PERFORMANCE AUDIT
OF THE

CHILDREN'S PROTECTIVE SERVICES PROGRAM

FAMILY INDEPENDENCE AGENCY

October 1997

43-284-96

EXECUTIVE DIGEST

CHILDREN'S PROTECTIVE SERVICES PROGRAM

INTRODUCTION	This report, issued in October 1997, contains the results of our performance audit* of the Children's Protective Services* Program, Family Independence Agency (FIA).
AUDIT PURPOSE	This performance audit was conducted as part of the constitutional responsibility of the Office of the Auditor General. Performance audits are conducted on a priority basis related to the potential for improving effectiveness* and efficiency*.
BACKGROUND	The FIA Division of Prevention and Protective Services is responsible for developing Program policies and procedures. County FIA offices are primarily responsible for implementing provisions of the Child Protection Law (the Law) and Program policies and procedures. The Law (Act 238, P.A. 1975, as amended, being Sections 722.621 - 722.636 of the *Michigan Compiled Laws*) established FIA as the department responsible for implementing the Program. The mission* of the Program is to protect children* who are at risk of child abuse* and/or child neglect* (CA/N). FIA has identified the Program as one of its core responsibilities.

** See glossary on page 60 for definition.*

FIA, formerly known as the Department of Social Services, is responsible for investigating all reported instances of suspected CA/N. FIA also provides, enlists, and coordinates services for families with substantiated CA/N committed by a "person responsible for the child's health or welfare"* as defined in the Law. Harm to a child by a person not responsible for the child's health or welfare is referred to law enforcement officials.

FIA maintains a Central Registry* (Registry) of all cases of substantiated* CA/N. FIA is required to notify all perpetrators* that they have been placed on the Registry and that they have the right to request expunction* of inaccurate information placed on the Registry.

As of December 31, 1996, FIA had 624 staff employed in the Program. FIA expended approximately $48.1 million in the fiscal year ended September 30, 1996 to investigate CA/N and to provide services to families when CA/N has been substantiated to help prevent further CA/N.

OVERALL AUDIT OBJECTIVE, CONCLUSION, AND NOTEWORTHY ACCOMPLISHMENTS

Audit Objective: To assess the overall effectiveness of the Program.

Conclusion: FIA needs to improve its management of the Program in an effort to help reduce the risk of harm to children who have been abused or neglected by their parents or other persons responsible for the children's health or welfare. Our assessment disclosed five material conditions* and 11 other reportable conditions* that FIA should address to help improve the Program.

At the same time, Program staff should be commended for implementing a very difficult program in which caseworkers

** See glossary on page 60 for definition.*

are expected to confront openly hostile parents and suspected perpetrators of CA/N on a daily basis and attempt to document if abuse or neglect occurred.

Noteworthy Accomplishments: FIA is in the process of implementing a number of projects and policy changes to help keep children safe, to help families provide adequate care for their children, and to request court intervention when families are unable or unwilling to do so (see proposed projects and policy changes presented as supplemental information). These initiatives include:

1. The Child Safety Assessment Project*
2. Child Death Review Teams
3. Child Protection Assessment Tool
4. Forensic Interviewing
5. Solution-Focused Interventions*
6. Training on Domestic Violence
7. Complaint Screening Protocol
8. Structured Decision Making*
9. Services Workers Support System*
10. Children's Protective Services Training Program
11. Additional Staffing
12. Proposed revisions to the Child Protection Law

INDIVIDUAL AUDIT OBJECTIVES, CONCLUSIONS, AND NOTEWORTHY ACCOMPLISHMENTS

Audit Objective: To assess the Program's effectiveness and compliance with laws, regulations, policies, and procedures in investigating and substantiating referred cases of CA/N.

Conclusion: We concluded that the Program frequently was not effective in investigating and substantiating referred cases of CA/N which often resulted from

** See glossary on page 60 for definition.*

noncompliance with certain laws, regulations, policies, and procedures. Our assessment disclosed three material conditions:

- The Program intake screening process used by county FIA offices frequently did not result in an investigation of complaints* of suspected CA/N, as required by the Law. As a result, children in 23.9% of our random sample of rejected complaints from six county FIA offices remained at risk of suspected CA/N (Finding 1).

  FIA agreed and will comply with our corresponding recommendation.

- FIA sometimes did not commence and complete investigations* on a timely basis, conduct thorough investigations of suspected CA/N, and substantiate some cases although considerable evidence that CA/N had occurred was obtained. Also, FIA had not established authoritative guidance for investigating suspected CA/N involving violence between teens and their parents. As a result, children remained at risk of suspected CA/N in 10.9% of our random sample of investigated cases from six county FIA offices (Finding 2).

  FIA agreed and will comply with our three corresponding recommendations.

- FIA had not established a method to uniformly measure and assess whether CA/N had occurred when investigating complaints of CA/N. As a result,

** See glossary on page 60 for definition.*

there was a lack of consistent standards used among county FIA offices in determining if children have been abused or neglected (Finding 3).

FIA agreed and will comply with our corresponding recommendation.

Our assessment also disclosed other reportable conditions regarding the timeliness of initial face-to-face contact, written reports from mandated reporters*, notification of disposition of complaints made by mandated reporters, families in need of services, and the recording and referral of suspected sexual abuse* or sexual exploitation* to law enforcement officials (Findings 4 through 8).

