CFSPP) allocation. The local office determines the amount of CFSPP funds designated for FRA. FRA funds are for the individualized needs of families and must avert and/or prevent unnecessary removal of children from their home, facilitate return home, or achieve permanency through relative placement. The local office is responsible for certifying that the concrete/direct service purchase meets eligible use criteria.

For FRA eligibility requirements and request and exception processes; see FOM 722-12, Financial Supports.

FAMILY REUNIFICATION PROGRAM (FRP)

Family Reunification Program (FRP) provides therapeutic, skill-based interventions designed to help families reunify and maintain children safely at home. Only families with children who are in out-of-home placement and are returning home are eligible for FRP

services. For more information on FRP services see FOM 903-17, Support Services to Families.

FAMILIES TOGETHER/ BUILDING SOLUTIONS (FTBS)

Families Together/Building Solutions (FTBS) offers in-home, solution-focused clinical interventions designed to serve families with multiple barriers to enhance the family's well-being, improve safety of the child(ren) and address family issues and risk factors in the home. FTBS services require family participation of three hours per week, or as needed, to address any risks that arise. FTBS intervention is available for up to 90 days with an option to extend for another 90 days.

PARENT PARTNERS

Parent Partners is a program that assists parents whose children have been placed in foster care by teaming them with peers who have first-hand experience navigating through the child welfare system. This is done through the guidance and mentorship of other parents who have successfully reunified with their own children. Referrals to the program can be made by the CPS caseworker when a petition has been filed to remove the child(ren).

POST-ADOPTION SERVICES

Families who have adopted children from the Michigan child welfare system, adopted in Michigan through an international adoption or through direct placement adoption can utilize resources through the Post-Adoption Resource Centers (PARC's). The PARCs provide a variety of services including in-home crisis intervention, free of charge to families who adopted children or have an active guardianship assistance agreement for a child from Michigan's child welfare system.

MDHHS also maintains a post-adoption resource toolkit that contains a list of services available to adoptive families, including adoption education resources, parent support groups, and social media safety, among others.

Information on PARCs and the post-adoption resource toolkit can be found in the MDHHS website under Post Adoption Parent Resources.

Adoption Medical Subsidy

Adoption medical subsidy is intended to assist with payment for necessary services related to the treatment of a physical, mental or emotional condition certified by the Adoption and Guardianship Assistance Office (AGAO). Related Expenses may include therapies, prescriptions, medical supplies or laboratory expenses; see AAM 640, Post Placement Use of the Adoption Medical Subsidy Program.

PREVENTION SERVICES

Prevention services are provided on a continuum to ensure the safety of children in the home and improve the family well-being. Prevention services may be offered in various circumstances as determined by a child's eligibility as a candidate for foster care. Children and families should be assessed for eligibility for prevention services. For information on available prevention services, see SRM 108, Prevention Services: Family First Prevention Services Act.

PSYCHOLOGICAL OR PSYCHIATRIC ASSESSMENTS AND EXAMINATIONS

Psychiatric or psychological diagnostic assessments or examinations may be used to assist in determining the capacity of the parents to participate in and benefit from services, identify the parent's strengths and any areas of concern and assist with developing a treatment plan for further services, as appropriate. The DHS-93, Examination Authorization for Services, may be used for assessment or examination costs in Children's Protective Services cases. The DHS-93 should be routed and submitted using the electronic case record.

Funding for a psychiatric or psychological assessment/examination may be requested using the DHS-93 if **all** the following apply:

- The service is not available without charge through local resources, including community mental health (CMH) agencies.
- The service is not a covered service through Medicaid (MA). If MA eligibility exists and the service is covered under the MA program, the provider must bill the MA program.

- The parents are unable or unwilling to pay and do not have Medicaid or private insurance that will cover the needed service.

An exception may be made for payment of a unique assessment/examination with prior approval from the MDHHS county director, district manager or designee, even though third party payment is available.

Use of the DHS-93 for payment of psychological and psychiatric services is restricted to psychological and psychiatric assessment or examination only. Treatment services may not be authorized using the DHS-93. Treatment services may be funded through MA, when it is a covered service, private insurance, or appropriate purchase of service contracts.

Payment maximums for psychological and psychiatric assessments can be found in SRF 800, DHS-93 Medical Service Authorization.

An estimated cost of the assessment or examination must be obtained prior to the provision of service. The vendor's fee for service should not exceed the estimated cost. The estimate and the billing for service must include a detailing of services, including the cost of:

- Individual testing.
- Clinical interviews.
- Writing the report.
- Recommendations for treatment.

Note: Treatment recommendations **must** be included in each assessment or examination report.

Court ordered assessments/examinations must be paid for by the court issuing the order or from county funds. The DHS-93 must not be used to access state funds to pay for court-ordered assessments/examinations unless the department has specifically requested that the court order the assessment or examination.

SUBSTANCE USE DISORDER SERVICES

The MDHHS website has information on substance use disorder services available in each county. Contact information is also available for regional Prepaid Inpatient Health Plan (PIHP) units.

The PIHPs help administer substance use disorder prevention and treatment services to Michigan residents who have Medicaid insurance coverage or are underinsured. Collaboration between local child welfare staff and their regional PIHP units should occur to facilitate timely access to substance use disorder services.

Under MCL 330.1275(1), substance use disorder treatment agencies that have a waiting list for services must give priority to a parent whose child has been removed or is in danger of being removed due to substance use disorders. Concerns with treatment agency providers should be forwarded to the identified treatment coordinator in your region.

Substance Use Disorder Family Support Program

The Substance Use Disorder Family Support Program (SUDFSP) provides intensive services for substance affected families that are at risk of experiencing a removal due to child abuse and/or neglect. SUDFSP provides skill-based interventions and support for families when a parent is alcohol- or drug-affected or has a co-occurring disorder.

A family support specialist works directly with participating families in their home and community. Interventions may focus on communication, family functioning, increased awareness of the impact that alcohol and/or substance abuse has on the parenting relationship with children, reduction of the use of substances, physiology and cognitive functioning, and recovery supports.

U NONIMMIGRANT STATUS CERTIFICATION

U Nonimmigrant Status (U Visa) is the United States nonimmigrant visa set aside for victims of certain crimes (and their immediate family members) who have suffered mental and/or physical abuse and are willing (or have been willing) to assist law enforcement and government officials in the investigation of a qualifying criminal activity. Individuals who do not have legal status can request U Nonimmigrant Status certification from a qualifying agency when they are a victim of a qualifying crime, an indirect victim, or a bystander who suffered unusually severe harm and was helpful, are helpful or is likely to be helpful in an investigation of child abuse and/or neglect.

The MDHHS Children's Services Agency executive director has delegated authority to each county director to act as a designee to authorize certifications on behalf of the Department by completing Form I-918, Supplement B, U Nonimmigrant Status Certification. The I-918, Supplement B form, along with instructions, can be found on the U.S. Citizenship and Immigration Services website.

For information on completing U Nonimmigrant Status Certifications see the U Nonimmigrant Status Resource Guide.

WRAPAROUND

Wraparound is a team planning process that creates an individualized plan to meet the needs of children and their families by utilizing a strengths-based approach. Wraparound is an established practice of coordinating services and supports for families and their children, who have a serious emotional disturbance, are involved with multiple systems and where other forms of intervention have not had successful outcomes. Community Mental Health determines if a child is eligible for Wraparound services. Wraparound is available to eligible children from birth through 21 years of age and their families involved in the Community Mental Health system and are available in every community in Michigan.

POLICY CONTACT

Questions about this item may be directed to the Child Welfare Policy Mailbox.

COMMUNITY COOPERATION

A cooperative working relationship between protective services and community referral and treatment resources is to be developed, maintained, and used.

Establishing cooperative relationships should assist the Agency and the community in reducing the incidence of child neglect and abuse and in providing needed services to families and children.

Multi-Disciplinary Teams

Child abuse and neglect is a multidisciplinary problem. It is a sign of social breakdown which may require medical diagnosis and treatment, legal authority to intervene, and psychiatric and social work intervention. The Agency must communicate to the community that the responsibility for the development of a comprehensive program is largely that of the community. It cannot be borne by the Agency alone.

The Agency is mandated by law to investigate child abuse and neglect and to seek protection for children in danger. Yet protective services is primarily a crisis intervention service and cannot effectively provide long term treatment. Therefore, community diagnostic and treatment resources are essential.

Local office administration is responsible for and is to take the initiative in assessing the community's services needs as it relates to child protection. The assessment is to include the need for establishment or strengthening of multidisciplinary teams.

Three types of multidisciplinary teams (MDT's) have emerged:

1. Community action teams

   Community action multidisciplinary teams are composed of various professionals and laypersons united to plan, **implement, and coordinate multidisciplinary services** within a given community. They do not become directly involved with clients, but do serve as a vehicle to raise money and coordinate needed programs. In addition, they may provide education and public information. The goal of the community action MDT is to establish a comprehensive, coordinated community protective service program which has a high degree of interagency cooperation.

2. Consultative teams

   Consultative MDT's are usually composed of a physician, lawyer, psychiatrist or psychologist, public health, and mental health professionals. They provide consultation to protective services, community action groups, and hospital or school diagnostic teams. They do not provide direct services to clients. Their purpose is to provide expertise to direct service professionals in exceptionally complicated or difficult cases.

3. Diagnostic teams

   Diagnostic teams are most often located in medical/hospital facilities. Their purpose is to provide early diagnosis and intervention. Such a team can be of great benefit in the initial stage of the protective services investigation.

   One, all three, or a combination thereof may be appropriate to meeting the needs of a community. The local office is to take the lead in assuring that needed teams are developed and operational for their community.

CRITERIA AND TIME LIMITS FOR ON-GOING SERVICE CASES

On-going services are provided to cases where there is confirmed child abuse and/or neglect (CA/N) and the family is in need of services. On-going services must be provided in the following case types following an investigation:

- Category I cases where children remain placed in their home with court jurisdiction, or where children have been returned home within seven days and court jurisdiction is continuing.
- Category II cases.
- Category III cases.
- Category III open/close cases do not require on-going services.

On-going service cases should be kept open until the child is determined to be safe, the risk level is decreasing, and the family is demonstrating benefit from services thereby reducing the likelihood of recurrence of maltreatment in the future.

On-going service cases which have an intensive or high risk score on the Risk Assessment or Reassessment must be kept open until the risk level is moderate or low or supervisory approval is obtained to close. The caseworker and supervisor together should consider when it is appropriate to close an on-going service case. On-going service cases with either of the following factors should be kept open for a **minimum of 90 days**:

- Cases with an extensive history of CA/N.
- The severity of the CA/N was significant and there is indication that future recurrence could result in harm to the child.

DHS-152, UPDATED SERVICES PLAN (USP)

The USP consists of the following:

- Risk Reassessment.

- Reassessments of the Family Assessment of Needs and Strengths (FANS) and the Child Assessment of Needs and Strengths (CANS).
- Safety Reassessment.
- Service Agreement.
- IV-E Prevention Plan when a child is determined to be a candidate for foster care and receiving an evidence based program.

In instances where a case member is receiving Family First Prevention Services Act (FFPSA) title IV-E Prevention Service, elements of the Prevention Record and Child Specific Prevention Plan will populate in the USP. For more information on FFPSA title IV-E Prevention Services, see SRM 108, Prevention Services, Famly First Prevention Services Act.

Prevention Plan

Children who are eligible as a candidate for foster care and have been approved to receive title IV-E prevention services under the Family First Prevention Services Act will also have a prevention plan in the USP. The prevention plan will automatically generate into the USP when one youth participant is identified and there is a prevention plan begin and end date which coincides with the USP period. For more information on completing the prevention plan and linking needs, strengths and services, see job aids; *Maintaining a Prevention Service Case* and *Matching a Provider for Case Services*. For more information on prevention services available and eligibility, see SRM 108, Prevention Services, Famly First Prevention Services Act.

Time Frame for Completion

The first Updated Service Plan (USP) must be completed within 60 days after the date the investigation was submitted for supervisory approval. Additional USPs are due every 90 days thereafter or more frequently, if reclassification of the case is necessary. For more information on reclassification of a case, see PSM 714-1, Post-Investigative Services.

A Risk and Safety Reassessment and reassessments of the FANS and CANS must be completed at times other than the 90-day USP intervals if:

- There is a new report of abuse/neglect in which a preponderance of evidence is found to exist.
- There are other significant changes in case status.

Any Risk and Safety Reassessments and reassessments of the FANS and CANS completed between USPs should be documented in the next USP. Include any changes made to the service agreement and service level based on the interim Risk Reassessment and reassessments of the FANS and CANS.

Overdue USPs

If an USP is overdue, notify the supervisor by completing an *exception request* in the electronic case record. The notification must document the reasons the USP is overdue and when the USP will be completed. **The notification does not extend the timeframe for completion of the USP or provide approval for the overdue USP; it only provides notice to the supervisor.**

Social Work Contacts

All contacts, either attempted or successful, must be entered into the electronic case record. This includes the required case consultation between the on-going services worker and supervisor as outlined in PSM 714-1, Post Investigative Services. When entering social work contacts on a case, the date and time of the contact must be included. Include the specific reason for the contact and a brief summary of the information obtained during the contact. All social work contacts with accompanying narratives will pre-fill into the USP.

The social work narrative **must** include statements, evidence and actions taken by the worker that address the safety of the child.

Motivational Interviewing

Once an ongoing services worker is trained in Motivational Interviewing, the ongoing worker is expected to utilize this skill as an engagement tool with families. Use of Motivational Interviewing must be documented in social work contacts after an FFPSA IV-E prevention record is approved. For more information on Motivational Interviewing, see SRM 108, Prevention Services, Famly First Prevention Services Act.

Safety Reassessment

The Safety Reassessment must be completed in the electronic case record. The accompanying explanation, the safety response-protecting interventions entered, and the safety decision will pre-fill into the USP for any Safety Reassessment. The caseworker **must** update the Safety Assessment narrative to reflect what child safety planning occurred. See PSM 713-11, Assessments for information on completing Safety Assessments.

Risk Reassessment

When a case is transferred to on-going services, a new Risk Reassessment cannot be completed by the on-going caseworker until contact has been made with the family. Risk Reassessments require that one score be selected for each question along with an explanation for the selection if the question is scored as a risk factor. Any narratives provided for the Risk Reassessment will pre-fill into the USP. For more information on the Risk Reassessment, see PSM 713-11, Assessments.

Risk Reassessment Overrides

Mandatory or discretionary overrides may be considered only after completing the Risk Reassessment.

Discretionary Override: A worker may override the reassessment score based on relevant factors that support a higher risk level than indicated by the scale. The reason for the discretionary override must be documented in the *override risk level box* and approved by the supervisor.

Mandatory Override: A mandatory override, which indicates a higher risk has occurred since the last assessment, must be identified when the Risk Reassessment is completed and the risk level increased to intensive. The reason for the mandatory override must be documented in the electronic case record.

If a mandatory override reason was identified at the time of the initial assessment, or at the most recent reassessment, and case progress indicates a lower risk level, the original override reason does not have to be identified at reassessment or continue to be used to increase the risk level to intensive.

See Risk Assessment section of PSM 713-11, Assessments for more information on discretionary and mandatory overrides.

FANS/CANS

Provide an explanation for each selection if the question is scored as a strength or a need (score other than 0). The explanations entered for each question on the FANS and the CANS will pre-fill into the USP. See FOM 722-09A, Family Assessment of Needs and Strengths and FOM 722-09, Child Assessment of Needs and Strengths for more information on completing the FANS and CANS.

Updating/Adding Services for Family

After the FANS is completed, update the case services screen in the electronic case record. For each need, link a case service and enter a review for the reporting period. The narrative should include all the following:

- The family's progress toward achieving service goals and activities in that need area.
- Information from service providers.
- Any revisions to the services provided in that need area.

Updating/Adding Services for Children

After the CANS is completed, update the case services section in the electronic case record. For each identified need, link a case service and enter a review for the reporting period for each need. The narrative should include all of the following:

- Progress towards goals in the service.
- Engagement in the service.
- Any service revisions needed.

Reclassification

See PSM 714-1, Post-Investigative Services, for more information on reclassification of a case.

Note: See PSM 713-13, Child Abuse/Neglect Central Registry (CA/NCR), for information on providing notice to the perpetrator when reclassification of the case has occurred and the perpetrator is placed on central registry.

Progress Report Tab

If the case will remain open, document the following in the progress report tab:

- A summary of the reasons why the case was opened.
- The family's overall progress toward achieving service goals and activities.
- Specific examples of changes in behaviors or other conditions that explain a reduction in risk to the child.
- Any revisions in the service agreement, including changes in services.
- A summary of any new complaints investigated during the report period.
- Explain any new safety issues and how the service agreement has been amended to address them.
- Any other information relevant to the risk to and safety of the child.