Audit Objective: To assess the Program's effectiveness and compliance with laws, regulations, policies, and procedures in coordinating and providing services for substantiated cases of CA/N.

Conclusion: We concluded that Program actions were sometimes not effective in protecting children at risk of further CA/N. Generally, the Program was in compliance with laws, regulations, policies, and procedures for substantiated cases of CA/N. However, our assessment disclosed one material condition:

- Based on our random sample of substantiated cases from 6 county FIA offices, we determined that for 21 cases (11.7%) FIA did not take sufficient, appropriate, or timely action to protect the children involved. As a result, FIA failed to reasonably protect these children from risk of further CA/N (Finding 9).

** See glossary on page 60 for definition.*

FIA agreed and will comply with our corresponding recommendation.

Our assessment also disclosed other reportable conditions regarding notification of perpetrators on the Registry, Registry data integrity, and controls over access to the Registry (Findings 10 through 12).

Audit Objective: To assess other pertinent issues related to the Program.

Conclusion: Our assessment disclosed one material condition:

- FIA had not established a comprehensive continuous quality improvement process to monitor and improve the Program's effectiveness in protecting children (Finding 13).

  FIA agreed and will comply with our corresponding recommendation.

In addition, we identified other reportable conditions in the areas of implementation of training for caseworkers, contracting and competitive bidding for purchased services, and confidentiality of Program information (Findings 14 through 16).

Noteworthy Accomplishments: We noted significant improvements in the training of Program staff since our last audit. Also, central office and county offices have made significant improvements to the contracting process since our last audit, which resulted in improved competition in bidding and improved monitoring and documentation of the contracting process.

AUDIT SCOPE AND METHODOLOGY

Our audit scope was to examine the program and other records of the Children's Protective Services Program. The audit scope primarily included the examination of case file and other records at six county FIA offices: Cass, Genesee, Isabella, Muskegon, Shiawassee, and Wayne. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Our audit procedures included examination of FIA's Program records and activities for the period October 1, 1994 through December 31, 1996.

We reviewed applicable State statutes and FIA polices and procedures. We assessed the internal control structure* pertaining to intakes, investigations, and substantiated cases.

We selected a random sample of complaints, investigations, and substantiated cases. These cases were reviewed for compliance with the Law and FIA policies and procedures and to determine if FIA adequately addressed the issues in an effort to reduce risk to the child(ren) involved.

We evaluated the effectiveness of the process used to record known perpetrators of CA/N on the Registry and analyzed controls over access to the Registry.

* *See glossary on page 60 for definition.*

We reviewed the current status of training programs and the contracting process in county FIA offices. In addition, we interviewed various Program staff and mandated reporters to determine how the reporting system was working.

AGENCY RESPONSES AND PRIOR AUDIT FOLLOW-UP

Our audit report includes 16 findings and 20 corresponding recommendations. FIA's preliminary response indicated that it agreed with all 20 recommendations.

FIA complied with 19 of the 24 prior audit recommendations included within the scope of our current audit. We repeated 1 of the prior audit recommendations and rewrote 4 for inclusion in this report.

Mrs. Marva Livingston Hammons, Director
Family Independence Agency
Grand Tower
Lansing, Michigan

Dear Mrs. Hammons:

This is our report on the performance audit of the Children's Protective Services Program, Family Independence Agency.

This report contains our executive digest; description of program; audit objectives, scope, and methodology and agency responses and prior audit follow-up; comments, findings, recommendations, and agency preliminary responses; proposed projects and policy changes presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after the release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Thomas H. McTavish, C.P.A.
Auditor General

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FAMILY INDEPENDENCE AGENCY

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Description of Program

The Division of Prevention and Protective Services, Family Independence Agency (FIA), is responsible for developing Children's Protective Services policies and procedures. FIA's 83 county offices are to implement the provisions of the Child Protection Law (the Law) and Program policies and procedures.

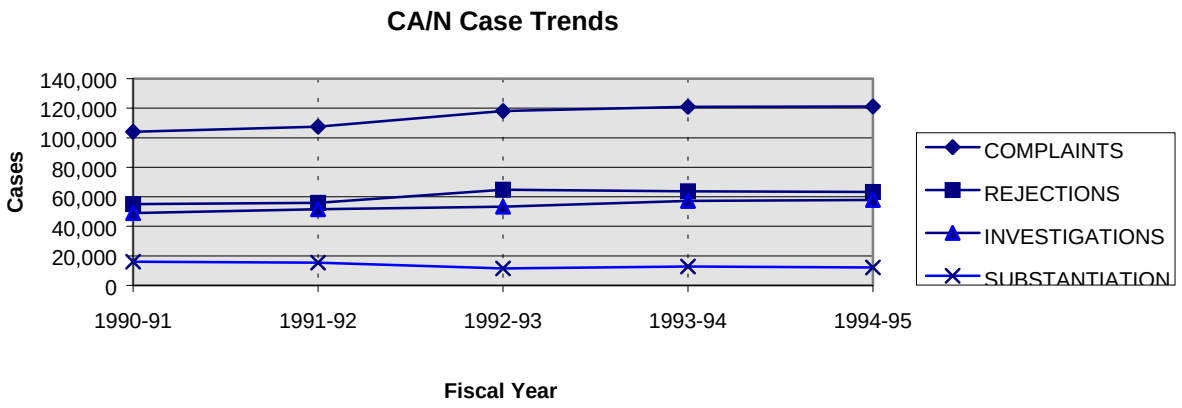
In accordance with the Law (Act 238, P.A. 1975, as amended, being Sections 722.621 - 722.636 of the *Michigan Compiled Laws*), FIA is responsible for investigating all reported instances of suspected child abuse and/or child neglect (CA/N); referring complaints of CA/N not involving persons responsible for the child's health or welfare to law enforcement officials; providing, enlisting, and coordinating necessary services to families with substantiated CA/N to attempt to prevent further abuses, safeguard and enhance the welfare of the child, and preserve family life where possible; and taking necessary action to prevent further abuses, which could include filing petitions with the county probate court to temporarily or permanently terminate parental rights and place the child in foster care.

The Law also requires FIA to maintain a Central Registry (Registry) of all cases of substantiated CA/N. Effective August 1, 1992, the Law required FIA to notify in writing each individual who is named in the Registry as a perpetrator of CA/N, including their right to request expunction of inaccurate information placed on the Registry.

The mission of the Children's Protective Services Program is to protect children who are at risk of CA/N. FIA has identified the Program as one of its core responsibilities.

As of December 31, 1996, FIA had 624 staff employed in the Program. FIA expended approximately $48.1 million in the fiscal year ended September 30, 1996 to investigate CA/N and to provide services to families when CA/N has been substantiated to help prevent further CA/N.

The following chart shows the trends in complaints, rejections, investigations, and substantiated CA/N cases for the five fiscal years ended September 30, 1995.



The Program continues to receive more complaints of suspected CA/N each year. Approximately 52% of all complaints are rejected without a field investigation, and approximately 78% of investigated complaints are not substantiated. Also, the ratio of substantiated cases to complaints dropped from approximately 15% of complaints received prior to fiscal year 1992-93 to approximately 10% of complaints in fiscal year 1994-95. There was a significant drop in the substantiation rate at the end of fiscal year 1991-92 at approximately the same time that the Law was changed to require caseworkers to notify perpetrators that they have been placed on the Registry. FIA has not determined major causes for the reduction in substantiation rates.

Audit Objectives, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up

Audit Objectives

Our performance audit of the Children's Protective Services Program, Family Independence Agency (FIA), had the following objectives:

1. To assess the Program's effectiveness and compliance with laws, regulations, policies, and procedures in investigating and substantiating referred cases of child abuse and/or child neglect (CA/N).

2. To assess the Program's effectiveness and compliance with laws, regulations, policies, and procedures in coordinating and providing services for substantiated cases of CA/N.

3. To assess other pertinent issues related to the Program.

Audit Scope

Our audit scope was to examine the program and other records of the Children's Protective Services Program. The audit scope primarily included the examination of case file and other records at six county FIA offices: Cass, Genesee, Isabella, Muskegon, Shiawassee, and Wayne. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Audit Methodology

Our audit procedures were performed between March 1996 and February 1997 and included examination of FIA's Program records and activities for the period October 1, 1994 through December 31, 1996.

To accomplish our objectives, we reviewed applicable State statutes and FIA policies and procedures. We followed up on audit findings and recommendations from our prior audit of the Program. We assessed the internal control structure pertaining to intakes, investigations, and substantiated cases and interviewed program staff and county caseworkers and supervisors to determine how the Program works and to develop case reading forms and interview instruments. We obtained statistical data from the

Protective Services Management Information System* (PSMIS) and data from other FIA computerized systems and analyzed this information to identify trends and potential problems. Also, we met with various individuals and organizations that interact with the Program (stakeholders) to identify both positive and negative aspects of the Program.

In connection with our first objective, we selected a random sample of complaints and investigations. We reviewed the complaints and investigations for compliance with the Child Protection Law and FIA policies and procedures, including compliance with time requirements. We examined the process that caseworkers use to determine whether a preponderance of evidence* of CA/N (credible evidence* prior to September 20, 1996) existed. In addition, we assessed, for the cases reviewed, whether caseworkers performed the intake and investigation process in a manner that assessed risk of abuse or neglect to the child(ren) and protected the child(ren) from further abuse and neglect, including timely referral to law enforcement officials and the court system when the family could not be located or did not cooperate in the investigation.

In connection with our second objective, we selected a random sample of substantiated cases of CA/N. We reviewed the disposition of the substantiated cases, including the provision of services to these families and compliance with requirements of the Child Protection Law and FIA policies and procedures pertaining to substantiated cases. We also assessed, for the cases reviewed, whether caseworkers assessed risk of CA/N to the child(ren) and whether these cases were effectively managed to protect the child(ren) from further abuse and neglect. We evaluated the effectiveness of the process used to record known perpetrators of CA/N on the Central Registry and analyzed controls over access to the Registry.

In connection with our third objective, we assessed FIA's management control structure, including systems developed to monitor how counties implemented the Program and test Program effectiveness. We also reviewed the current status of training programs offered to caseworkers and reviewed FIA studies of staff turnover in

** See glossary on page 60 for definition.*

the Program. We examined the process that county FIA offices used to contract for services provided to families. We interviewed various Program staff and mandated reporters to determine how the reporting system is working and to determine if caseworkers are providing feedback on the status of reported cases to mandated

reporters. We obtained and analyzed staffing level and caseload data for the county programs and overall program statistics and program trends.