CASE CLOSURE

Before an on-going case may be closed, complete a closing USP and document the following:

- A summary of the reasons why the case was opened.
- The current family situation and how any identified safety concerns or risk factors have been mitigated.
- Progress made as a result of the provision of protective services and the reasons for closure of the case, including the impact of services on the risk and needs items scored on prior assessments.
- Necessity of providing follow-up or further services to the family by other agencies.

At closure, notify all active service providers of the closing of on-going services case. Document the notice in social work contacts.

Note: When a family is participating in Home Visiting Services and the case is transferring to a prevention worker/monitor, the ongoing worker must contact the active service provider and provide them with contact information for the prevention worker/monitor. See SRM 108, Prevention Services, Famly First Prevention Services Act.

SUPERVISORY APPROVAL

A supervisor must review and approve, within 14 calendar days of receipt, all DHS-152 Updated Services Plans. Approval indicates agreement with the:

- Thoroughness, completeness, and accuracy of the USP.
- Reassessment of risk and safety of the child.
- Reassessments of the FANS and CANS and the services provided to the family.
- Progress made by the family.
- Appropriateness of continued provision of services or case closure.

LEGAL AUTHORITY

Federal Law

Family First Prevention Services Act, Public Law 115-123, Sec. 50711 (2)(e)(4)(A)

Prevention plan. The State maintains a written prevention plan for the child that meets the following requirements (as applicable):

- Candidates. In the case of a child who is a candidate for foster care described in paragraph (2)(A), the prevention plan shall:
  - Identify the foster care prevention strategy for the child so that the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver;
  - List the services or programs to be provided to or on behalf of the child to ensure the success of that prevention strategy; and

- Comply with such other requirements as the Secretary shall establish.

- Pregnant or parenting foster youth. In the case of a child who is a pregnant or parenting foster youth described in (2)(B), the prevention plan shall:
  - Be included in the child's case pan required under section 475(1);
  - List the services or programs to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent;
  - Describe the foster care prevention strategy for any child born to the youth; and
  - Comply with such other requirements as the Secretary shall esablish.

State Law

Child Protection Law, Act 238 of 1975, MCL 722.628d (1)(c)

Category III - community services needed. The department determines that there is a preponderance of evidence of child abuse or neglect, and the structured decision-making tool indicates a low or moderate risk of future harm to the child. The department shall 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 services, or the family voluntarily participates in services, but does not progress toward alleviating the child's risk level, the department shall consider reclassifying the case as category II.

Child Protection Law, Act 238 of 1975, MCL 722.628d (1)(d)

Category II - child protective services required. The department determines that there is evidence of child abuse or child neglect, and the structured decision-making tool indicates a high or intensive risk of future harm to the child. The department shall open a protective services case and provide the services necessary under this act. The department shall also list the perpetrator of the child abuse or child neglect, based on the report that was subject of the field investigation, on the central registry as provided in section

7(7), either by name or as "unknown" if the perpetrator has not been identified.

Child Protection Law, Act 238 of 1975, MCL 722.628d (1)(e)

Category I - court petition required. The department determines that there is evidence of child abuse or child neglect and one or more of the following are true:

- A court petition is required under another provision of this act.
- The child is not safe and a petition for removal is needed.
- The department previously classified the case as a Category II and the child's family does not voluntarily participate in services.
- There is a violation, involving the child, of a crime listed or described in section 8a(1)(b), (c), (d), or (f) of child abuse in the first or second degree as prescribed by section 136b of the Michigan penal code, 1931 PA 328, MCL 750.136b.

POLICY CONTACT

Questions about this item may be directed to the Child Welfare Policy Mailbox.

OVERVIEW

The Children's Protective Services Maltreatment in Care unit (CPS-MIC) ensures the safety and well-being of children under the care and supervision of the Michigan Department of Health and Human Services (MDHHS). The CPS-MIC unit investigates alleged abuse/neglect involving:

- Licensed foster homes.
- Licensed or unlicensed relative placements.
- Independent living settings.
- Child caring institutions (CCIs).
- Child care licensed programs (CCLPs).
- Children under court jurisdiction returned to the parental home.

DEFINITIONS

Child Care Organization

A government or nongovernment organization having as its principal function receiving minor children for care, maintenance, training, and supervision, notwithstanding that educational instruction may be given. Child care organization includes organizations commonly described as child caring institutions, child placing agencies, children's camps, children's campsites, children's therapeutic group homes, child care centers, day care centers, nursery schools, parent cooperative preschools, foster homes, group homes, or child care homes. Child care organization does not include a governmental or nongovernmental organization that does either of the following:

- Provides care exclusively to minors who have been emancipated by court order under section 4(3) of 1968 PA 293, MCL 722.4.

- Provides care exclusively to persons who are 18 years of age or older and to minors who have been emancipated by court order under section 4(3) of 1968 PA 293, MCL 722.4, at the same location.

Child Care Licensed Program (CCLP)

A child care program designed to provide care and supervision for children in licensed facilities including family child care homes, group child care homes and child care centers.

Child Caring Institution (CCI)

A child care facility organized for the purpose of receiving minor children for care, maintenance, and supervision, usually on a 24-hour basis, in buildings maintained by the child caring institution for that purpose, and operates throughout the year. An educational program may be provided, but the educational program shall not be the primary purpose of the facility. Child caring institution includes a maternity home for the care of unmarried mothers who are minors and an agency group home. Child caring institution also includes an institution for developmentally disabled or emotionally disturbed minor children. Child caring institution does not include hospital, nursing home, or home for the aged or an adult foster care family home or an adult foster care small group home.

Serious Physical Harm

Any physical injury to a child that seriously impairs the child's health or physical well-being, including, but not limited to, brain damage, a skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprain, internal injury, poisoning, burn or scald, or severe cut, MCL 750.136b(1)(f).

INTAKE

The *Intake Decision Table for Investigation of Child Abuse and Neglect in Child Care Organizations/Relative Care* specifies the responsibilities of CPS and the CPS-MIC unit for investigation of child abuse/neglect.

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
Licensed foster home or licensed/unlicensed relative caregiver when allegations involve:	**CPS**	**CPS-MIC**
A foster parent or relative caregiver, and the alleged child victim is in foster care residing in the foster home or relative placement.		X
A foster parent or relative caregiver, biological/adoptive children, and children in foster care residing in the foster home or relative placement, regardless of which child(ren) in the home is/are the alleged victim.		X
A legal parent, and the child victim is in foster care, regardless of placement type.		X
A foster parent, and the alleged child victim has returned to the parent's care.		X
A foster parent with biological/adoptive children and there are/were no foster children placed in home at the time of the alleged abuse/neglect.	X	

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
Legal parents (including in-home placement or following return home from foster care with court jurisdiction), when allegations involve:	**CPS**	**CPS-MIC**
A child in their care, under in-home court jurisdiction, who does not have an open foster care case.	X	
A child in their care, **not** under court jurisdiction.	X	
A child in their care who has returned home from foster care and the court maintains jurisdiction.		X
Alleged abuse or neglect occurred prior to their child going into out of home care.	X	
Adding a non-respondent parent to active court cases.	X	
A child goes from one parent directly to another parent (no out of home placement).	X	

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
CCIs (such as, detention centers, youth homes, shelter homes, residential care facilities (long- and short-term), halfway homes, court operated facilities) when allegations involve:	**CPS**	**CPS-MIC**
An employee of a CCI and an alleged child victim residing in a CCI.		X
A legal parent and an alleged child victim under MDHHS supervision; for example, allegations occurred during visit.		X
An employee or volunteer of a CCI and an alleged child victim who was returned home to a parent's care, if the abuse or neglect was alleged to have occurred during the child's placement in the CCI.		X
A licensed provider or an employee of a CCI and the alleged victim is the alleged perpetrator's own child.	X	
An employee or volunteer of a CCI and a child placed in the CCI who is not under supervision of MDHHS.		X

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
CCLPs (referrals involving children, regardless of court jurisdiction) when allegations involve:	**CPS**	**CPS-MIC**
A child in a licensed facility.		X
A legal parent, licensed to operate a child care facility, and the alleged victim is their biological/adopted child.	X	
Unlicensed facilities.	N/A	N/A

INTAKE DECISION TABLE FOR CPS AND CPS-MIC INVESTIGATIONS		
Facility/Placement Type	**Responsible Unit - Department**	
Licensed camp facility when allegations involve:	**CPS**	**CPS-MIC**
Children at a licensed camp facility.		X
A legal parent at a licensed camp facility, and the victim is the alleged perpetrator's own child.	X	

Multiple Families in Same Household

When multiple families reside in a home, CPS-MIC is responsible for the investigation if one family meets CPS-MIC criteria for assignment; see *Intake Decision Table for CPS and CPS-MIC Investigations* in this policy.

Preliminary Investigation

Certain situations require a preliminary investigation be completed; see PSM 712-1, CPS Intake .

The preliminary investigation must include attempted contact with the following, where applicable:

- The assigned foster care case manager.
- The foster home certification case manager.
- The Division of Child Welfare Licensing (DCWL) consultant.
- The Bureau of Community and Health Systems (BCHS) consultant within Licensing and Regulatory Affairs (LARA).

Transferred Referrals

When a referral involving a child under the care and supervision of MDHHS does not meet criteria for assignment for investigation by CPS-MIC or CPS, Centralized Intake (CI) must transfer the referral to the Placement Collaboration Unit and the appropriate agency for

investigation and/or follow up. Transfer the referral to one of the following within 24 hours, dependent upon the type of entity subject to the referral:

- MDHHS DCWL.
- Michigan Department of LARA.
- Law enforcement and prosecuting attorney.
- American Indian tribal unit.
- MDHHS and contracted private agency case manager and supervisor assigned to the child(ren) involved in the referral.
- MDHHS and the contracted private agency licensing case managers and supervisor assigned to the provider.

Division of Child Welfare Licensing

CI must notify DCWL of referrals involving:

- Licensed foster homes.
- Licensed relative foster care placements.
- CCIs.
- Court operated facilities (COFs).
- Child placing agencies (CPAs).
- Children in foster care who were in any setting other than a parental home or daycare when the alleged maltreatment occurred.

Information on referral participants and allegations must be sent to DCWL. Contact information for the DCWL area managers can be found on the Child Welfare Licensing Division Contact Information page.

Licensing and Regulatory Affairs

CI must notify LARA and email referral information to the BCHS Children and Adult Licensing Complaint Mailbox for referrals involving:

- Children's camps.
- Child care centers.
- Licensed family and group childcare homes.
- Adult foster care homes.

- Homes for the aged.
- Child care programs not required to be licensed, such as:
  - Parent programs with parents and children on-site.
  - Indian tribal programs.
  - Enrolled day care aids and unlicensed providers through the Child Development and Care program.

The CI case manager must also complete and send the law enforcement notification (LEN) form located within the electronic case management system, to the appropriate law enforcement jurisdiction when the referral involves a child care program not required to be licensed.

CI must notify LARA and email referral information to the Bureau of Community Health Systems Health Facility Complaint Mailbox for referrals involving:

- Hospitals.
- State psychiatric facilities.
- Nursing homes.

Law Enforcement and Prosecuting Attorney

Law enforcement agencies are solely responsible for investigating child abuse/neglect alleged to have occurred in the following settings:

- Schools (both public and private), including boarding schools.
- Incidental out-of-home or in-home child care (babysitting).
- Mental health facilities not subject to PA 116.
- Family and group child care homes and child care centers operating without a license/registration.

CI must transfer referrals for these entities and refer to the local law enforcement agency/prosecuting attorney using the law enforcement referral notification (LEN) located within the electronic case management system.

Note: Referrals involving teachers residing in a facility may also need to be transferred to LARA.

Intake Decision Notification

For referrals involving children with an open CPS, foster care, or adoption program type in the electronic case management system,

CI must notify the following of the intake decision via email, as applicable:

- All active assigned CPS, foster care, and adoption case managers and supervisors.
- MDHHS purchase of service (POS) monitor and supervisor.
- The Michigan Children's Institute (MCI) superintendent if the child is an MCI ward.
- DCWL, except when the alleged maltreatment occurred when the child was placed with a parent.
- West Michigan Partnership for Children (WMPC), for cases in Kent County.
- Active, assigned licensing case manager and supervisor if the referral involves a licensed or enrolled foster home.

The notification must include:

- Intake ID.
- Case Name.
- Allegations.
- Intake decision.
- Intake decision comments.

The intake decision notification must identify the receiving agency to which the referral was assigned or transferred.

County of Assignment

CPS-MIC investigations are assigned to the county where the alleged CA/N occurred regardless of the victim's current residence.

Referrals received after-hours are assigned to the county where the alleged child victim is located to ensure contact is made within the designated priority response timeframe.

COORDINATION OF CONCURRENT INVESTIGATIONS

Instances exist in which separate but coordinated investigations need to be completed concurrently, dependent upon the circumstances of the referral. CPS-MIC may be coordinating investigations with the following:

- DCWL/LARA for compliance with PA 116 and applicable licensing rules for the type of agency/facility involved.
- MDHHS or private agency foster home certification staff for special investigations or home studies on licensed or enrolled foster homes.
- Foster care (MDHHS and/or private agency) for appropriateness of child placement.
- Law enforcement for criminal allegations.

Prison Rape Elimination Act (PREA)

There may be instances when a juvenile justice facility will conduct an investigation under the Prison Rape Elimination Act (PREA), for which there is also CPS-MIC involvement. To support compliance with 28 CFR 115.371, both the facility and CPS-MIC may coordinate investigations and the facility may request and receive copies of redacted CPS investigation reports. (P.L. 108-79)

Foster Care and Unlicensed Relative Home Investigations

Required Contacts

As soon as possible, but no later than the business day after receipt of the CPS referral, the CPS-MIC case manager must contact the following for the alleged child victim(s):

- The assigned foster care case manager and supervisor. In cases being managed by a private agency, the private agency case manager and supervisor and the MDHHS monitoring case manager and supervisor must be contacted.

- The MDHHS county director.
- The MCI superintendent, if applicable.
- The assigned MDHHS and/or private agency licensing/certification case manager.
- An Indian child's tribe, if applicable.

Notification must indicate that a referral has been received and that CPS-MIC is investigating.

Whenever applicable and feasible, the licensing case manager and CPS-MIC must coordinate investigations.

Face-to-Face Contact with Children

CPS-MIC case managers must make face-to-face contact with all alleged child victims within designated timeframes (24 or 72 hours), as determined by the priority response criteria; see PSM 712-1, CPS Intake.

When necessary, CPS-MIC case managers should also contact other children who may have witnessed or been exposed to the alleged child abuse or neglect.

The DHS Pub 779, Forensic Interviewing Protocol, should be used to interview all children who are developmentally capable to be interviewed.

Case Assessments

- Safety assessments are required for all investigations involving licensed foster homes and unlicensed relative caregivers.
- Risk assessments are not required on a licensed foster parent/unlicensed relative unless the licensed foster parent/unlicensed relative is an alleged perpetrator of child abuse/neglect on their own children.
- A firearm assessment is intended to be used when a case manager becomes aware of a firearm in a home during an open case. The goal of this assessment is to evaluate and ensure the safety of the child and guide caregivers through the safe storage of firearms. See PSM 713-01, CPS Investigation - General Instructions for guidance on assessing firearm safety.

Note: Specialists must continue to utilize licensing rules for licensed foster homes. Case managers must also follow criteria regarding weapons, firearms, and/or ammunition outlined in the MDHHS-5770, Relative Placement Safety Screen, and MDHHS-3130-A, Relative Placement Home Study.

Case Closure

CPS-MIC case managers may request case closure if the allegations are not confirmed by a preponderance of evidence or services will not be provided by CPS ongoing. The CPS-MIC case manager must clearly explain the basis for case closure in the disposition.

Child Caring Institutions (CCIs)

Required Contacts

The CPS-MIC case manager must notify DCWL as soon as possible, but no later than 24 hours after the referral is received, for all assigned referrals in a CCI. See *DCWL section* in this policy for information on filing a referral.

The CPS-MIC case manager must notify the following as soon as possible, but no later than the next business day, after receipt of the referral:

- The assigned foster care case manager and/or MDHHS monitoring case manager, (if applicable).
- The county director if the child is a court ward.
- The MCI superintendent, (if applicable).
- The Indian child's tribe, (if applicable).

The case manager must indicate in the notification that a child abuse/neglect referral was received and is being investigated.

During the investigation, the CPS-MIC case manager must have contact with the CCI administrator or licensee designee at both of the following points:

- Prior to contact with the alleged child victim.
- Prior to completion of the investigation.