Agency Responses and Prior Audit Follow-Up

Our audit report contains 16 findings and 20 corresponding recommendations. FIA's preliminary response indicated that it agreed with all 20 recommendations.

The agency preliminary response which follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of Management and Budget Administrative Guide procedure 1280.02 require FIA to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

FIA complied with 19 of the 24 prior audit recommendations included within the scope of our current audit. We repeated 1 of the prior audit recommendations and rewrote 4 for inclusion in this report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

OVERALL COMMENT AND AGENCY PRELIMINARY RESPONSE

COMMENT

Background: The protection of a child is primarily the parents' responsibility. When parents fail to protect their child and the child is harmed or is at risk of harm, it is the responsibility of the Children's Protective Services Program to intervene to safeguard the welfare of the child.

The Family Independence Agency (FIA) has established the Program as a child-centered, family-focused system which attempts to stabilize and strengthen families in an effort to keep the family intact. This is done by providing services to help parents carry out their duties and responsibilities for substantiated cases of child abuse or child neglect (CA/N). Should FIA determine that a child cannot remain at home because the child is not safe, Program staff are to petition the Juvenile Division of the Probate Court to remove the child.

The Program has statutory responsibility to receive and investigate all complaints of CA/N. For any complaint with a preponderance of evidence (credible evidence prior to September 20, 1996) of CA/N by a person responsible for the child's health or welfare, FIA must provide services to the family until the conditions affecting the child no longer place the child at risk, until other services are in place to alleviate the risk, or until the child is removed from the home. Federal law requires the State to put forth "reasonable efforts" to keep the family together. However, "reasonable efforts" has not been clearly defined. FIA policy states that placement of children out of their homes should occur only if the children's well-being cannot be safeguarded in their homes.

The Program does not have responsibility for suspected CA/N committed by a person not responsible for the child's health or welfare. These complaints are to be referred to local law enforcement officials for investigation and disposition.

For CA/N complaints referred to county FIA offices, policies and procedures require that caseworkers determine whether the complaint has a basis-in-fact*, assess risk of abuse

or neglect to the child, determine the seriousness of the CA/N, and provide sufficient services to the family to prevent additional harm to the child. This process relies heavily on professional judgment and training of caseworkers and supervisors.

Evidence must be obtained to substantiate that harm or threatened harm exists before the Program can take action to protect a child. Also, the Program is one component of the child protection system. Law enforcement officials and the court systems play important roles in determining whether a child is at risk and if the CA/N is serious enough to place the child in temporary or permanent foster care, especially in cases of serious physical abuse and in cases involving sexual abuse or sexual exploitation of a child.

Audit Objective: To assess the overall effectiveness of the Program.

Conclusion: FIA needs to improve its management of the Program in an effort to help reduce the risk of harm to children who have been abused or neglected by their parents or other persons responsible for the children's health or welfare. Our assessment disclosed 5 material conditions and 11 other reportable conditions that FIA should address to help improve the Program.

At the same time, Program staff should be commended for implementing a very difficult program in which caseworkers are expected to confront openly hostile parents and suspected perpetrators of CA/N, some of whom are understandably upset by an investigation. Caseworkers do this on a daily basis and attempt to document if abuse or neglect occurred. The Program also investigates complaints when complainant information can be, intentionally or unintentionally, biased, distorted, or incomplete.

Noteworthy Accomplishments: FIA is in the process of implementing a number of projects and policy changes to help keep children safe, to help families provide adequate care for their children, and to request court intervention when families are

** See glossary on page 60 for definition.*

unable or unwilling to do so (see proposed projects and policy changes presented as supplemental information). These initiatives include:

1. The Child Safety Assessment Project

2. Child Death Review Teams
3. Child Protection Assessment Tool
4. Forensic Interviewing
5. Solution-Focused Interventions
6. Training on Domestic Violence
7. Complaint Screening Protocol
8. Structured Decision Making
9. Services Workers Support System
10. Children's Protective Services Training Program
11. Additional Staffing
12. Proposed revisions to the Child Protection Law

INVESTIGATION AND SUBSTANTIATION OF RECORDED CA/N CASES

COMMENT

Background: FIA county offices receive CA/N complaints from a variety of sources. Each complaint is initially screened to determine if it involves a child under the age of 18, if it indicates that there is harm or threat of harm to the child, and if the suspected perpetrator is a person responsible for the child's health and welfare as defined in the Law. Accepted complaints are referred to a caseworker for a field investigation. Rejected complaints can be referred to law enforcement officials or to other community agencies.

In a field investigation, the caseworker determines if evidence exists to substantiate that a child was abused or neglected. Cases involving serious physical abuse, sexual abuse, or the death of a child are to be referred to law enforcement officials to help ensure a coordinated investigation.

Audit Objective: To assess the Program's effectiveness and compliance with laws, regulations, policies, and procedures in investigating and substantiating referred cases of CA/N.

Conclusion: We concluded that the Program frequently was not effective in investigating and substantiating referred cases of CA/N which often resulted from

noncompliance with certain laws, regulations, policies, and procedures. Our assessment disclosed three material conditions. The Program intake screening process used by county FIA offices frequently did not result in an investigation of complaints of suspected CA/N, as required by the Law. As a result, children in 23.9% of our random sample of rejected cases from six county FIA offices remained at risk of suspected CA/N. In addition, FIA sometimes did not commence and complete investigations on a timely basis, conduct thorough investigations of suspected CA/N, and did not substantiate some cases, although considerable evidence that CA/N had occurred was obtained. Also, FIA had not established authoritative guidance for investigating suspected CA/N involving violence between teens and their parents. As a result, children remained at risk of suspected CA/N in 10.9% of our random sample of investigated cases from six county FIA offices. Further, FIA had not established a method to uniformly measure and assess whether CA/N had occurred when investigating complaints of CA/N. As a result, there was a lack of uniformity in county FIA offices' established standards for use in determining if children have been abused or neglected.

Our assessment also disclosed other reportable conditions regarding the timeliness of initial face-to-face contact, written reports from mandated reporters, notification of disposition of complaints made by mandated reporters, families in need of services, and the recording and referral of suspected sexual abuse or sexual exploitation to law enforcement officials.

FINDING

1. Intake Screening Process

The Program intake screening process used by county FIA offices frequently did not result in an investigation of complaints of suspected CA/N, as required by the Law. As a result, children often remained at risk of suspected CA/N.

Section 8 of the Law requires FIA to investigate all reports of suspected CA/N. Services Manual* procedure 712, page 14, requires that county FIA offices use an intake process to screen out complaints that clearly do not constitute CA/N. This intake screening process does not constitute an investigation as required by the Law, is often based on limited information from the complainant, and is subject to the caseworker's interpretation.

The intake process at all county FIA offices is to use three criteria:

a. The child must be under the age of 18 years.

b. The complaint must involve a parent or person responsible for the health and welfare of the child.

c. There must be an allegation of harm or threat of harm to the child.

Caseworkers, with the approval of their supervisor, will either reject a complaint or will accept a complaint for investigation based on information obtained from the complainant, a limited review of county records for prior complaints, and the caseworker's interpretation of the facts as presented in the complaint.

We recognize that FIA needs to have the ability to screen out cases which clearly do not constitute CA/N. However, the current screening process allows caseworkers, based on their interpretation of the facts, to reject complaints from mandated reporters and other credible sources without an investigation, which is contrary to the Law. Such an investigation may include collateral contacts* or fact-finding to verify the accuracy of the complaint.

The intake screening process has routinely rejected approximately 50% of all complaints received annually. In fiscal year 1994-95, FIA rejected 63,326 (52.2%) of 121,240 complaints received. Based on our review of 71 randomly selected rejected complaints at six county FIA offices, we questioned the propriety of the

** See glossary on page 60 for definition.*

rejection of 17 (23.9%) complaints of suspected CA/N for the period January through September 1996. For example, caseworkers rejected the following complaints involving:

(a) A child, age 8. The report, from the child's mother, stated that the child had a hand print on her hip after returning from visitation with the father. The child reported that the father spanks her with a belt and that she was afraid to go back to his home. The caseworker rejected the complaint because there was

no indication whose hand print was on the child and no indication of a belt mark. The case record stated that there was no current evidence of CA/N.

(b) A child, age 14. Reports by a State Police trooper and a certified social worker stated that the child had bruises and a bloody nose inflicted by the mother during a fight. The caseworker rejected the complaint because it involved an incorrigible child and because the family was involved with community mental health.

(c) A child, age 4. The report from the maternal grandmother stated that the mother's living-together partner* (LTP), noted in the file as possibly the child's father ("paternity never established"), took the child somewhere and would not tell where. At the time of the referral, the grandmother did not make a statement indicating that the child may have been harmed. The grandmother indicated to the intake worker that the mother informed her she would locate the child. The caseworker rejected the complaint after two attempts to contact the mother and concluded that there was no reasonable cause. Further attempts to contact either the mother or maternal grandmother to determine if the child was safe or to notify the police were not documented in the case file.

Failure to investigate complaints of CA/N places children at continued risk of suspected abuse or neglect after the alleged CA/N has been reported.

The Children's Commission* Report, which was issued in July 1996, also noted that FIA had not investigated all reports of suspected CA/N and recommended that FIA conduct investigations of all complaints of CA/N.

** See glossary on page 60 for definition.*

RECOMMENDATION

We recommend that FIA revise the Program intake screening process and investigate complaints of suspected CA/N as required by the Law.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the recommendation. A joint project between the Lieutenant Governor, the National Council on Crime and Delinquency, and FIA was initiated in summer 1997 to revise the intake screening process. The new policy will be finalized by January 1998.

FINDING

2. Investigations of Suspected CA/N

FIA sometimes did not commence and complete investigations on a timely basis, conduct thorough investigations of suspected CA/N, and substantiate some cases although considerable evidence that CA/N had occurred was obtained. Also, FIA had not established authoritative guidance for investigating suspected CA/N involving violence between teens and their parents.

Section 8 of the Law states that within 24 hours after receiving a report of suspected CA/N, FIA shall refer the report to the prosecuting attorney or shall commence an investigation of the child suspected of being abused or neglected. In the course of the investigation, FIA shall determine if the child is abused or neglected.