Face-to-Face Contact

CPS-MIC case managers must make face-to-face contact with all alleged child victims within designated timeframes (24 or 72 hours), as determined by the priority response criteria; see PSM 712-1, CPS Intake.

CPS-MIC case managers should also contact other children who may have witnessed or been exposed to the alleged child abuse or neglect.

The DHS Pub 779, Forensic Interviewing Protocol, should be used to interview all children who are developmentally capable to be interviewed.

Case Assessments

The following are not required for CCI investigations:

- Safety Assessments.
- Risk Assessments.

Case Closure

CPS-MIC investigations involving a CCI may be closed without opening an ongoing case. Prior to case closure, the CPS-MIC case manager must make appropriate referrals for services or consult with the active foster care case manager to notify of any service needs for the child victim.

Child Care Licensed Program (CCLP) and Camp Investigations

Notification to Bureau of Community and Health Systems (BCHS)

When a referral is received alleging child abuse/neglect at a CCLP or camp and is assigned, the CPS-MIC case manager must notify BCHS as soon as possible, but no later than 24 hours after the referral is received. Referrals may be submitted online on the BCHS website or by phone at 866-865-0126.

High Risk Investigation

MCL 722.113f (6) defines a high-risk investigation as involving one or more of the following:

- CA/N is the suspected cause of a child's death.
- Suspected sexual abuse or sexual exploitation.
- CA/N resulting in serious physical harm.

During a high-risk investigation, the CPS-MIC case manager must inform the CCLP or camp of their requirement to notify parents of all children at the CCLP or camp. The CPS-MIC case manager may inform the CCLP or camp through any of the following means:

- Providing verbal direction regarding the steps required to inform parents including verbal and written notification.

- Providing the DHS-216, High Risk PA 116, Special Investigations Instructions for Notifying Parents, and/or the DHS 217, Notification to Parents of a High-Risk PA 116 Special Investigation.

The CPS-MIC case manager must document that the notification to the CCLP or camp occurred, as well as the method of delivery (verbal or provision of form) within a social work contact.

Face-to-Face Contact

CPS-MIC case managers must make face-to-face contact with all alleged child victims within designated timeframes (24 or 72 hours), as determined by the priority response criteria; see PSM 712-1, CPS Intake.

CPS-MIC case managers may also contact other children who may have witnessed or been exposed to the alleged child abuse or neglect.

The DHS Pub 779, Forensic Interviewing Protocol, should be used to interview all age and developmentally appropriate children.

Case Assessments

Safety assessments and risk assessments are not required if the victim is not their own child.

Safety assessments and risk assessments are required if the licensed provider is also a perpetrator of child abuse/neglect for their own child (biological or adoptive).

Case Closure

CPS-MIC investigations involving a CCLP or camp may be closed without opening an ongoing case. Prior to case closure, the CPS-MIC case manager must make appropriate referrals for services or consult with the active foster care case manager to notify of any needs for ongoing services for the child victim.

CPS-MIC case managers may request case closure when any of the following criteria are met:

- The allegations are not confirmed by a preponderance of evidence.
- There are no children other than non-victim biological/adoptive children of the perpetrator remaining in the facility.
- The identified perpetrator(s) is no longer in the facility and has no access to children.

The CPS-MIC case manager must clearly indicate in the disposition the reason the case is being closed and why services are not being provided.

CCI/CCLP/Camp Referrals Regarding an Employee's Child(ren)

If, during a CPS-MIC investigation of a CCI, CCLP, or camp, there are concerns regarding child abuse/neglect to biological/adoptive children of an employee, a new referral must be called into CI. CI must complete a separate referral for the household at the address where the alleged perpetrator and child(ren) reside. The CPS-MIC investigator must also document concerns regarding the biological/adoptive child(ren) within a social work contact.

If assigned, the referral will be investigated by the local CPS unless the family residence meets the requirements for CPS-MIC assignment. The CPS-MIC and CPS case manager should coordinate investigations whenever possible.

The results of assignment and/or disposition of a CPS investigation on a licensed/registered child care home or an employee of a child care facility regarding abuse/neglect of their own children ***cannot*** be shared with their employer.

REQUIREMENTS FOR ALL CPS-MIC INVESTIGATIONS

CPS-MIC case managers are required to follow the procedures established for all CA/N investigations as outlined in the Protective Services Manuals (PSM).

CPS-MIC case managers must assess safety throughout the investigation. Safety plans must be documented in social work contacts. If in writing, the safety plan should be uploaded to the document tab of the investigation in the electronic case management system.

If CPS-MIC determines that a child currently in foster care is unsafe and no provision of service can safeguard the child in the home, foster care must be contacted to assist with replacement. Whenever possible, the foster care case managers should handle the replacement.

If it is determined that replacement must occur after-hours, the assigned foster care case managers must be notified of the removal within 24 hours or the next business day.

Notifying Parents

All parents or legal guardians must be notified of CPS-MIC investigations involving their children by the CPS-MIC case managers, as soon as possible. Case managers must be mindful of case confidentiality of other parties to the case when notifying parents. For information on confidentiality see SRM 131, Confidentiality.

Face-to-face contact with parents or guardians is required in the following situations:

- When the parent or guardian is residing in the home where the alleged CA/N occurred.
- When the parent or guardian is identified as an alleged perpetrator.

- When there is indication the parent or guardian is a witness to the alleged CA/N or is otherwise able to provide details regarding the incident.

In situations where face-to-face contact is not required, or documented efforts are unsuccessful, a case manager must still contact the parent or guardian by phone to obtain information and discuss pertinent details of the investigation.

In instances where parents or guardians are unable to be located or attempts to make contact have been unsuccessful, the parent or guardian should be notified by letter of the investigation. The letter should be sent to the most recent address.

Medical Exams

A CPS-MIC case manager may request the foster parent or relative provider take a child for an emergent medical exam to assess potential child injury (MCL 722.124a(1)).

For more information on medical exams, see PSM 713-04, Medical Examination and Assessment.

During a CPS-MIC investigation, the CPS-MIC case manager should serve as the lead for medical examination steps including:

- Securing and arranging medical examinations.
- Communicating with medical professionals regarding need for the examination and results, need for treatment, etc.
- Obtaining medical examination records and documents pertinent to the investigation.

Interviewing Child Witnesses

CPS-MIC must always receive permission from the parent/guardian before the case manager can interview a non-ward child who may have been a witness; see PSM 713-01, CPS Investigation-General Instructions and Checklist, General Instructions.

Note: If a child is already a court ward and the allegations are against the placement, parental permission is not required to interview non-victims.

Central Registry

A confirmed CPS-MIC case for serious abuse, serious neglect, sexual abuse, sexual exploitation, or methamphetamine production requires the perpetrator's name be placed on central registry. Individuals whose names are added to central registry must be properly notified through use of the DHS 847, Notice of Placement on Central Registry. Individuals determined to be perpetrators of child abuse or child neglect but for whom the maltreatment type finding does not meet central registry requirements, must be properly notified using the DHS 847c, Notice of a Confirmed Case.

For more information on Central Registry, PSM 713-13, Central Registry and Confirmed Perpetrator Notification.

Dispositional Conference

Prior to disposition of the investigation, the CPS-MIC case manager must coordinate a dispositional case conference with the following individuals:

- The assigned CPS-MIC supervisor.
- Each MDHHS and private agency foster care (PAFC) case manager and supervisor active at the time of the referral, including the MDHHS purchase of service (POS) monitor and supervisor, if applicable.
    - For confirmed cases where the foster child(ren) remain in the home, the MDHHS county director or their designee must attend the dispositional case conference.
- Licensing certification case manager.
- DCWL/BCHS licensing consultant, for referrals involving a CCI, CCLP, COF, camp, or other facility.
- MCI consultant or superintendent.
- Adoption case manager and supervisor, if applicable.
- The Indian child's tribe, if applicable.

The purpose of the conference is to formulate action steps to be taken and determine the person responsible for implementing

action to maintain safety, permanency, and child/family well-being. The action steps discussed must be documented in the investigative report within a social work contact. Documentation must identify who is responsible for completion of each action step. If services are needed for the child or family, CPS-MIC must discuss this during the dispositional conference, and document it within the social work contact.

Report Sharing

The CPS-MIC case manager must ensure that within five business days of supervisory approval, an appropriately redacted copy of the DHS-154, CPS Investigative Report, is forwarded to:

- DCWL/BCHS consultant and supervisor.
- MDHHS and/or PAFC licensing consultant and supervisor.
- MDHHS or PAFC supervisor(s) assigned to the foster care case(s).
- MDHHS or private agency adoption supervisor(s) assigned to the adoption case(s).
- The Indian child's tribe, if applicable.

For proper redaction; see SRM 131, Confidentiality.

The CPS-MIC case manager should also request a copy of reports from any coordinating agency, such as law enforcement and DCWL. All reports obtained should be scanned and uploaded into the electronic case management system in the documents tab.

Petitioning the Court

The CPS-MIC case manager must file a supplemental petition when a child is under court jurisdiction and an investigation results in confirmation of additional child abuse/neglect if the perpetrator of the abuse/neglect is a parent or other person with legal right to reunification. The supplemental petition should be filed with the court who has jurisdiction. (MCL 712A.19(1)). For additional court information see *working with legal counsel* in PSM 715-3, Family Court: Petitions, Hearings and Court Orders.

The CPS-MIC case manager must also collaborate with the local MDHHS county director and the assigned public or private foster care staff regarding court hearings, details of the court case, and other court related responsibilities.

When the Child Protection Law (CPL) requires a mandatory petition be filed, CPS MIC case manager must write the petition and ensure all supporting documentation is completed as required.

OPEN CASES

All cases requiring ongoing services will be transferred to the appropriate unit.

Foster Care

If the only identified victim in the home is a foster child, and the child remains placed with the confirmed perpetrator, foster care must provide services to the family to support safe placement and rectify the issues which caused the CPS-MIC confirmation. The CPS-MIC case will be processed as an open/close, documenting that foster care will be providing services to the family via their open foster care case. Preventative services for the family must be initiated by foster care at the time of case opening.

If the foster child victim is moved to a new placement separate from the perpetrator, but the perpetrator is licensed, the case must transfer to CPS ongoing services in the county where the licensee resides, to provide services that address the risks identified during the confirmation.

CPS Ongoing

If there is a combination of both confirmed victims, including biological/adoptive children of the identified perpetrator and foster child victims, the case must transfer to CPS ongoing in the county where services will be provided to the family.

If the identified victims are biological/adoptive children of the identified perpetrator and a foster child is not confirmed as a victim, the case must transfer to CPS ongoing in the county where services will be provided to the family.

CPS ongoing will oversee the provision of services for the family. Regular updates to the foster care agency of responsibility must

occur to ensure suitability of continued placement. Preventative services must be initiated by CPS ongoing at case opening.

To ensure services to the family are being completed timely and efficiently, the following steps must occur:

- Timely notification and transfer to the appropriate unit to coordinate efforts to initiate services for the family.
- When a foster child remains in the home at the time of the CPS-MIC confirmation, the following must occur:
    - Within three (3) business days of the decision to confirm a CPS-MIC case that involves a home where foster children continue to reside, CPS-MIC must conduct a Family Team Meeting (FTM) to include:
        - Confirmed caregiver.
        - Other adult household members.
        - Age-appropriate children.
        - Active case managers.
        - Service providers, family supports.
        - CPS ongoing case manager from county of residence and the county director responsible for overseeing the foster care case.
    - The county director is responsible for approving placement decisions for foster youth in confirmed homes and must have all relevant information to determine suitability of continued placement.
    - Once the FTM is completed, the case must transfer to CPS ongoing within 5-business days.
    - The acceptance of the ongoing CPS case and provision of services cannot be delayed.
    - At the time of case transfer, services must be immediately initiated to address risk associated with the confirmed case.
    - All requirements for CPS ongoing case management must be met.
- For all other cases, a case conference must be conducted within 5-business days after confirmation of child abuse and/or

neglect. The case conference should review needed services, safety plans, and monitoring to be provided to ensure child safety. The following should be included in the case conference:

- The CPS-MIC case manager.
- The CPS-MIC supervisor.
- The local office case manager.
- The local office supervisor.
- The BCHS/DCWL consultant, if applicable.
- The Indian child's tribe, if applicable.

Note: Continued placement of a foster child in a home with a caregiver who is confirmed in a child abuse and/or neglect investigation requires county director approval.

Family Team Meeting

The CPS-MIC case manager and the CPS ongoing case manager should coordinate with the family to schedule and prepare for the FTM. Both the CPS-MIC case manager and the CPS ongoing case manager must participate with the FTM, either in person, by phone, or virtually. For more information on the FTMs; see FOM 722-06B, Family Team Meeting.

CONTACT

Questions about this policy item may be directed to the Child-Welfare-Policy@michigan.gov.

OVERVIEW

When a petition alleging abuse is filed, MCL 712A.13a(4) requires the court to consider removing the alleged perpetrator or other person from the home.

See PSM 713-08, Special Investigative Situations, Coordination with Friend of the Court for requirements on determining if the family has an open Friend of the Court case when a petition is filed.

Removal of Alleged Perpetrator from the Home

The court may order a parent, guardian, custodian, non-parent adult, or other person residing in the child's home to leave the home and, except as the court orders, not subsequently return to the home, if all of the following take place:

- The petition is authorized.
- The court, after a hearing, finds probable cause to believe the individual in question committed the abuse.
- The court finds **on the record** that the presence of the alleged perpetrator in the home presents a substantial risk of harm to a child's life, physical health or mental well-being.

If the court orders the alleged perpetrator out of the child's home, the court must order with whom the child is placed and find that the conditions of custody (placement) are adequate to safeguard the child from the risk of harm to the child's life, physical health or mental well-being.

The court may consider, in making its order, whether the parent who is to remain in the home is married to the person being removed from the home or has a legal right to retain possession of the home. It may also order:

- The alleged abusive parent to pay appropriate support to maintain a suitable home environment for the child.
- The alleged perpetrator to surrender to local law enforcement any firearms or other weapons the alleged perpetrator may own, use or possess.

- Any other reasonable term or condition necessary to safeguard the child's physical or mental well-being or necessary to protect the child.

In addition to taking the actions described above, the court may issue an order permanently restraining a nonparent adult from coming into contact with or being in close proximity to the child (MCL 712A.6b).

CPS Recommendations to the Court

CPS must be prepared to address, in the best interests of the child, as many of these issues as possible in the development of the petition and recommendations to the court and at the court hearing.

OVERVIEW

When a child is in imminent danger and supports and services cannot be put in place to ensure child safety, Children's Protective Services (CPS) must take prompt action to protect the child. Efforts should first be made to enable the child to remain in the home or with their own family, if at all possible. Efforts to create child safety within their own home include:

- Temporary voluntary arrangements.
- Family supports.
- Services such as, Families First, Families Together Building Solutions, etc.
- Safety planning.
- Fililng a petition for removal of the perpetrator from the home and/or in home jurisdiction.

When CPS identifies safety concerns which do not rise to the level of court involvement, the MDHHS-5433, Temporary Voluntary Arrangement, can be utilized. The MDHHS-5433 documents a temporary voluntary arrangement between the caregiver(s) and an individual who agrees to care for the child(ren) until identified safety issues can be resolved; see PSM 713-01, CPS Investigation - General Instructions.

CONSIDERING COURT INTERVENTION

Temporary voluntary arrangements, supports, services and safety planning should be considered to prevent the removal of the child from the home. If the child is removed from the home, efforts must be made to reunify children with their siblings and families as soon as safely possible.

When filing a petition, a request for removal may not be necessary. Relief requested should be the least intrusive necessary for protection of the child or resolution of the emergency.

A worker, in consultation with his/her supervisor, should discuss those cases in which it is not reasonable to provide services for reunification. A mandated petition for termination of parental rights is not a reason for not providing services to reunify the family.The DHS-154, Investigation Report, and the DHS-152, Updated

Services Plan, must contain clear documentation of the reasons why the department believes that providing services towards reunification is not reasonable.

Exception: The local office may, but is not required to, make reasonable efforts to reunify the child with a parent who is required by court order to register under the sex offenders registration act.

Reasonable Efforts

While reasonable efforts are a legal standard, the department requires that CPS caseworkers attempt to engage with families to enable children to remain safe in their homes. When filing a petition, reasonable efforts must be documented in the petition. Examples of reasonable efforts include the following, among other efforts:

- Holding a family team meeting.
- Safety planning to address concerns.
- Offering services to allow the child to remain in the home.

If unable to provide reasonable efforts to the family to prevent the removal of the child, the CPS worker must document why it was not possible to provide reasonable efforts.

Family Team Meetings (FTM)

Family Team Meetings (FTM) will occur at multiple stages throughout the life of a CPS case. A FTM must occur no later than seven days after a preliminary hearing.