Services Manual procedure 712, page 14, states that commencing an investigation requires contact with someone other than the referring person within 24 hours of receipt of a complaint. The procedure also provides instructions to caseworkers about how to conduct investigations of reports of suspected CA/N. This procedure requires caseworkers to obtain historical information from the Client Information System and the Central Registry (Registry) about victims and perpetrators. Also, the procedure states that caseworkers should review local office files to determine the history and credibility of former reports. The investigation of each report should include contacts with the person reporting the suspected CA/N, the family, and other information sources to verify the accuracy of the report and clarify the situation. All reports assigned for field investigation are required to have a face-to-face contact with suspected victims, parents, and perpetrators. This face-to-face contact is for the purpose of conducting a complete assessment of the situation, including a visual assessment of the suspected CA/N. In addition, Services Manual procedure 712, page 21, requires that caseworkers complete field investigations within 21 calendar days from receipt of complaints of suspected CA/N.

Our review of 175 randomly selected Program investigation case files disclosed:

a. Caseworkers did not commence 31 (17.7%) of 175 investigations within 24 hours as required by the Law. Statewide statistics provided by FIA showed that, in fiscal year 1994-95, caseworkers did not commence investigations within 24 hours for 9,152 (16.2%) of 56,439 reports of suspected CA/N. Also, caseworkers did not complete 88 (50.3%) of the 175 investigations of suspected CA/N within 21 days as required by FIA procedure. Therefore, FIA frequently did not comply with the statute and procedures for these cases.

In our prior audit, we also noted that caseworkers often did not complete investigations on a timely basis.

b. Caseworkers did not conduct thorough investigations of suspected CA/N for 34 (19.4%) of the 175 randomly selected cases as required by FIA procedures. For example:

(1) Caseworkers did not:

(a) Review the Registry for historical information about victims and perpetrators involved in 18 (10.3%) of the 175 investigations.

(b) Review the Client Information System for historical information on families involved in 7 (4.0%) of the 175 investigations.

(c) Make sufficient collateral contacts to obtain additional information regarding the condition of children in 15 (8.6%) of the 175 investigations.

(d) Make face-to-face contacts or visual assessments with children involved in 11 (6.3%) of the 175 investigations.

(2) One county office consistently did not combine reports of CA/N on the same family into one file. Caseworkers indicated that they either could not find files for prior reports or did not have time to pull and review files for prior reports when investigating a new report about the same family.

We compared historical information provided by this county office to historical information on PSMIS. For 25 of the 50 investigations in this county office, the information on PSMIS contained significantly more substantiated and unsubstantiated complaints than information provided

to us by the local office. As a result, caseworkers at this county office did not have complete historical information for use in conducting complete and thorough investigations of reports of suspected CA/N.

(3) The Services Manual does not adequately address the unique problems that caseworkers encounter in dealing with the interaction between teens and their parents. As a result, caseworkers do not have authoritative guidance on how to treat difficult cases involving violence between teens and their parents.

Based on our samples of investigations and substantiated cases in which we identified teen/parent violence, we concluded that caseworkers did not take sufficient, timely, and appropriate action to determine if CA/N occurred or to provide services to the family to reduce the risk of abuse or neglect to both the teen and parent for 3 investigations and 3 substantiated cases.

c. Caseworkers did not substantiate CA/N for 5 (2.9%) of the 175 randomly selected cases although considerable evidence that CA/N had occurred was obtained.

Section 8(2) of the Law requires that FIA determine if the child is abused or neglected and that FIA shall provide, enlist, and coordinate services and take necessary action to prevent further abuses and to enhance the welfare of the child.

As a result, children remained at risk of suspected CA/N in 19 (10.9%) of the 175 cases we reviewed. Of the 19 cases, 14 cases involved incomplete investigations and 5 involved unsubstantiated cases with considerable evidence that CA/N occurred. The following are examples of cases involving incomplete investigations and cases with considerable evidence that CA/N had occurred:

(a) Incomplete Investigations

(1) The reporter indicated that the mother hit a 5-year-old for wetting herself, the child had a belt mark on her inner thigh, and the mother had dragged the child upstairs by her hair. The caseworker received the report and did not act on it promptly. After seven weeks, the caseworker visited the home, but no one was there. The caseworker called the school, but was not able to speak to the secretary. The caseworker's supervisor concluded that the untimely attempts to make contacts were due to a history of repeated unsubstantiated reports. The caseworker's initial assessment was that this report was similar to those in the case record and would not be substantiated. The caseworker never made face-to-face contact with the family. We concluded that this investigation was incomplete because only minimal attempts were made to investigate the report and because the caseworker and supervisor discounted the allegations based on past history of unsubstantiated reports. Also, attempted contacts were not in compliance with time requirements established by the Law and FIA procedures.

(2) The reporter indicated that, while in a safe house (domestic violence shelter), the mother asked the reporter to keep one of her children while the mother went into a drug rehabilitation program. The reporter had custody of the child (age unknown) at the time of the complaint. The family had been in the safe house because the mother's LTP had tied her to the couch and set fire to it. The child reported that the LTP was back in the home at the time of the complaint. With a history of the mother being involved in drugs and suggestions that the LTP was back in the home, this complaint warranted additional investigation. We concluded

that this investigation was incomplete because the caseworker did not commence the investigation within 24 hours as required by statute, did not make face-to-face contact with any of the family at any time during this investigation, made only minimal attempts to contact the family (three attempted home calls over one month), did not attempt to locate the family through its public assistance caseworker, and did not document any contacts with law enforcement officials or the safe house. It appears that additional steps should have been taken to determine whether the four children in this family were in a safe environment.

(b) Considerable Evidence of CA/N

The reporter indicated that a 3-year-old was hit and had a black eye. The caseworker met with the mother who denied all allegations of physical abuse. The caseworker tried to talk to the child but the child refused to talk to the caseworker. The caseworker met with the mother's LTP who denied all allegations of physical abuse. The caseworker contacted the child's babysitter who stated that the mother had told her that the LTP hit the child, causing the black eye. The babysitter also mentioned that one month earlier she noticed the child's upper body was covered with red marks. The caseworker contacted another babysitter who stated that she saw the black eye and that the mother would not tell her how the child got the black eye. The file included 3 other unsubstantiated reports that indicated the mother and LTP shook, bruised, and hit the child. The caseworker did not substantiate the case because of a lack of evidence. We question the disposition of this case because the caseworker had obtained considerable evidence from collateral contacts that the child had been abused by the mother and/or the LTP. The caseworker wrote in the narrative that she suspected the mother and LTP had abused the child but did not substantiate the case.

RECOMMENDATIONS

We recommend that FIA commence investigations on a timely basis, conduct thorough investigations of suspected CA/N, and substantiate cases with considerable evidence that CA/N had occurred.

We also recommend that FIA revise its Services Manual to provide caseworkers with authoritative guidance for investigating suspected CA/N involving violence between teens and their parents.

WE AGAIN RECOMMEND THAT CASEWORKERS COMPLETE INVESTIGATIONS OF SUSPECTED CA/N ON A TIMELY BASIS AS REQUIRED BY FIA PROCEDURE.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the three recommendations. The Child Safety Assessment Project will provide an ongoing vehicle to monitor Program performance in the areas cited. A policy regarding interventions in families with teenagers who are victims of child abuse will be issued by November 1, 1997.

The standard of promptness is being revised to permit supervisors to extend the time period for completing an investigation in a limited number of appropriate cases. The policy will be implemented in fiscal year 1997-98 after the Services Worker Support System can be modified to support the new policy. Finally, the curriculum for the Child Welfare Training Institute was implemented in January 1997. This eight weeks of training will help ensure that workers receive the type of training needed to conduct thorough investigations, substantiate appropriate cases, and intervene to protect children when needed. In addition, forensic interviewing, solution-focused interventions, and domestic violence training will provide staff with information and training which will assist them to determine whether a child has been abused and/or neglected and is at risk of harm.

FINDING

3. CA/N Complaint Investigation Risk Analysis

FIA had not established a method to uniformly measure and assess whether CA/N has occurred when investigating CA/N complaints. As a result, there was a lack of consistent standards used among county FIA offices in determining if children have been abused or neglected.

Programs at county FIA offices receive reports of suspected CA/N and investigate to determine if CA/N occurred. Our review of 175 investigations and 180 substantiated cases disclosed significant differences in investigating and substantiating similar cases. For example, in the six counties that we visited:

a. Caseworkers did not substantiate 6 reports involving young children who were left home alone for extended periods of time but did substantiate 15 similar cases.

b. Caseworkers did not substantiate 2 reports involving babies who tested positive for drug use by the mother while she was pregnant but did substantiate 4 similar cases.

The Children's Commission Report, issued in July 1996, and the 1995-96 Annual Report of the Children's Ombudsman* noted that FIA had not developed an objective risk-based method for investigating reports of CA/N. Both the Children's Commission Report and the Ombudsman's Annual Report recommended that FIA establish a risk-based method for investigating reports of suspected CA/N.

FIA has developed a structured decision-making system to assess the risk of further abuse or neglect to the child for substantiated complaints. This provides a basis for decisions about providing services to the family. Development of a risk-based tool for assessing risk of CA/N during the intake and investigation process should provide for more consistent treatment of similar cases Statewide.

RECOMMENDATION

We recommend that FIA establish a method to uniformly measure and assess the risk of CA/N when investigating CA/N complaints.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the recommendation. The Child Protection Assessment Project was implemented in 10 pilot counties in July 1997. This project centers on the development and implementation of a valid, reliable assessment tool and protocol for assessing child safety. This tool is being used from the point in time an investigation is initiated until the case is closed or the child is placed in Foster Care.

** See glossary on page 60 for definition.*

FINDING

4. Timeliness of Initial Face-to-Face Contact

Caseworkers did not document that they had obtained supervisory approval to waive time requirements for initial face-to-face contacts prior to the expiration of the time requirement.

Services Manual procedure 712, page 21, requires initial face-to-face contacts between the family and the caseworker within 72 hours of receipt of a report of CA/N. If the caseworker does not consider it necessary to meet these time requirements, the Manual requires the caseworker to note the reason in the case record and obtain supervisory approval. However, the Manual does not clearly state that caseworkers should obtain supervisory approval to waive time requirements for initial face-to-face contacts before expiration of the time requirements.

All six local offices that we visited considered supervisory approval of an investigation report as fulfilling the supervisory approval requirements for noncompliance with initial contact requirements. However, supervisors were permitted to review investigation reports weeks or even months later, which was well after the 72-hour waiver requirement had expired. As a result, children may have remained at risk of suspected CA/N during this period.

Our review of 175 CA/N investigations disclosed 49 (28.0%) instances when caseworkers did not make initial face-to-face contacts within 72 hours of receipt of reports of CA/N, and did not document whether they had requested advance approval to waive the 72-hour requirement. In all 49 cases, supervisors did not document that prior approval had been given.