Emergency Removal

Emergency removal and placement, sometimes referred to as ex parte orders, must only occur in rare and extreme circumstances and must be based on conditions which present immediate danger to a child. A preliminary hearing is the preferred venue for the court to decide on removal and placement of children.

The need for emergency removal must be evaluated prior to contacting the court. A judge or referee may issue a written ex parte order upon receipt, electronically or otherwise, of a petition or affidavit of facts and the court finds all of the following:

- Reasonable cause to believe that the child is at imminent risk of harm and emergency removal is the only option to protect the child.
- The circumstances warrant an ex parte order pending the preliminary hearing.
- Consistent with the circumstances, reasonable efforts were made to prevent or eliminate the need for removal of the child.
- No remedy other than protective custody is reasonably available to protect the child.
- Continuing to reside in the home is contrary to the child's welfare.

American Indian Child

Active efforts must be made to prevent removal for American Indian children; see NAA 205, Indian Child Welfare Case Management, and see NAA 235, Emergency Placement , for information on safety planning and removal of American Indian children.

Child Hospitalization

In the absence of a court order, CPS must not request that a hospital detain a child.

LAW ENFORCEMENT

Law enforcement may remove a child with or without a court order based upon their own statutory requirements. CPS cannot take custody of a child from law enforcement or remove a child from his/her home or arrange emergency placement without a **written** court order, electronically or otherwise, authorizing the specific action. When the Michigan Department of Health and Human Services (MDHHS) is contacted by law enforcement seeking the assistance of CPS in the removal of a child, CPS must immediately contact the designated judge or referee.

Caseworkers can request law enforcement assistance in the removal of children. Assistance from law enforcement must be requested when:

- A written court order has been obtained and the parents refuse to allow the child to be removed.
- A child's life or safety is in immediate danger because of the parent's condition or because a young child is alone and no parent or other responsible person can be located.
- A crime is being committed (for example, methamphetamine production, or domestic violence).
- A child or worker may need protection against bodily harm.

COURT ORDERED REMOVAL OF CHILD FROM HOME

When the only available option to protect a child from danger is removal from his/her home, the Family Division of Circuit Court must be contacted immediately for written authorization of removal and to arrange placement or authorize the department to arrange for placement. The legal module of MiSACWIS CPS must be completed. Under *removal reasons*, the worker must document why it is contrary to the welfare of the child to remain in the home and what reasonable efforts were made to prevent removal.

When court involvement is necessary to protect a child, a petition or affidavit of facts must be submitted, electronically or otherwise, to the Family Division of Circuit Court. Before requesting removal of children caseworkers should consider alternate home conditions including removal of the perpetrator from the home or other creative options that achieve safety for the children.

Note: Consider requesting the court to order the alleged perpetrator out of the home; see PSM 715-1, Removal of the Alleged Perpetrator from the Home.

See PSM 713-08, Special Investigative Situations, Coordination with Friend of the Court, for requirements on determining if the family has an open Friend of the Court (FOC) case when a petition is filed and notifying FOC when there is a change in a child's placement.

The Family Division of Circuit Court in each county should designate an official of the court to be available after hours (nights, weekends, and/or holidays) to provide written authorization for removal and placement of a child in out-of-home care in emergency

situations. If the designated official is not available, contact local law enforcement and request assistance in taking the child into custody. Law enforcement may remove a child temporarily without court authorization; see Michigan Court Rule 3.963(A) and the Probate Code of 1939, MCL 712A.14(1).

Note: Do not take any child into custody or arrange emergency placement without a **written** court order authorizing the specific action even when law enforcement takes the child into custody without court authorization.

The local office must have formal written agreements with the Family Division of Circuit Court, local law enforcement, and with shelter care resources, so that written emergency authorization of removal and placement can be completed without delay.

Case Record Documentation When Child Removed

The following should be documented in the DHS 154 or DHS 152, USP, when a child is removed:

- In an emergency removal with no services provided it must indicate why no services were provided to the family prior to removal of the child which would make it possible for the child to remain home. Specifically identify the facts which indicate imminent risk of harm to the child.
- If services were provided prior to the removal, identify the services provided by the department to the family in an effort to prevent the need for removal of the child from the home. Documentation must indicate why services did not eliminate the need for removal.

NOTIFICATION TO PARENTS WHO ARE INCARCERATED

The CPS worker must provide notice to the parent who is incarcerated by mail or telephone.

The caseworker must do the following to ensure the parent who is incarcerated partipates in the FTM:

- Provide prior notice of a scheduled FTM to a parent who is incarcerated only in the case of a considered removal. The worker must document this notification in the DHS 154 and DHS-152.
- If time allows, send a copy of the DHS-1107, Family Team Meeting Attendance Report, and ask the parent to sign and return it.
- Notify the parent's attorney of the FTM and the attorney must be allowed to attend the FTM.
- Ensure that the parent receives copies of the DHS-1105, Family Team Meeting Activity Report, and the DHS-1107, Family Team Meeting Attendance Report, after all FTM's.

The caseworker must do the following to ensure the incarcerated parent particpates in court proceedings:

Notify the court that a parent is under Michigan Department of Corrections jurisdiction by including the statement: "a telephonic hearing is required pursuant to MCR 2.004," near the top of the petition. The clause must also contain the parent's prisoner number and location.

Note: For information on how to locate parents who are incarcerated see PSM 713-01, CPS Investigation - General Instructions.

PLACEMENT

When a child cannot remain safely in their family home, the child should be placed in the most family-like and least restrictive setting required to meet their unique needs. Siblings should be placed together whenever possible. MDHHS must strive to make the first placement the best and only placement.

Placement with Non-Custodial Parents

Every removal must consider and evaluate placement with the non-custodial parent, and other relatives. When CPS evaluates placement with the non-custodial parent, CPS must complete the following as soon as possible but within 24 hours or the next business day:

- Central registry clearance on all members of the household who are age 18 or older.
- Criminal history checks on all household members.
- A home visit.
- Risk Assessment and Family Assessment of Needs and Strengths on the non-custodial parent's household; see PSM 713-11, Risk Assessment, and PSM 713-12, Family and Child Assessments of Needs and Strengths, sections for more information on completing these assessments.

Unless ordered by the court, children must not be placed in the home of the non-custodial parent if:

- Any adult household member has a felony conviction for any of the following:
  - Child abuse or neglect.
  - Spousal abuse.
  - A crime against a child or children, including pornography.
  - A crime involving violence, including rape, sexual assault, or homicide.
  - Physical assault or battery for which there is a felony conviction in the last five years.
  - A drug-related offense for which there is a felony conviction in the last five years.
- An adjudicated sex offender (adult or juvenile) resides in the home.

If a member of the household has a felony conviction for physical assault, battery or a drug-related offense from more than five years ago, evaluate this information to determine whether there are safety issues that must be addressed. Document the rationale and obtain signature approval from a county director or district manager before allowing a child to be placed in the non-custodial parent's home. This documentation must describe and support the basis for the approval, and why the child is safe in the non-custodial parent's home.

If a member of the household is listed on central registry, evaluate this information to determine whether there are safety issues that must be addressed. Document the rationale and obtain signature approval from a supervisor before allowing a child to be placed in the non-custodial parent's home.

The results of the clearances and assessments outlined above must be documented in the DHS-154, or the current DHS-152, Updated Services Plan.

Relatives

See FOM 722-03B for requirements to search and evaluate placement with a relative.

Limitations on Number of Children in Foster home

Limitations exist to placing a child in a foster home. See FOM 722-3, Foster Care - Placement Selection and Standards, for more information about these limitations.

Exceptions to these limitations may be made when it is determined to be in the best interest of the child being placed. Exceptions cannot be given for increases to licensing capacity or other licensing rules for licensed foster homes except as outlined in foster home licensing rules.

When an exception to the limitation on the number of children in a home is needed, see FOM 722-03E, Foster Care- Placement Exception Requests and Approvals, for more information on the exception request and approval process.

Note: Placement cannot be made until the exception approval process is complete.

Placement With Siblings

Every effort must always be made to place siblings together, including requesting an exception to the limitation on the number of children in a foster or relative home can, as outlined above. All siblings who enter foster care at or near the same time must be placed together, unless:

- One of the siblings has exceptional needs that can be met only in a specialized program or facility.
- Such placement is harmful to one or more of the siblings.
- The size of the sibling group makes a joint placement impractical, notwithstanding diligent efforts to make a joint placement.

If the sibling group is not placed into the same out-of-home placement, the efforts made must be documented in Question 4 of the *Transfer Needs/Services* tab of the *Transfer to Foster Care* module.

Children Are In Out-Of-Home Care, But Siblings Remain At Home Or Are New To The Home

See PSM 713-08, Special Investigative Situations, New Child to Parent with Child(ren) in Out-Of-Home Placement, for policy information on children being in care while their siblings remain at home or are new to the home.

MEDICAL NEEDS OF CHILDREN IN FOSTER CARE

A child's health status must be assessed, and medical needs must be identified and documented in the health profile screens in MiSACWIS, located in person overview under the health profile link, prior to the child's placement into foster care. CPS must make every effort to obtain this medical information, including names of medical provider(s), the child's last medical visit, current medications, and current mental health status before the removal of a child. This information must be provided to the foster care worker and the foster placement. CPS should contact their designated health liaison officer health liaison officer (HLO) before the removal occurs. CPS must contact the HLO within 24 hours of the child's removal and provide the name and contact information for the foster care home or relative caregiver and any known medical information for the child. CPS must also provide the placement with a completed DHS-3762, Medical Authorization Card, and the DHS-Pub-268, Guidelines for Foster Parents and Relatives Caregivers for Health Care and Behavioral/Mental Health Services.

CITIZENSHIP AND NOTIFICATION OF CONSULATE

The CPS worker must inquire and attempt to verify citizenship status at the time of removal. Any child who is not a United States citizen, regardless of immigration status, is considered a foreign national. When a foreign national is taken into protective custody, or placed with the department for care and supervision, the Vienna Convention on Consular Relations requires that the appropriate consulate receive notification within 48 hours. The department is required to complete and submit a DHS-914, Notice to Foreign Consul/Embassy, to the appropriate consulate. A listing of foreign consular offices in the United States may be found at:

https://travel.state.gov/content/travel.html

After entering the U.S. State Department Foreign Consular Offices website, click on the box on the left side of the page to access consular offices by country.

The CPS worker must document and share this information with the assigned foster care worker.

Refer to FOM 722-6K for more information.

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ASSISTANCE CASES

When out-of-home placement has occurred and the family has an open assistance case, contact the family's assistance worker immediately to inform them that out-of-home placement has occurred.

OVERVIEW

In most cases, safety concerns for children may be resolved through active engagement with families and provision of services, without court involvement. When efforts to achieve and maintain a child's safety in their own home or with family have failed, or where the Child Protection Law (CPL), MCL 722.621 et seq., requires, a petition must be filed. A petition can be filed to maintain placement of the child with their family, to request court ordered participation in services, to request removal of a perpetrator from the home, or for placement of a child outside of the home.

When filing a court petition, the least intrusive relief needed to keep a child safe should be requested. Petitions seeking to remove a child from their home should only be filed in extreme cases when all efforts to assure child safety have failed or the child cannot be protected short of removal.

The assigned caseworker files the petition on behalf of Michigan Department of Health and Human Services (MDHHS), but the Family Division of Circuit Court in each county decides whether to authorize or grant the petition.

DEFINITIONS

Power of Attorney

A written agreement in which a parent or guardian of a child delegates any or all their powers regarding the care, custody, or property of the child to another adult.

Severe Physical Injury/Serious Physical Harm

Severe physical injury means serious physical harm to a child, as defined in MCL 750.136b. Serious physical harm means any physical injury that seriously impairs the child's health or physical well-being, including but not limited to, brain damage, a skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprain, internal injury, poisoning, burn or scald, or severe cut.

Sexual Abuse

A confirmed case that involves sexual penetration, sexual contact, attempted sexual penetration, or assault with intent to penetrate as

those terms are defined in section 520a of the Michigan penal code, 1931 PA 328, MCL 750.520a.

WORKING WITH LEGAL COUNSEL

The local MDHHS office must work with the prosecuting attorney's office (or alternate counsel) to develop and maintain a protocol outlining procedures for submitting petitions.

When a caseworker presents a mandatory petition to the prosecuting attorney's office for filing with the court and the prosecutor refuses to file the petition, the caseworker **must** then file the petition directly with the court. If the Family Division of Circuit Court refuses to accept or authorize the mandatory petition, a copy of the unauthorized petition must be scanned and uploaded into the Document tab of the Investigation Task page in the electronic case record.

If the prosecuting attorney's office (or alternate legal counsel) refuses to file a non-mandatory petition with the court, the caseworker may file the petition directly with the court. Document the prosecuting attorney's refusal and any action taken in social work contacts.

Attorney General Representation

If the local prosecuting attorney refuses to represent the department in a mandatory child welfare action, the local office must request representation by the attorney general or a private attorney; see FOM 903-9, Case Service Payments, for information on receiving reimbursement for costs.

PETITIONS

Various circumstances outlined below require that a caseworker file a petition for court jurisdiction over a child. The following considerations should be made if filing a petition:

- All petitions do not warrant a request for removal of the child.
- The least intrusive relief necessary for protection of the child should be requested.

- Circumstances may exist in which a caseworker must also include a request for termination of parental rights.

Non-offending Parent Evaluation

When a mandatory petition is required and there is a non-offending parent, the caseworker must evaluate whether the child should remain or be placed with the non-offending parent. The caseworker must consider whether the non-offending parent failed to protect the child. The evaluation, specific to the non-offending parent, must include the following:

- The ability and willingness to keep the child safe from the perpetrator by preventing access.
- The ability to adequately care for the child and provide love and affection to the child.
- The ability to follow through with any trauma response services for the child/family, if recommended.
- Evidence of current or previous failure to protect the child or any other children.
- Evidence of attempts to influence the child's portrayal of the events that led to the current court action.
- Other relevant factors, including best interests of the child.

The petition and supporting documents must include all relevant facts, including all information available concerning the non-offending parent's involvement, lack of involvement, or knowledge of the risk the perpetrator presented to the child.

Supervisor Approval

Prior to presenting a petition to the court caseworkers must review the case concerns with their supervisor, or designee. If the relief requested is for removal of the child from their home, the supervisor/designee must review and approve the decision to petition the court. Approval by the supervisor or designee must be based on review of the following:

- Compliance with CPL (MCL 722.637 and 722.638).
- Review of current safety concerns and protective interventions.
- Review of case history and services provided to the family.
- Discussion and identification of alternatives to removal of the child, when appropriate.

Mandatory Petition- Court Jurisdiction

Child Protection Law, Section 8d(1)(e) (MCL 722.628d(1)(e)

A caseworker must submit a petition if there is evidence of child abuse or neglect and one or more of the following are true:

- The child is not safe, and a petition is needed to ensure the child's safety.
- A petition is required under another provision of the CPL.
- The department previously classified the case as a Category II and the child's family does not voluntarily participate in services.
- The abuse or neglect is caused by one of the following crimes:
  - MCL 722.628a(1)(b) - Assault with intent to commit criminal sexual conduct (in violation of section 520g of the penal code, MCL 750.520g).
  - MCL 722.628a(1)(c) - A felonious attempt or a felonious conspiracy to commit criminal sexual conduct.
  - MCL 722.628a(1)(d) - An assault on a child that is punishable as a felony.
    - Child abuse in the 3rd degree is not included as an offense that requires a mandatory petition; however, this does not prevent DHHS from filing a petition and/or getting another opinion from the local prosecutor.

- MCL 722.628a(1)(f) - Involvement in child sexually abusive material or child sexually abusive activity (in violation of section 145c of the penal code, MCL 750.145c).
- MCL 750.136b(1)-(4) - First- or second-degree child abuse including:
  - Intentionally causing serious mental or physical harm.
  - Intentionally committing an act that would likely cause serious mental or physical harm, regardless of whether harm occurs.
  - A person's omission causes serious physical or mental harm.

See PSM 718-5, CPS Appendix F - The Michigan Penal Code, for a listing of the penal code violations.

Note: Caseworkers must remember when requesting a petition that a request for removal is not necessary in all required petition situations. Relief requested should be least intrusive necessary to protection of the child or resolution of the emergency.

Child Protection Law, Section 17 (MCL 722.637)

A caseworker must submit a petition within 24 hours after determining that the parent or legal guardian either perpetrated or failed to protect the child from:

- Sexual abuse. See *Definitions* in this policy item.
- Severe physical injury, due to abuse or neglect. See *Definitions* in this policy item.
- Exposure to, or had contact with, methamphetamine production.

A caseworker is not required to submit a petition if it is determined that the parent or legal guardian is not a suspected perpetrator of the abuse/neglect and the following apply:

- The parent or legal guardian did not neglect or fail to protect the child.

- The parent or legal guardian does not have a historical record that shows a documented pattern of neglect or failing to protect the child.
- The child is safe in the parent's or legal guardian's care.

Child Protection Law, Section 18, MCL 722.638

A caseworker must submit a petition when it is determined there is a preponderance of evidence that a parent, guardian, custodian, or a person who is 18 years of age or older and who resides for any length of time in the child's home, has abused the child or a sibling of the child and the abuse includes one or more of the following:

- Abandonment of a young child.
- Criminal sexual conduct involving penetration, attempted penetration, or assault with intent to penetrate.
- Battering, torture, or other severe physical abuse.
- Loss or serious impairment of an organ or limb.
- Life-threatening injury.
- Murder or attempted murder.

The department must also submit a petition when it is determined that there is a risk of harm, child abuse, or child neglect to the child and either of the following is true:

- The parent's rights to another child were **involuntarily terminated** under section 2(b) of MCL 712A.2, or similar law of another state, and the parent has failed to rectify the conditions that led to the prior termination of parental rights.
- The parent's rights to another child were **voluntarily terminated** following the initiation of proceedings under section 2(b) of MCL 712A.2, or similar law of another state, the parent has failed to rectify the conditions that led to prior termination of parental rights, and the proceeding involved abuse that included one or more of the following:
  - Abandonment of a young child.

- Criminal sexual conduct involving penetration, attempted penetration, or assault with intent to penetrate.
- Battering, torture, or other severe physical abuse.
- Loss or serious impairment of an organ or limb.
- Life-threatening injury.
- Murder or attempted murder.
- Voluntary manslaughter.
- Aiding and abetting, attempting to commit, conspiring to commit, or soliciting murder or voluntary manslaughter.

Note: If a parent is a suspected perpetrator or is suspected of placing the child at an unreasonable risk of harm due to the parent's failure to take reasonable steps to intervene to eliminate that risk, the department shall include a request for termination of parental rights at the initial dispositional hearing.

Mandatory Termination Petitions - Plea Agreements

Caseworkers must not initiate or negotiate a plea agreement with a mandatory termination petition. If the prosecutor's office (or alternate legal counsel) advises that a plea agreement is appropriate, the caseworker must first obtain supervisory approval before supporting a plea agreement on the record.

If the supervisor does not support a plea agreement, the caseworker must inform legal counsel that the department does not support the plea agreement and state the department's opposition on the record. If time constraints prevent the attainment of supervisory review/approval, the worker must neither support nor oppose a plea agreement.

The caseworker must document in social work contacts whether the plea agreement was supported by the department and why. If

supported, document the supervisor's approval of the plea agreement.

Non-Mandatory Termination Petitions - Case Conference

If the department is not required to petition for termination of parental rights at the initial disposition hearing but is considering doing so, the caseworker must hold a conference with the appropriate agency personnel (CPS, foster care, etc.) to agree upon the course of action. The caseworker shall notify the attorney representing the child of the time and place of the conference and the attorney may attend. If an agreement is not reached at this conference, the local office director or designee must resolve the disagreement after consulting with the attorneys representing both the department and the child.

Non-Mandatory Court Jurisdiction Petition - Temporary Custody

Where no conditions requiring a mandatory petition exist, the caseworker may consider filing a petition when:

1. Court authority is needed to order the parent to do something to allow the child to remain safely in their own home.
2. Court authority is needed to secure safety of the child.
3. If requesting removal, caseworkers must document through use of social work contacts, and on the petition that reasonable efforts were provided or attempted and that services did not eliminate the need for removal.

When one or more of the following conditions exist, the juvenile code (MCL 712A.2) provides for jurisdiction of a child:

- Whose parent or other person legally responsible for the care and maintenance of the child, when able to do so, neglects or refuses to provide proper or necessary support, education,

medical, surgical, or other care necessary for their health or morals, who is subject to a substantial risk of harm to their mental well-being, who is abandoned by their parents, guardian, or other custodian, or who is without proper custody or guardianship.

- Whose home or environment, by reason of neglect, cruelty, drunkenness, criminality, or depravity on the part of a parent, guardian, or other custodian, is an unfit place to live.

Note: Caseworkers must remember when requesting a petition that a request for removal is not necessary for all petitions. The relief requested should be the least intrusive to ensure protection of the child, or resolution of the emergency.

Supplemental/ Amended Petitions

If a caseworker becomes aware of additional confirmations of abuse/neglect for a child whose case has been adjudicated by the court, CPS must file a supplemental petition and testify at the adjudication hearing, if necessary. If adjudication is pending, CPS must file an amended petition and testify at the adjudication hearing, if necessary.

The caseworker must immediately notify the court if new facts or evidence becomes known which contradict the alleged abuse/neglect contained within a previously filed petition already authorized by the court.

COURT PROCESS

Court Hearing

The department bears the burden of proof as a petitioner. The caseworker signing the petition is responsible for being able to prove the facts contained within the petition. When filing a petition with the Family Division of Circuit Court, the caseworker should be prepared to present the following:

- The severity of the safety concerns for the child.
- Evidence and proof supporting the determination of abuse or neglect. Evidence may be contained in documents obtained

from collateral sources; for example, police records, school, and attendance reports, visiting nurse and medical reports.

- All efforts made by the department to improve the situation to prevent the need for court involvement. Emphasis should be made to indicate how the direct services were:
  - Adequate.
  - Applicable to the problem.
  - Sufficient in frequency and duration.
  - Appropriate to parental capacity.
- Reasonable efforts to prevent removal, in cases where removal of the child is requested.
- Potential placement options for the child, including the non-custodial parent, or relatives.

In presenting the department's position, the caseworker should provide information that was gathered and recorded as a part of the investigation.

Court Decisions

Once a petition has been filed, the court has several options in disposing of the petition:

- Dismiss the petition, with or without warning; see *Problem Court and Administrative Hearing Orders* below for required further action.
- Postpone a decision pending the provision of further services designed to improve the situation.
- Authorize the filing of the petition and setting an adjudicative hearing.
- Issue an order removing the perpetrator from the home.
- Make the child a temporary court ward and leave the child in their own home.
- Make the child a temporary court ward and remove the child from their home and place the child with the department for care, supervision, and out-of-home placement.

- Remove the child from their home, terminate parental rights, and make the child a permanent court ward.

Problem Court and Administrative Hearing Orders

If the court or referee refuses to authorize a petition, dismisses the petition, or if the court order conflicts with CPL, the caseworker must notify their supervisor. The supervisor must notify the Children's Services Legal Division (CSLD) to determine if further legal action is necessary. The supervisor must include the following in the email to the CSARequestforLegalResearch@michigan.gov;

- Petition.
- Pertinent Court Order.
- A brief description of the conflict.
- Synopsis of the local prosecutor's position or alternative counsel's position.
- Explanation of any action they plan to take.

Mediation

A court may order mediation in child abuse/neglect cases. Mediation, as applied in child protective proceedings, is defined in MCR 3.970(A)(2) as a process in which "a neutral third party facilitates communication between parties, assists in identifying issues, and helps explore solutions to promote a mutually acceptable settlement." It is a judicially initiated process ordered by a court and is not a department reimbursable service.

A court may order mediation at any stage in the child protection proceeding after consultation with the parties. The order must at least:

- Specify, or make provision for selection of a mediation provider.
- Provide time limits for initiation and completion of the mediation process.

The court cannot order a party to pay for a fee for mediation services.

Objection to Mediation

A party may object to mediation, orally or in writing, based on one or more of the following:

- Domestic violence unless attorneys for both parties will be present at the mediation session.
- Inability of one or both parties to negotiate for themselves at the mediation unless attorneys for both parties will be present at the mediation session.
- Reason to believe that one or both parties' health or safety would be endangered by mediation.
- A showing that the parties have made significant efforts to resolve the issues such that mediation is likely to be unsuccessful.
- For other good cause shown.

The caseworker should consult with the department's attorney to determine if MDHHS should make an objection on the record to the use of mediation in a case. However, simply making objections to mediation alone does not excuse a party from participating in the process. The court must act upon the objections.

Attendance and Participation at Mediation

The court may direct the parties and their attorneys (if ordered) to attend mediation proceedings. If an opposing party's attorney is ordered to attend and the department's attorney is not, the caseworker should object and request that the department's attorney also be ordered to attend. Such an order should be treated as a problem court order; see *Problem Court and Administrative Hearing Orders* in this item for more information.

The court may further order that the parties to the action, including the caseworker:

- Attend the mediation proceeding or be immediately available by some other means at the time of the proceeding; and

- Participate in the proceeding.

The caseworker may not bring anyone who is not a party to the action unless agreed to by the mediator and the notice is given to the attorneys on the case. If the court orders attorneys for the parties to attend, the attorney for the department must also attend. When other parties have their attorneys present, caseworkers must also have an attorney present. If attorneys for the other parties are present to participate in mediation and the department attorney is not, the caseworker should immediately bring this discrepancy to the attention of the mediator and request discontinuation of the mediation on that basis.

If the caseworker, or any party ordered by the court to participate in mediation fails to appear in accordance with the provisions of MCR 3.970, the caseworker or party may be held in contempt of court.

Mediation Process

The mediator may direct the caseworker to submit to either the mediator or the court in advance or bring to the mediation, documents or summaries providing information about the case.

The caseworker and/or legal counsel for MDHHS must, if ordered, participate in the mediation, and may ask to meet separately with the mediator throughout the mediation process.

Mediation will continue until one of the following occurs:

- An agreement is reached.
- The mediator determines that an agreement is not likely to be reached.
- The end of the first mediation session.
- Until a time agreed to by the parties.

Withdrawal from Mediation

Additional sessions may be held if it appears to the mediator that the process may result in an agreement. However, after the caseworker attends the first mediation session, the department may withdraw from the mediation process. The caseworker and/or legal

counsel for the department are not required to return for further sessions. There is no penalty for failing to appear for any subsequent sessions. Although not required under MCR 3.970, it is recommended that withdrawal from the mediation process be submitted to the court and parties in writing.

Confidentiality in Mediation

In general, mediation communications are confidential, subject only to disclosure under the provisions of MCR 2.412(D). However, previously uninvestigated allegations of abuse or neglect identified during the mediation process are not confidential and may be disclosed; see SRM 131, Confidentiality.

END OF LIFE DECISIONS

In situations where a child has been placed on life support systems and medical professionals question the decision-making of the parent/guardian or no parent/guardian can be located, CPS may find it necessary to petition the Family Division of Circuit Court. The following activities must be completed prior to petitioning the court:

- Contact the parents to confirm they have not and will not authorize medical treatment for the child. Parents are to be informed that the department will file a petition with Family Division of Circuit Court.
- Review and approval of the petition by the caseworker's immediate supervisor and the county director or designee.

The petition must state only the facts as provided by medical professionals (for example, direct quotes from doctors, medical reports, etc.).

The petition must request that the court make an appropriate decision regarding the provision of care for the child and should not offer any recommendations regarding the court's decision.

See PSM 716-8, Medical Neglect of Disabled Infants and Other Forms of Medical Neglect.

ADDITIONAL CONSIDERATIONS

A Parent's Guide to the Child Protective Process

If CPS files a petition on behalf of a child under the CPL, CPS must provide the child's parents and/or legal guardian a copy of DHS PUB-31, A Parent's Guide to Working With Foster Care.

Right To Be Heard

The caseworker must ensure children know and understand their right to attend and have input in court hearings based on the child's age and level of development. The caseworker must relay the child's desires to have input into their court hearings to the L-GAL or GAL to ensure the child an opportunity to be heard regarding their case. The L-GAL or GAL will relay this information to the court. Discussion with youth regarding their right to be heard and the relaying of the information to the L-GAL or LGAL must be documented within the social work contacts section in the electronic case management record.

Absent Parent Protocol

The Absent Parent Protocol is a resource for identifying, locating, and involving absent parents in child protection proceedings. The caseworker must search for and locate the absent parent as early as possible in child protection proceedings to prevent disruption of a permanency plan.

The court may question the specific efforts made to identify and locate absent parents.

Children Absent Without Legal Permission (AWOLP)

For more information on steps to take when a child is AWOLP; see FOM 722-03A, Absent Without Legal Permission (AWOLP).

Child Located in Another State

When a court order has been issued ordering removal of a child not physically present in Michigan, the department must contact the other state's CPS equivalent. If the other state is willing to take custody of the child, then the court of the other state and the Michigan court must communicate in accordance with the Uniform Child Custody Jurisdiction and Enforcement Act (UCCJEA) (see MCL 722.1101 et seq.).

For the department to take physical custody of a child in another state, the department must have **both** of the following:

- A written court order:
  - Naming the department; and
  - Ordering MDHHS staff to pick up the child;
- Written consent to return the child to Michigan from the LGAL.

Death of a Child Under the Court's Jurisdiction

Upon notification that a child under the court's jurisdiction has died, the caseworker must notify the court immediately, but no later than the next business day; see SRM 172, Child/Ward Death Alert Procedures and Timeframes.

Friend of the Court

In cases where there is Friend of the Court (FOC) involvement, FOC must be notified of any family court action initiated by the department; see PSM 713-08, Special Investigative Situations, for requirements on coordination with FOC.

Guardianships

During CPS involvement, another caretaker may seek to obtain legal guardianship of a supposed child abuse/neglect victim. Caseworkers need to consider if child safety can be assured through the guardianship. If a petition is required by the CPL or is needed to ensure child safety, a petition must be filed. The fact that a guardianship is being sought or was obtained is not sufficient

basis to not file a petition; see PSM 713-08, Special Investigative Situations, for more information on when a family seeks to obtain or obtains a guardianship for a child during the investigation.

Power of Attorney

A parent's initiation of a power of attorney does not alleviate the need to file a court petition in cases where a petition is required by law or needed for child safety.

Vital Records

The court may request that the caseworker provide a copy of the child's birth certificate to the court. When requesting in-home jurisdiction, the CPS caseworker may need to provide a copy.

MDHHS Vital Records and Health Statistics (VRHS) division has two formats for vital records, administrative copies, and certified copies. The caseworker may provide an administrative copy to the court unless the court requests a certified copy.

See FOM 910, Obtaining Vital Records, for information on obtaining a birth certificate for a child.

POLICY CONTACT

For more information contact the Child-Welfare-Policy@michigan.gov.

COORDINATION WITH FOSTER CARE

The provision of services to abused or neglected children and their household is a CPS function when the children are living in their own homes. Reasonable efforts must be made to prevent or eliminate the need for removal prior to the removal of a child from his/her own home, except in emergency removal situations. When children have been removed from their homes and placed in the care and supervision of the department, the provision of services to abused or neglected children and their families is a function of foster care staff. Transition of responsibility should be facilitated by a case conference to outline protective services activity, objectives, and recommended treatment. Relatives should be identified for placement or as potential placement options and these options should be discussed with the foster care worker. See PSM 713-08, Special Investigative Situations, Coordination with Friend of the Court, for requirements on notification to Friend of the Court when there is a change in a child's placement.

Removal of Child-Case Management Responsibility

CPS retains responsibility of the case if the child remains in his/her own home (including when a child is placed with the non-custodial parent) and the court requests continued department supervision or if the child is in out-of-home placement which is expected to last 7 days or less.

When removal of the child is necessary and the child is made a temporary ward, responsibility of the case is transferred to foster care staff. CPS must initiate transfer of case management responsibility as soon as a decision is made to place the child in out-of-home placement that is expected to last more than 7 days.

Note: Initial placement with a non-custodial parent, voluntary or court-ordered, is not considered an out-of-home placement per 1973 PA 116 (Child Care Organization Licensing Act) and it is therefore the responsibility of CPS to monitor and provide services.

Responsibilities and Functions

The following describes the responsibilities and functions of CPS and foster care when the court orders out-of-home placement:

1. The local office must ensure there are adequate procedures for appropriate placement in emergency situations, with priority given to relative caregivers. It is also to ensure that a child and the relative or licensed foster home placement are suitably matched. The child must be placed in the most family-like setting available and in as close proximity to the child's parents' home as is consistent with the best interests and special needs of the child.

   CPS must provide supportive services during this transition period to ensure that at no time will the children or parents be without a responsible worker. Efforts to resolve the issues leading to the out-of-home placement must continue. Where possible, reunification of the child with family should be pursued.

   Within five working days of the initial out-of-home placement, the CPS worker must transfer the case to Foster Care.

2. When out-of-home placement has been ordered and is expected to last more than 7 days, foster care is to assume responsibility for the case upon transfer in MiSACWIS.

   See FOM 722-06I, Maintaining Connections Through Visitation and Contact for information on how often parenting time should occur. CPS will implement visitation until service responsibility is transferred to foster care.

   When a child is placed in out-of-home care and the duration of care is expected to be less than 7 calendar days, CPS will continue to carry responsibility. If care is expected to extend beyond 7 days, foster care must assume responsibility for the case once the CPS worker completes the transfer in MiSACWIS.

   The CPS worker must transfer case responsibilities by completing the transfer in MiSACWIS, within five working days of placement. Prompt completion of the transfer is essential to allow foster care time to develop case plans which must be submitted to the court within 30 calendar days of a child's removal.

   When the transfer is complete, CPS is no longer responsible for provision of services to the child and family. The CPS case must be closed in MiSACWIS once the case is successfully

transferred to the Foster Care worker.

CPS would still be required to testify at necessary hearings and submit amended petitions when required.

3. The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) requires that within 30 days of removal, the state must make diligent efforts to identify and provide notice to a child's relatives that a child is in foster care. See PSM 715-2, Removal and Placement of Children, Placement with Relatives and Non-Custodial Parents section, for more information on identifying and notifying relatives. The CPS worker should notify the foster care worker of what has been completed. Copies of the relative search forms must be scanned and uploaded into MiSACWIS.

4. Supervision of a child placed in a relative's home for protective purposes is the responsibility of foster care. When a child is placed in a relative's home without a court order for out-of-home placement, the case must be supervised by CPS; see PSM 713-01, CPS Investigation - General Instructions and Checklist, Temporary Voluntary Arrangements section.

5. See PSM 716-3, Voluntary Foster Care, for information on voluntary foster care cases.

6. In situations in which the court orders one or more children removed from a home due to child abuse and/or neglect, but leaves a sibling(s) in the home with court jurisdiction, case management for all children is the responsibility of foster care. The DHS-3, Sibling Placement Evaluation, form must be completed in these situations. See PSM 713-08, Special Investigative Situations, Child(ren) Currently in Out-Of-Home Placement/ Prior Termination of Parental Rights section, for more information on completing the DHS-3.

7. When a child in foster care is returned to his/her own home, follow-up or after-care supervision must be provided by foster care staff. Ongoing casework responsibility must not be returned to CPS from foster care if the child has been in foster care for more than 7 calendar days. If CPS has transferred case responsibility to foster care and the child is returned home prior to having been in placement for 7 days, case management responsibility must revert to CPS. If the child has been in foster care for 7 calendar days foster care would resume case responsibility.

Note: Case management responsibility should be transferred from CPS to foster care no later than five working days following placement of the child into foster care. **However, in certain circumstances, a child may be removed with the expectation that the child's time in foster care will be less than 7 days. CPS should retain case management responsibility in these situations for a maximum of 7 days.** If the child is not returned home by the 7th day, case management responsibility must be transferred to foster care. Such circumstances require that the local office establish procedures to ensure that the DHS-65, Initial Service Plan, is prepared and made available to the court within 30 calendar days of the child's removal.

8. In all cases in which CPS has filed a petition in the Family Division of Circuit Court to terminate parental rights at the first dispositional hearing, a case conference must be held between CPS and foster care within five working days of placement. Minimally, the CPS and foster care worker and their respective supervisors must attend this meeting. Other involved parties and staff should be included, as appropriate. See PSM 715-3, Family Court: Petitions, Hearings and Court Orders, Termination Petitions - Case Conference section, for information on involving a child's attorney and attorney-guardian ad litem in case conferences.

CHILDREN ARE IN OUT-OF-HOME CARE, BUT SIBLINGS REMAIN AT HOME OR ARE NEW TO THE HOME

A DHS-3, Sibling Placement Evaluation, form must be completed on all cases in which a child remains in the home when sibling(s) has/have been removed or sibling(s) are/were permanent wards as a result of a child abuse/neglect (CA/N) court action. See PSM 713-08, Special Investigative Situations, Child(ren) Currently in Out-Of-Home Placement/ Prior Termination of Parental Rights section, for more information on completing the DHS-3.

A foster care worker who becomes aware of the existence of a new child to a parent or parents who have other children in temporary care or who have had parental rights terminated in the past, either

voluntarily or involuntarily as a result of a CA/N, must make a complaint of suspected (or actual) neglect/abuse regarding the new child to CPS. This might occur when a new child is born or moves into the home or was previously undiscovered, perhaps even hidden by the family, at the time of the previous court action. The CPS complaint must be made immediately when foster care becomes aware of the existence of such a child. See PSM 712-1, CPS Intake-Initial Receipt of Complaint, regarding the process for making a complaint.

OVERVIEW

A referral involving only substance use is insufficient for investigation or confirmation of child abuse or child neglect. Parents and caregivers may use legally or illegally obtained substances and prescribed medications to varying degrees and remain able to safely care for their children.

Substance use by a parent/caregiver may be a risk factor for child maltreatment. For cases involving known substance use, case managers must evaluate its impact on child safety. Substance abuse is a mental health disorder. Case managers should assist the parent/caregiver in accessing relevant supports and services.

DEFINITIONS

Controlled Substance

A drug, substance, or immediate precursor. Controlled substances include illicitly used drugs or prescription medications.

Meconium

The earliest stool of an infant. The meconium is composed of materials ingested during the time the infant spends in the uterus.

Medication Assisted Treatment (MAT)

The use of medications, in combination with counseling and behavioral therapies, to provide a holistic approach to substance use disorders. Examples include Suboxone and Methadone.

Serious Physical Harm

Any physical injury to a child that seriously impairs the child's health or physical well-being, including, but not limited to, brain damage, a skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprain, internal injury, poisoning, burn or scald, or severe cut, MCL 750.136b(1)(f).

INTAKE

To assign for investigation, referrals containing allegations of substance use must meet Child Protection Law (CPL) definitions of suspected child abuse and/or neglect.

Assignment of Referrals involving Infants Exposed to Substances or Alcohol

Mandated reporters who know, or from the infant's symptoms have reasonable cause to suspect that an infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in the infant's body, not attributed to medical treatment, must make a referral of suspected child abuse to Children's Protective Services (CPS).

A CPS referral is not required if the mandated reporter knows the alcohol, controlled substance, or metabolite, or the child's symptoms are the result of medical treatment administered to the infant or the infant's mother (MCL 722.623a).

Note: Medical marijuana and MAT are medical treatment.

CPS will investigate referrals alleging an infant was born exposed to substances not attributed to medical treatment when exposure is indicated by any of the following:

- Positive urine screen of the infant.
- Positive result from meconium testing.
- Positive result from umbilical cord tissue testing.
- A medical professional report(s) the child has symptoms that indicate exposure.

RESPONSE TO SAFETY CONCERNS

The following conditions may exist in homes where illegal substances are manufactured, sold, used, or distributed:

- Criminality.
- Loss of household control (individual who controls the drug trade usually controls the environment).
- Unsecured weapons.
- Potential for violence, including threats of physical assault; assaultive or coercive behavior.
- General neglect, such as squalor, lack of food, etc.

- Unmet needs of the child.
- Presence of individuals who endanger the child's welfare and may have history of child abuse and/or neglect, and/or may be unwilling or unable to safely care for children.

Coordination with law enforcement is encouraged if there are safety concerns for the case manager**.** Case managers must have law enforcement accompany them to homes where illegal substances are manufactured and/or distributed.

Methamphetamine, Carfentanil, and Marijuana Butane Hash Oil Extraction

Coordination with law enforcement must occur when the following allegations or concerns exist:

- Suspected manufacturing, selling or distribution of methamphetamine.
- Suspected presence or use of carfentanil.
- Production or extraction of marijuana butane hash oil.

Case managers should not enter these homes without the assistance of law enforcement.

Methamphetamine

Methamphetamine is a highly addictive and very potent central nervous system stimulant. The production of methamphetamine poses a significant danger due to risk of fire, explosion, and exposure to chemicals and fumes. Those using methamphetamine may be highly agitated and unpredictable.

If children are removed from an environment where it is known they were exposed to methamphetamine use or production, they should be immediately transported to the closest hospital emergency room for a medical assessment. Case managers should not transport anyone suspected of exposure to methamphetamine production. Case managers should request the children be transported to the hospital by ambulance or law enforcement.

Carfentanil

Carfentanil is a synthetic opioid that comes in several forms, including powder, blotter paper, tablet, patch, and spray. ***Carfentanil and other Fentanyl analogues present a serious risk to child welfare case managers,*** public safety, first responders, medical, treatment, and laboratory personnel. ***Case managers must not enter homes where there are concerns of use and/or manufacturing of any Fentanyl-related substance. Law enforcement must be contacted immediately and utilized to ensure the home is safe to enter and safety protocols are in place to avoid accidental exposure.***

The United States Department of Justice Drug Enforcement Administration has published Carfentanil: A Dangerous New Factor in the U.S. Opioid Crisis, which is a factsheet containing public safety information about Fentanyl, carfentanil and other dangerous synthetic opiates.

Marijuana Butane Hash Oil Extraction

A marijuana concentrate is a highly potent Tetrahydrocannabinol (THC) concentrated mass that can be consumed orally by infusing the concentrate in various food or drink products or ingestion by use of a water pipe or e-cigarette/vaporizer.

Many methods are utilized to convert or manufacture marijuana into marijuana concentrates. One method is the butane hash oil extraction process. This process is particularly dangerous because it uses highly flammable butane to extract the THC from the cannabis plant. Given the extremely volatile nature of heating butane and creating a gas, this process has resulted in violent explosions. The United States Department of Justice Drug Enforcement Administration has published What You Should Know about Marijuana Concentrates, which is a factsheet containing public safety information on the dangers of converting marijuana into marijuana concentrates using the butane extraction process.

Case managers must not enter homes where there are concerns for manufacturing marijuana into concentrates. Contact must be made with law enforcement to ensure the home is safe to enter.

Raids

A CPS investigation must occur when law enforcement contacts Centralized Intake and indicates a drug raid has occurred in the home and reports suspected child abuse and/or neglect.

Case managers should assist the parent(s)/caregivers with securing safety and shelter for the children, if necessary, when the home is not safe for the children to return.

INVESTIGATION REQUIREMENTS

Verification of Medication

Case managers may ask a parent to verify medication such as anti-depressants, anti-psychotics, narcotic pain medications or prescriptions identified as MAT.

Verification of medication may occur by any of the following:

- Observing the written prescription.
- Observing the prescription bottle.
- Contacting the prescribing medical professional.

A signed DHS 1555-cs, Authorization to Release Confidential Information, must be signed by the caregiver prior to contacting the medical provider; see SRM 131, Confidentiality.

Investigations involving Infants

Along with standard investigation activities that apply in all other cases, investigations involving infants exposed to substances or alcohol must also include:

- Contact with medical staff to obtain the following information, if available:
  - Results of medical tests indicating infant exposure to substances and/or alcohol.
  - The health and status of the infant.
  - Documented symptoms of withdrawal experienced by the infant.

- Medical treatment the infant or birthing parent may need.
- Observations of the parent's care of the infant and the parent's response to the infant's needs.
- To be considered serious physical abuse, a medical practitioner must confirm the infant's exposure and any related symptoms meet the definition of serious physical harm.
- Interview with the infant's parents and any relevant caregivers to assess the need for a referral for substance use disorder prevention, treatment, or recovery services.

- Assessment of the parent's capacity to adequately care for the infant and other children in the home.
- Coordination between the case manager, medical professional(s) and family to co-develop an Infant Plan of Safe Care (POSC) if necessary.
- Contact with substance use treatment providers, if applicable, to determine the parent's level of participation.

DECISION MAKING FOR INVESTIGATIONS INVOLVING SUBSTANCES

Parental substance use and/or positive toxicology in an infant does not in and of itself indicate that child abuse and/or neglect has occurred or that the infant has experienced serious physical harm.

For investigations involving allegations of parental substance use or infant exposure, case managers must reach conclusions based on the presence or absence of evidence of child abuse and/or neglect as defined; see PSM 711-4, CPS Legal Requirements and Definitions.

For guidance in assessing parenting capacity, whether child abuse and/or neglect occurred and how to best address safety, case managers should consider the following:

- Does the use extend to the point of intoxication, unconsciousness, or inability to make appropriate decisions for the safety of their child(ren)?
- Does the use of substances cause reduced capacity to respond to the child's cues and needs?
- Is there evidence to demonstrate difficulty regulating emotions or controlling anger?
- Are the following emotions regularly demonstrated?
  - Aggressiveness.
  - Impulsivity.
- Is there an appearance of being sedated or inattentive?
- Is there demonstrated ability to consistently nurture and supervise the child(ren) according to their developmental needs?
- Do co-occurring issues exist which would impact parenting or exacerbate risk such as:
  - Social isolation.
  - Poverty.
  - Unstable housing.
  - Domestic violence.
- Are there supports such as family and friends who can care for the child(ren) when the parents are not able to? Are the parents willing to use their supports when necessary?
- Has the use of substances caused substantial impairment of judgement or irrationality to the extent the child was abused or neglected?
- Any other factor which demonstrates inability to protect the child(ren) and maintain child safety.

Early On®

Children age 0 to 3 who are alleged or confirmed to have been affected by substances in utero, and/or a development delay, must be referred to Early On®; see PSM 713-01 - CPS Investigation - General Instructions.

Infant Plan of Safe Care

In an investigation involving an infant born exposed to substances or having withdrawal symptoms, or Fetal Alcohol Spectrum Disorder (FASD), the case manager must develop an infant plan of safe care that addresses:

- The health and safety needs of the infant.
- The health and substance use treatment needs of the birthing parent or caregiver.
- The needs of all household members, including caregivers who reside outside of the home. For example, a parent involved in the care of the infant who does not reside in the home or other consistent caregivers, like babysitters.

Regardless of case disposition, in addition to a referral to Early On, services must be provided to the infant and family by MDHHS or another service provider, including, but not limited to, one of the following services:

- Michigan Home Visiting Program.
- Families First.
- Families Together Building Solutions (FTBS).
- Substance use disorder prevention, treatment, or recovery.
- Family Preservation.

The referral and implementation of these services **must** be documented by the case manager in the Newborn Toxicology section located in CPS History and Trends.

LABORATORY SCREENING

There may be situations in which case managers determine that substance/alcohol screens for parents or other persons responsible are necessary. Screening frequency should not exceed twice monthly; unless there is a need to verify use or abstinence, or a court order requiring additional screening. Substance use screening should not be completed as punitive action.

Regardless of the outcome of the drug screen, case managers should continuously engage with the parent, provide the parent with

applicable services, and assess the impact of the parent's substance use.

Consent

Federal regulations require the civil rights of a client be protected. Informed consent is a mandatory component of screening procedures and case managers should ensure that a consent form is signed. If a client is screened, they must be provided with information on the potential subsequent action of screening.

If a client refuses to consent to screening, the case manager should engage with the client and continue to assess for potential risks to the child(ren).

Screening of Minors

CPS must **not** conduct a drug screen on a child.

RELEASE OF INFORMATION

Because of the highly confidential status given to information concerning substance use disorder treatment, case managers must follow policy and only release this type of information under the provisions given; see SRM 131, Confidentiality - Substance Abuse Records.

LEGAL

Child Protection Law, MCL 722.621 et seq.

CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox.

MEDICAL NEGLECT OF DISABLED CHILDREN

The Child Abuse Amendments of 1984, PL 98-457, including section 4 (b) (2) (K) of the federal Child Abuse Prevention and Treatment Act, 42 USC 5101 et. seq. and USC 5116 et. seq., and subsequent federal regulations implementing the act, establish the role and responsibility of the state's CPS system in responding to complaints of medical neglect of children, including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions.

The federal regulations implementing the act emphasize the role and functions of the CPS system, its focus on the family, and the locus of decision-making in relation to the medical neglect of disabled children. The decision to provide or withhold medically indicated treatment is, except in highly unusual circumstances, made by the parents or legal guardian.

Parents are the decision-makers concerning treatment for their disabled children, based on the advice and reasonable medical judgment of their physicians. The counsel of an Infant Care Review Committee (ICRC) or other hospital review committee might be sought, if available. Therefore, if a complaint is made to CPS regarding the withholding of medically indicated treatment from disabled infants with life-threatening conditions, the focus of CPS's work will be, as it is in responding to other complaints of child abuse or neglect, to protect the child and to assist the family.

The federal regulations further emphasize that it is not the CPS program, the ICRC or similar committee that makes the decision regarding the care of and treatment for the child. This is the parents' right and responsibility. Nor is the aim of the statute, regulation, and the child abuse program to regulate health care.

The parents' role as decision-maker must be respected and supported unless they choose a course of action inconsistent with applicable standards established by law. Where hospitals have an ICRC or similar committee and the review and counsel of the ICRC is sought, it is the role of the ICRC to review the case, provide additional information as needed to ensure fully informed decision-making, and recommend that the hospital seek CPS involvement when necessary to ensure protection for the infant and compliance with applicable legal standards.

The federal regulations highlight several key points:

- Current procedures and mechanisms already in place for CPS for responding to complaints of suspected child abuse and neglect should be used for responding to complaints of the withholding of medically indicated treatment from disabled infants with life-threatening conditions.
- CPS must coordinate and consult with individuals designated by and within the hospital in order to avoid unnecessary disruption of hospital activities.
- The legislation is not intended to require CPS workers to practice medicine or second guess reasonable medical judgments. Rather CPS must respond to complaints under procedures designed to ascertain whether any decision to withhold treatment was based on reasonable medical judgment consistent with the definition of "withholding of medically indicated treatment."
- If CPS determines on the basis of medical documentation there is withholding by the parent/guardian of medically indicated treatment from a disabled infant with life-threatening conditions, CPS must pursue the appropriate legal remedies to prevent the withholding.

Definitions

Medical Neglect

The failure to provide adequate medical care in the context of the definitions of "child abuse and neglect". The term "medical neglect" includes, but is not limited to, the withholding of medically indicated treatment from a disabled child with a life-threatening condition.

Withholding of Medically Indicated Treatment

The failure to respond to the disabled child's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which in the treating physician's reasonable medical judgment, will most likely be effective in ameliorating or correcting all such conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's reasonable medical judgment any of the following circumstances apply:

- The infant is chronically and irreversibly comatose.
- Treatment would merely prolong dying, not be effective in ameliorating or correcting all of the disabled infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant.
- Treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

Infant

A child less than one year of age. The reference to less than one year of age must not be construed to imply that treatment should be changed or discontinued when an infant reaches one year of age, or to effect or limit any existing protections available under state laws regarding medical neglect of children over one year of age.

Children

In addition to infants less than one year of age, the standards set forth in the above definition of "withholding of medically indicated treatment" should be considered thoroughly in the evaluation of any issues of medical neglect involving a child older than one year of age who has been continuously hospitalized since birth, who was born extremely prematurely, or who has a long-term disability. This includes children who may be seen as medically fragile, or those who may be seen at an increased level of vulnerability based on their medical needs; see PSM 713-04.

Reasonable Medical Judgment

A medical judgment made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

Infant Care Review Committee (ICRC)

A voluntarily established, generally hospital based multidisciplinary group which may be composed of, but is not limited to, such members as a practicing physician (e.g., a pediatrician, a neonatologist, or pediatric surgeon), a practicing nurse, a hospital administrator, a social worker, a representative of a disability group, a lay community member, and a member of the facility's organized medical staff, whose purpose and functions are:

- To educate hospital personnel and families of disabled infants with life-threatening conditions.
- To recommend institutional policies and guidelines concerning the withholding of medically indicated treatment from disabled infants with life-threatening conditions.
- To offer counsel and review in cases involving disabled infants with life-threatening conditions.

Report and Investigation

To clarify when CPS is the appropriate department for responding to the alleged medical neglect of a disabled child, the chart below indicates the appropriate system or process available for responding based on the party alleged to be neglecting the child and the reporting person.

CPS RESPONSE TO COMPLAINTS OF MEDICAL NEGLECT OF DISABLED CHILDREN		
	NEGLECTING PARTY	
Reporting Person	**Parents**	**Hospital Staff**
Hospital Staff	CPS investigates	Not applicable
Parents	Not applicable	Existing hospital review process
Other/Anonymous	CPS investigates	Existing hospital review process

CPS is responsible for responding to complaints that parents are neglecting their child's health and welfare by withholding medically indicated treatment, as noted in Column A. Complaints from parents or others that the hospital or health care provider is neglecting (Column B) to provide proper or suitable care for the infant is outside the scope and responsibility of CPS and are not appropriate for CPS investigation. Existing procedures, including medical review committees within the health care facility, should be used for addressing such concerns.

Complaint of Parental Neglect from Health Care Provider or Hospital

Most complaints of medical neglect involving the withholding of medically indicated treatment from disabled children with life-threatening conditions by parents are reported by a health care provider or hospital staff. This reporting person is logically in the best position, with their medical expertise, to know what is medically indicated and necessary treatment. The complaint must be accepted for investigation with appropriate steps taken to ensure that necessary care and treatment are provided.

Required steps include:

1. Contact the designated hospital liaison person regarding the condition of the child and treatment needed and confirm or determine:

    a. Does the child have a life-threatening condition which falls outside the three conditions specified in the federal regulation in which treatment is not considered medically indicated? Examples are:

        (1) The child involved is chronically and irreversibly comatose.

        (2) Treatment would merely prolong dying, not be effective in ameliorating or correcting all of the life-threatening conditions, or otherwise be futile in terms of the survival of the child.

        (3) Treatment would be virtually futile in terms of the survival of the child and the treatment itself under such circumstances would be inhumane.

    b. What is the diagnosis and condition of the child?

    c. What treatment has been provided and what treatment is still needed?

    d. Consequences if treatment is not provided?

    e. Has the treating physician recommended that treatment be provided?

    f. Have parents refused to consent to treatment? If so, on what basis?

g. What was the analysis of the ICRC, or other reviewing body, if available?

2. Face-to-face interview with the parents (discuss first with the hospital social worker, if involved, to determine the context for interviewing parents) to determine parents' understanding of child's condition and treatment alternatives and the decisions they have made and the basis for those decisions.

3. Determine whether further investigation is needed.

a. No.

(1) If there is no withholding of medically indicated treatment, a preponderance of evidence of child abuse/neglect will not be found to exist

(2) If treatment is indicated and recommended by the treating physician and other consultants, but the parents have refused to consent to the treatment, court action must be sought for the protection of the child as follows:

a) Contact the parents to confirm that they have not and will not authorize medical treatment for the infant. Parents must be told the department will file a petition in the Family Division of Circuit Court seeking a court order to authorize medical treatment.

(b) File a petition in the Family Division of Circuit Court requesting that the court make an appropriate decision regarding the provision of care for the child. The petition must state **only** the facts as provided by medical professionals (**direct quotes** from doctors, medical reports, etc.). The worker filing the petition must **not** offer any recommendations regarding the court's decision. The petition must be reviewed and approved by the supervisor and the county director (or designee) prior to filing with the court; see PSM 715-3-Family Court: Petitions, Hearings and Court Orders, End of Life Decisions section.

(c) Subsequent to resolution of an emergency condition, there is to be follow-up services for

the parents. Services may include information about parental support groups composed of parents with children having similar disabilities as well as community services and resources to assist families in the care of children. At an appropriate time and when parents can better evaluate their options and decisions, they may also be advised of voluntary release services if they are unable to provide the continuing care necessary for the child.

b. Yes.

There remains some doubt or uncertainty regarding the hospital's recommendations, the parents refuse to authorize medically indicated treatment, or there is a need for additional documentation to arrive at a conclusion, there must be further consultation with the ICRC, other review committee or medical consultant, if available.

If further consultation with the ICRC or other medical staff does not yield sufficient information to assist in determining whether there is medical neglect involving withholding of medically indicated treatment from a disabled child with a life-threatening condition and the parents are not cooperative in authorizing medical treatment, a petition must be filed with the Family Division of Circuit Court requesting that the court make an appropriate decision regarding the provision of care for the child.

If the court orders an independent medical evaluation, it should empower the court appointed medical consultant to make whatever inquiries and investigations he/she considers appropriate including access to hospital personnel and to pertinent hospital records.

The medical consultant should determine whether a child is at risk due to the withholding of medically indicated treatment, and may include:

(1) Notifying the designated hospital liaison person that a judicial order has been obtained to conduct an independent investigation and to gain access to the hospital and its pertinent records.

(2) Interviewing the treating physician and others involved in treatment.

(3) Reviewing medical records.

(4) Interviewing parents to determine the basis for their decisions.

(5) Arranging, if necessary, a meeting with the ICRC, its designees, or other hospital review mechanism to determine the following: Did the ICRC or other hospital review committee verify the diagnosis? Were all the facts explained to the parents? Did the parents have time to think about their decision? Did the parents appear at the meeting and articulate their objections to treatment before the committee? Were all the facts before the committee? Did all physicians, nurses and others involved in treatment have an opportunity to present information to the committee? Did the committee recommend treatment or make any other recommendation? Was there significant dissent among committee members and/or medical staff? Was the committee recommendation consistent with the terms of "withholding medically indicated treatment."

The medical consultant is to notify the court of the findings and recommendations and submit a report in writing to the court and the department.

4. If requested or ordered by the court, the department is to provide follow-up services which may include:

- Monitoring the case through regular contact with the health care facility designee to assure that appropriate nutrition, hydration, medication and medically indicated treatment is provided. The court is to be notified whenever there is failure to authorize or provide necessary care or treatment for the child.

- Assisting the parents by initiating referrals to appropriate agencies that provide supportive services for disabled children and their families.

Complaint of Parental Neglect From Other Than a Health Care Provider or Hospital

If a complaint is received from someone other than a health care provider or hospital alleging medical neglect involving the withholding of medically indicated treatment from a disabled child with a life-threatening condition, the following steps must be taken:

1. Obtain the following information from the reporting person:

    a. Name, address, and telephone number of the health care provider.

    b. Names, addresses and telephone numbers of the child and parents.

    c. Name of the reporting person, source of their information (first hand or otherwise), position to have reliable information (such as a nurse on the ward, a friend or other), affiliation, address, and telephone number.

    d. Specific information as to the nature and extent of the child's condition and the reason and basis for suspecting that medically indicated treatment or appropriate nutrition, hydration or medication is being or will be withheld.

    e. Whether the child may die or suffer harm within the immediate future if medical treatment or appropriate nutrition, hydration or medication is withheld.

    f. Names, addresses and telephone numbers of others who might be able to provide further information about the situation.

2. Decide whether the information provided is sufficient to warrant an investigation based on the following criteria:

    a. The circumstances reported, if true, would constitute "child medical neglect" as defined by state law, e.g., "harm or threatened harm to a child's health or welfare by a parent or legal guardian which occurs through negligent treatment, including the failure to provide adequate...medical care".

    b. There is **reasonable cause to believe** that circumstances indicate the withholding of medically indicated treatment. Reasonable cause to believe is defined as: what

reasonable people, in similar circumstances, would conclude from such things as the nature of the condition of the child, health care professional statements, and information that the parents have refused to consent to recommended treatment.

The intake worker and supervisor, in consultation with a medical consultant if necessary, must decide whether these elements are present and an investigation is warranted. (Payment for medical consultation may be made using procedures described in PSM 713-04-Medical Examination and Assessment.) If an investigation is not warranted, the reporting person must be informed that the criteria for initiating an investigation are not present and an investigation will not be conducted. If an investigation is warranted, proceed under the steps indicated above for responding to a complaint received from a health care provider or hospital.

MEDICAL NEGLECT BASED ON RELIGIOUS BELIEFS

It is a parent's right and responsibility to consider recommendations from medical practitioner(s) and make an informed decision for treatment that they believe is in their child's best interest. These decisions may involve the need to weigh several competing opinions and recommended courses of treatment. Decisions are often made in the context of the family's religious or spiritual beliefs. A determination of medical neglect must include sufficient evidence that the parent had the opportunity, but failed to provide medical care for the child's health or welfare.

Under the Child Protection Law (MCL 722.634), when a particular type of intervention or a specific recommended medical treatment for a child is not provided based on a parent or guardian practicing his/her religious beliefs, the parent or guardian must **NOT** be considered negligent for that reason alone. To be clear, a finding of medical neglect may still be confirmed in such cases if sufficient evidence of neglect exists, but if so, the parent or guardian cannot be considered a perpetrator. The perpetrator must be indicated as "unknown." See below for guidance.

No Perpetrator

If medical neglect is confirmed as the result of a CPS investigation based **only** on the parent or guardian not providing the recommended medical treatment due to his/her religious beliefs, the parent's or guardian's name(s) must not be listed on the central registry as a perpetrator of child abuse or neglect. When completing the disposition in MiSACWIS, select the victim(s) of medical neglect and an unknown perpetrator. The disposition must provide a narrative documenting why an unknown perpetrator is being identified.

AMENDMENT OR EXPUNCTION

The Child Protection Law (CPL) contains provisions to amend an inaccurate report or record or expunge a person from central registry.

DEFINITIONS

Amendment

Correction of an inaccurate report or record.

Expunction

The process of removing or eliminating information within a record, such as removing an individual from central registry. Case records are not subject to expunction.

Central Registry Case

The department confirmed that a person responsible for the child's health or welfare committed serious abuse or neglect, sexual abuse, sexual exploitation of a child, or allowed a child to be exposed to or have contact with methamphetamine production.

Confirmed Case

The department has determined, by a preponderance of evidence, that child abuse or child neglect occurred by a person responsible for the child's health, welfare, or care but the perpetrator is not required to be placed on central registry.

AMENDMENT/ EXPUNCTION

Central Registry Placement

An individual who is the subject of a report or record made under the CPL may request the department amend or expunge an inaccurate report or record from the central registry and/or the case record within 180 calendar days from the date of service on the DHS-847a, *Notice of Placement on Central Registry.* If the department denies the request for an amendment and/or expunction of a report or record, an administrative hearing will be requested by the Expungement Unit; see PSM 717-3, Administrative Hearing Procedures MCL 722.627j.

Confirmed Cases (No Central Registry Placement)

An individual who is the subject of a report or record made under the CPL may request the department amend an inaccurate report or record within 180 calendar days from the date of service on the DHS-847c*, Notice of a Confirmed Case,* MCL 722.628.

Note: Confirmed cases can only be amended, not expunged.

Administrative Review Request Extension

If a written request is submitted within 60 calendar days after the 180 calendar days from the date of service on the DHS-847c*, Notice of a Confirmed Case* or DHS-847a*, Notice of Placement on Central Registry,* with good cause*,* a review and request for hearing must occur. Examples of good cause includes, but is not limited to, hospitalization or incarceration of the perpetrator.

REVIEW OF AMENDMENT/EXPUNCTION REQUEST

Upon receipt of a written request for an amendment/expunction of a case record or report from an individual who is the subject of the record or report, the local office may review the case record and determine the appropriate action within 45 calendar days or submit the request to the expungement unit for review.

When reviewing an amendment/expunction request, the department must consider an amendment when the case record reveals:

- Errors in facts.
- Missing information.
- Inaccuracies within assessments.
- Case records and/or witnesses are not available.
- The facts of the case do not support the outcome or do not meet a preponderance.

The local office must consider completing the administrative review for amendment/expunction for the following reasons:

- Emergency placement decisions.
- To expedite placement.
- For employment purposes.

Facts do not Support Amendment/ Expunction

If the local office completes the review and the determination is not to amend or expunge, the local office will forward the DHS-847a*, Notice of Placement on Central Registry,* or DHS 1200c*, Confirmed Case Amendment Action* request, along with reasoning for denial, and any supporting information to the Expungement Unit at DHHS-Expungement-Unit@michigan.gov within 2 business days. See PSM 717-3, Administrative Hearing Procedures, for the expungement unit administrative review process.

Amendment to Children's Protective Services (CPS) Record

If the local office supports amendment/expunction, CPS must create an amendment to the corresponding DHS-154*, Investigation Report,* and correct any inaccurate information in the electronic case record. The decision to amend/expunge must be made by a children's services supervisor. The individual must be notified via the DHS 1200c*, Confirmed Case Amendment Action* or the DHHS-1200*, Child/Abuse Neglect - Central Registry Expunction Action*.

Removal from Central Registry After 10 Years

Not more than once every 10 years after an individual has been listed on the central registry, the individual may request a hearing requesting removal from the central registry. Except for confirmed sexual abuse, confirmed sexual exploitation, and placement on the central registry as a result of a criminal conviction, the department must hold a hearing to determine whether the information should be maintained on the central registry; see PSM 717-3 Administrative Hearing Procedures.

Note: If an individual does not receive an expungement, the department must maintain the information in central registry until it receives reliable information the perpetrator of the child abuse or child neglect is deceased.

POLICY CONTACT

Questions about this policy item may be directed to the Child Welfare Policy Mailbox (Child-Welfare-Policy@michigan.gov).

OVERVIEW

A person who is the subject of a report or record made under the Child Protection Law (CPL) may request amendment or expunction of an inaccurate report or record. Primary responsibilites and duties contained in this policy are that of the Expungement Unit.

DEFINITIONS

Administrative Review

For purposes of this policy, a review of the case record conducted by the department.

Administrative Hearing

For purposes of this policy, a hearing conducted by an Adminstrative Law Judge (ALJ).

Administrative Law Judge

Any person assigned by the hearing system to preside over and hear a contested case or other matter assigned, including, but not limited to, tribunal member, hearing officer, presiding officer, referee, and magistrate.

ADMINISTRATIVE REVIEW

Upon receipt of a written request for amendment/expunction of case record or report, the expungement analyst must review the electronic case record within two business days of assignment to determine if additional documents need to be requested from the local office to complete the administrative review request. See Expunction and Administrative Hearing Procedures policy job aid for the administrative review process.

An assessment must be made by the expungement unit as to whether the case has sufficient evidence to support the dispositional findings. The findings must be supported and applied correctly based on CPL and policy that was in place at the time of the finding. All factors must be considered including the credibility of witness statements. All supporting evidence provided by the requestor must be reviewed prior to rendering a determination.

Contact must be made with those individuals necessary to discuss and verify pertinent information in rendering a decision. The following individuals include but are not limited to:

- The requestor.
- Witnesses.
- Assigned CPS specialist and/or supervisor.

Expungement Decision and Second Line Review

The reviewing expungement analyst is to have a case consultation with the expungement supervisor to discuss their decision based on the completed review. The expungement analyst must contact the local county office director or their designee to discuss the decision of amendment or expungement.

If there is not a consensus, the request will be brought to the BSC director's attention for further review.

Decision Notification - No Hearing Needed

If the decision is made to amend or expunge the case record, including removal from central registry, the completed DHHS-1200, *Child/Abuse Neglect - Central Registry Expunction Action,* will be sent to the local office point of contact. The local office point of contact will mail the requestor the DHHS-1200, *Child Abuse/Neglect - Central Registry Expunction Action*.

For confirmed cases regarding individuals not placed on central registry, the DHS-1200c, *Confirmed Case Amendment Action,* will be mailed to the requestor by the expungement unit.

Amendment of Case Record

The intake/Central Registry (CR) hyperlinks must be completed, and all proper documentation uploaded including:

- DHS-847a, *Notice of Placement on Central Registry*, signed by the petitioner.
- DHS-847c, *Notice of a Confirmed Case,* signed by the petitioner.

- Initial Service Plan.
- Supporting documentation.
- DHHS-1200, *Child Abuse/Neglect - Central Registry Expunction Action*.
- DHS-1200c, *Confirmed Case Amendment Action,* for confirmed cases that do not result in central registry placement.

Denial of Request to Amend or Expunge

Central registry cases

If the decision is to deny the request to amend or expunge from CR, the expungement analyst is to complete all hearing packet paperwork required to process for an administrative hearing. See below *Administrative Hearing Request* section.

Confirmed cases

After the administrative review process has been exhausted and the decision is to deny the request to amend a case record for an individual that is subject to the record or report of a confirmed case, the expungement unit will send the DHS-1200c, *Confirmed Case Amendment Action,* with determination and notification that the requestor has 30 calendar days from date of service on the DHS-1200c to request an administrative hearing.

ADMINISTRATIVE HEARING REQUEST

The expungement analyst is responsible for completing and sending the hearing packet to Michigan Office of Administrative Hearing and Rules (MOAHR) The packet must include the following:

- Cover sheet identifying the case.
- DHS-3050, *Hearing Summary* and following information:
    - Date of complaint.
    - Date of disposition.

- Date of placement on CR.
- Copy of the notice to the perpetrator.
- The allegations of abuse or neglect.
- Name and date of birth of the victim(s).
- Name and date of the perpetrator(s).
- Name of each witness (unless that would put the witness in danger).
- Prior administrative or judicial decisions on the alleged abuse/neglect, including prior decisions regarding requests for amendment or expunction involving the same placement on the central registry.

- County in which the client resides.
- Assigned expungement analyst name and contact information.

The DHS-3050 and hearing packet must be sent to MOAHR via email at: MOAHR-BSD@michigan.gov.

The expungement analyst must also email the hearing packet to the Children's Services Legal Division at CSARequestforRepresentation@michigan.gov mailbox if the petitioner is being represented by counsel.

Note: The hearing packet must also comply with SRM 131, Confidentiality requirements and Administrative Hearing rules for redaction.

A hearing packet must be emailed to the local county point of contact by the expungement analyst. The point of contact will send the packet to the petitioner via regular mail.

The expungement analyst will upload the hearing packet within the electronic case record in the Amendment/Expungement Document hyperlink.

Michigan Office of Administrative Hearing and Rules (MOAHR) Response to Hearing Requests

Only MOAHR has the authority to grant or deny the hearing request. MOAHR informs the petitioner and the local office in writing when a request is granted or denied. If the hearing request is granted, MOAHR will issue a Notice of Hearing giving the date, time, and location of the hearing. MOAHR denies requests signed by unauthorized persons and requests without original signatures (faxes or photocopies of signatures are acceptable).

Note: Staff must not call or email the Administrative Law Judge (ALJ) assigned to a hearing for any reason. Once a case is scheduled, any questions regarding the case must be directed to the MOAHR secretaries at (517) 373-0722.

Representation in Administrative Hearings

An assistant attorney general **must** be requested to represent the department in all administrative hearings where the petitioner is represented by counsel. Complete the DHS-1216 E, *Request for Attorney General Representation*, and send it, along with supportive materials to the Children's Services Legal Division's CSARequestforRepresentation@michigan.gov mailbox.

If the opposing party is represented by counsel at an administrative hearing and the department's authorized employee is not, the department must request an adjournment from the ALJ so that the department may request representation by counsel.

The expungement analyst will provide the assigned assistant attorney general assistance in coordinating conference calls, obtaining documentation, including the hearing packet and case recommendations.

Petitioner Access to Information

The petitioner has the right to review investigation reports and obtain copies of needed documents and materials. After confidential information has been redacted (see SRM 131,

Confidentiality - Children's Services), send a copy of all documents and records that will be used by the department to the petitioner and/or the petitioner's attorney, including a copy of the DHS-3050.

Pre-Hearing Conference

The assigned expungement analyst is required to schedule a pre-hearing conference with the petitioner once the decision has been made to deny the request to amend or expunge the case record and prior to an administrative hearing.

The expungement analyst will need to gather information from the petitioner if they have or will be obtaining representation in this matter. The pre-hearing conference must occur within 30 calendar days upon receipt of the request.

A pre-hearing conference does not need to be held in the following situations:

- The petitioner chooses not to attend the pre-hearing conference. The petitioner is not required to participate in the pre-hearing conference in order to have a hearing. This must be explained in any notice of the pre-hearing conference.
- A conference was held prior to the receipt of the request for hearing and:
  - The issue in dispute is clear.
  - Michigan Department of Health and Human Services (MDHHS) staff fully understands the positions of both the department and the petitioner.

The pre-hearing conference may be used to clarify the issues for the department and the petitioner. All of the following, actions must occur at the pre-hearing conference:

- Determine why the petitioner is disputing the MDHHS action.
- Review any documentation the petitioner offers in support of his/her request for hearing.
- Explain the department's position and identify and discuss the differences.
- Determine whether the dispute can be resolved prior to submission of the matter to MOAHR for administrative hearing.

The expungement analyst must participate in a pre-hearing conference with the Administrative Law Judge, if required.

PREPARATION FOR HEARING

The expungement analyst is responsible for the following in preparation of an administrative hearing:

- Drafting the questions for the testimony of witnesses.
- Completing the MDHHS-5602, *Payment Request* form, for witness fees.
    - Witness fees remain the responsibility of the local office.
- Preparing witnesses for the hearing.
- If necessary, requesting and ensuring delivery of subpoenas for witnesses to testify in coordination of the local office established contact. See below *subpoenas.*
- Determine necessary exhibits.
- Case consultation between the expungement analyst, expungement supervisor, and local office supervisor will occur to discuss any conflicts.

Notification Requirements

When a hearing date is identified, information will be updated within the Administrative Hearings Calendar as well as notification to the local county office designee and witnesses. If the expungement analyst is unable to attend a hearing, immediate (within 24 hours or the next business day) notification is to be made to the expungement supervisor.

Subpoenas

If the local office requires a person outside of MDHHS to testify at the hearing or to obtain a document outside of MDHHS to be offered as evidence, the local office must send a memo requesting a subpoena to MOAHR including:

- Case name (for example, Jane Doe v. Ingham County MDHHS).

- Docket number.
- The name and address of the person whose testimony is required.
- The document to be subpoenaed.
- The reason the person or document is needed.
- The manner in which the person's testimony or document relates to the hearing issue.
- A copy of the notice of hearing, if available.

Allow adequate time to mail or hand deliver the subpoena. Do not send a copy of the entire witness list with subpoena requests.

The requestor must serve the subpoena and must pay the attending witness fee plus the state-approved mileage rate from and to the person's residence in Michigan.

Depending on the type of service used by the department to issue the subpoena (i.e. personal, registered mail, certified/return receipt requested, etc.), checks must be attached to the subpoena or provided to the witness at the hearing. In no circumstances should the witness have to provide testimony prior to receiving the appropriate payment.

Witnesses are not required to be registered in SIGMA to receive payment. To request a check for witness fees and related travel, staff need to complete an MDHHS-5602. The "Agency Local Print" box located under the "Vendor Information" header must be marked "Yes." Completed requests must be submitted to: InvoiceMDHHS@michigan.gov.

Note: If a witness is called to court to testify to drug screen results, payment of the witness fee is not the responsibility of the department, but is a county government/court responsibility.

MDHHS employees are expected to participate in hearings without a subpoena when their testimony is required. If participation of an MDHHS employee cannot be arranged, send a memo to MOAHR giving the name and location of the employee and how the employee's testimony relates to the hearing issue. MOAHR will decide whether to require the employee's participation.

Amendment/ Expunction Settlement

If at any time during the hearing process the expungement analyst believes there is insufficient evidence/witnesses to keep the petitioner on CR or there is evidence that suggests an inaccurate report or record be amended, consultation must be held with the expungement supervisor.

If a settlement is determined after a hearing request has been made, the petitioner must complete the waiver of hearing form. The expungement analyst is to ensure a copy of the form is filed and all actions are completed. The form must uploaded into the electronic case record within the case *Amendment/Expungement* hyperlink.

Request for Adjournment

The petitioner or expungement unit may request an adjournment of a scheduled hearing. If an adjournment of a scheduled hearing is needed, the expungement analyst must send a request in writing to MOAHR with a copy to the petitioner. If the adjournment is granted, an *Order Granting Adjournment* will be issued containing the new hearing date, time, and location. If the request for adjournment is denied, the hearing will commence at its originally scheduled date.

Withdrawal of Request for Hearing

A petitioner may withdraw the request for a hearing any time prior to the ALJ issuing a hearing decision and order. When a petitioner wishes to withdraw a request, ask for a signed written withdrawal. The DHS-18A*, Hearing Withdrawal*, form should be used for this purpose. The petitioner must clearly state that they have decided to withdraw the request. The expungement unit analyst must enter all case identifying information on the withdrawal form, attach the original copy to the request, and forward both to MOAHR immediately. File a copy of the withdrawal in the electronic case record.

Administrative Hearing Decision

The ALJ determines the facts based solely on the evidence at the hearing, draws a conclusion of law, and issues a decision and

order. Copies of the decision and order are sent to the local office and the petitioner. In most cases, the petitioner has the right to appeal the final decision to the Family Division of Circuit Court within 60 calendar days after the decision is received.

The expungement analyst, within two business days of receipt of the Proposal for Decision, reviews the findings of fact and conclusion of the law made within the decision.

If MDHHS agrees with the decision, the expungement analyst will implement the findings as outlined.

Amendment of Case Record

If MDHHS is required to remove the petitioner from CR or amend an inaccurate report or record, this is to be completed by the expungement analyst within 10 calendar days of receipt of the hearing decision. If edits are required to the Service Plan this must be amended by the expungement analyst within 10 calendar days of receipt of the hearing decision.

The expungement analyst will complete all necessary actions within the electronic case record to comply with the administrative law judge's decision.

A copy of the expungement, as well as the DHHS-1200, *Child Abuse/Neglect - Central Registry Expunction Action,* must be provided to the MOAHR by the expungement analyst. The DHS-1200 must be provided to the local office point of contact who must then provide it to the petitioner.

The expungement analyst must complete the DHS-1844, *Administrative Hearing Order Certification* form within 10 calendar days and send it to the Children's Services Legal Division's CSARequestforRepresentation@michigan.gov mailbox to certify the implementation of the required action(s).

A copy of the Administrative Hearing Proposal for Decision is to be uploaded into the electronic case record within the case *Amendment/Expungement* hyperlink.

The expungement analyst will provide a copy of the Admininstrative Hearing Proposal for Decision to the local county point of contact for informational purposes.

Rehearing/Reconsideration

If MDHHS is not in agreement with the decision, the expungement analyst and expungement supervisor will consult the Office of Legal Affairs and/or the assigned attorney general.

A rehearing is a full hearing, which is granted when the original hearing record is inadequate for purposes of judicial review or there is newly discovered evidence that could affect the outcome of the original hearing.

A reconsideration is a paper review of the facts, law and any new evidence or legal arguments. A reconsideration is granted when the original hearing record is adequate for judicial review and a rehearing is not necessary but a party believes the ALJ failed to accurately address all the issues.

MOAHR determines if a rehearing or reconsideration will be granted.

The department should file a written request for rehearing/reconsideration if any of the following exists:

- Newly discovered evidence, which could affect the outcome of the original hearing.
- Misapplication of law in the hearing decision, which led to a wrong conclusion.
- Failure of the ALJ to address in the decision relevant issues raised in the hearing request.

The expungement analyst will process and complete a reconsideration within 10 calendar days. The expungement analyst will complete a written formal request for a rehearing/reconsideration.

MOAHR will grant or deny the request and will send written notice to all parties of the original hearing. If MOAHR grants a reconsideration, the hearing decision may be modified without another hearing unless there is need for further testimony. If a rehearing is granted, MOAHR will schedule and conduct the rehearing in the same manner as a hearing.

Pending a rehearing, the expungement unit analyst must implement the original decision and order unless a circuit court or other court

with jurisdiction issues an order delaying implementation of the original decision.

ADMINISTRATIVE HEARING STEPS

The usual steps for a hearing are:

- Introduction by the ALJ.
- Department representative addresses any administrative issues, such as how exhibits should be labeled, etc.
- Opening statements (first the department, then the petitioner).
- Testimony of witnesses (both direct and cross-examination).
- Closing statements.

Note: If the petitioner fails to appear at the hearing despite proper notice, the department should request to move forward with the hearing for a final decision.

Role of the ALJ

In general, the ALJ will follow the same rules used in circuit court to the extent practical in the issue being heard. The ALJ must ensure the record is complete and may:

- Take an active role in questioning witnesses and parties.
- Assist either side to ensure that all necessary information is presented on the record.
- Be more lenient than a circuit court judge in deciding what evidence may be presented.
- Refuse to accept evidence that is repetitious, immaterial or irrelevant.

Either party may object on the record stating disagreement with the ALJ's decision to include or exclude evidence. The ALJ must state on the record why evidence was not admitted.

APPEALS TO CIRCUIT COURT

Only the petitioner can appeal the results of the Administrative Hearing to Circuit Court. Any legal notices (or example, subpoena, notice and complaint, the Administrative Hearing decision and order, etc.) must be sent to the expungement unit for processing and forwarded to the Bureau of Legal Affairs.

Bureau of Legal Affairs
Children's Services Legal Division
333 S. Grand Avenue, 5th Floor
Lansing, MI 48933
Phone (517) 284-4853
CSARequestforRepresentation@michigan.gov

THE MICHIGAN PENAL CODES

Updated versions of all Michigan penal codes are located at: http://www.legislature.mi.gov

Michigan Penal Code, MCL 750.136b (definitions; child abuse).

Michigan Penal Code, MCL 750.145c (definitions; child sexually abusive activity or material; penalties; possession of child sexually abusive material; expert testimony; defenses; acts of commercial film or photographic print processor; applicability and uniformity of section; enactment or enforcement of ordinances, rules, or regulations prohibited).

Michigan Penal Code, MCL 750.520a (definitions).

Michigan Penal Code, MCL 750.520b (criminal sexual conduct in the first degree; felony).

Michigan Penal Code, MCL 750.520c (criminal sexual conduct in the second degree; felony).

Michigan Penal Code, MCL 750.520d (criminal sexual conduct in the third degree; felony).

Michigan Penal Code, MCL 750.520e (criminal sexual conduct in the fourth degree; misdemeanor).

Michigan Penal Code, MCL 750.520f (second and subsequent offense; penalty).

Michigan Penal Code, MCL 750.520g (assault with intent to commit criminal sexual conduct; felony).

Michigan Penal Code, MCL 750.85 (torture, felony; penalty; definitions; element of crime; other laws).

Michigan Penal Code, MCL 257.58c (serious impairment of a body function defined).