In our prior audit, we recommended that FIA revise the policy regarding supervisory approval for noncompliance with the 72-hour requirement for initial face-to-face contact. FIA revised the manual to require supervisory approval only when initial face-to-face contact was not made within 72 hours of receipt of reports of child abuse or neglect. The revised policy did not require supervisory approval prior to expiration of the 72-hour time requirement.

RECOMMENDATION

We recommend that caseworkers document requests for supervisory approval to waive time requirements for initial face-to-face contacts prior to the expiration of the time requirements.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the recommendation by modifying the Services Worker Support System to enable workers to document requests for supervisory approval prior to the expiration of time limits. FIA expects to complete this revision by September 1999.

FINDING

5. Written Reports From Mandated Reporters

FIA had not established an effective process for obtaining written reports of suspected CA/N from mandated reporters.

Section 3 of the Law requires that a mandated reporter submit, to FIA, a written report of suspected CA/N within 72 hours after making an oral report. The report shall contain other information available to the reporting person which might establish the cause of the abuse or neglect, and the manner in which the abuse or neglect occurred. Also, Section 3 of the Law requires FIA to inform a mandated reporter of the required contents of the written report at the time the mandated reporter provides the oral report.

FIA's current process requires caseworkers to verbally remind mandated reporters of the requirement to submit written reports within 72 hours of making an oral report of suspected CA/N. Caseworkers are required to document compliance with this procedure on intake documents. Our review of 179 randomly selected complaints from six county FIA offices disclosed that 73 complaints were from mandated reporters. For 19 (26%) of these 73 complaints, mandated reporters had not filed written reports and the intake documents did not indicate that caseworkers had verbally informed these reporters of their written report requirement.

In fiscal year 1993-94, FIA investigated 57,394 reports of suspected abuse and neglect. Of those 57,394 reports, 30,728 (53.5%) were filed by mandated reporters.

By requiring written reports from mandated reporters, it appears that the Legislature intended to provide FIA with information which is available to the reporting person that could help establish the cause of the CA/N and the manner in which the abuse or neglect occurred. This information would be of value to FIA during its investigation. Therefore, developing an effective process for obtaining written reports from mandated reporters should provide for compliance with the law and may provide additional documentation.

RECOMMENDATION

We recommend that FIA establish an effective process for obtaining written reports of suspected CA/N from mandated reporters.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with this recommendation by requesting an automation enhancement to support written notifications to mandated reporters when a written report has not been received.

FINDING

6. Notification of Disposition of Complaints Made by Mandated Reporters

Program Policy did not require caseworkers to notify mandated reporters of the disposition of their CA/N complaints.

Section 3 of the Law requires mandated reporters, such as doctors, nurses, and teachers, to report suspected CA/N. Feedback to mandated reporters would provide them some assurance that FIA has taken actions to determine if CA/N occurred and would encourage continued compliance with the Law.

Our review of 6 county FIA offices disclosed that only 1 office routinely provided written notification of the disposition of complaints to mandated reporters. This office used a form letter to provide notification. Caseworkers in the other 5 county offices stated that they do not have the time or resources to respond to each mandated reporter complaint.

The mandated reporters whom we interviewed were frustrated with the lack of feedback from county FIA offices. The 1995-96 Annual Report of the Children's Ombudsman noted that approximately 63% of the mandated reporters who

originated a child abuse or neglect complaint were not given a feedback or status report. The Ombudsman's Annual Report stated that mandated reporters may decide to not file future child abuse reports with the Program because they believe their reports are not taken seriously and they do not hear back regarding the results of their complaints. The Children's Commission Report also recommended that the Program provide follow-up information regarding reported cases to the mandated reporter who made the referral.

RECOMMENDATION

We recommend that FIA revise Program policy to provide mandated reporters with information regarding the disposition of their CA/N complaints.

AGENCY PRELIMINARY RESPONSE

FIA agreed and informed us that it has complied with this recommendation. New policy requiring notification to both mandated and nonmandated reporters was implemented in January 1997.

FINDING

7. Families in Need of Services

FIA had not determined if intervention services should be provided to families for which suspected CA/N was reported, but sufficient evidence was not obtained to substantiate that CA/N had occurred. Providing services to these families may help reduce the risk of CA/N in the future.

The Law and FIA policies do not provide for a third category of investigation disposition for certain families that may be in need of services to prevent further instances of potential CA/N. After the completion of an investigation, Program procedures require that caseworkers classify cases as either unsubstantiated or substantiated. Unsubstantiated cases are closed and receive no services. Families with a substantiated case are eligible to receive services to reduce the risk of CA/N to the child(ren).

The use of only two classification categories does not recognize that there are cases in which parents are involved in inappropriate behavior, but the behavior is not serious enough to substantiate the case as CA/N. These parents may be able to benefit from intervention services to reduce the risk of potential CA/N.

The 1995-96 Annual Report of the Children's Ombudsman also recommended that FIA establish a third category for classifying investigated cases to include families in need of services.

RECOMMENDATION

We recommend that FIA evaluate the benefits of establishing a third category of investigation disposition for families determined to be in need of services to help reduce the risk of CA/N in the future and seek amendatory legislation if appropriate.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with this recommendation. FIA supports implementation of investigation dispositions which identify families in need of services. Efforts are underway to accomplish this. The expected completion date is September 1999.

FINDING

8. Recording and Referral of Suspected Sexual Abuse or Sexual Exploitation to Law Enforcement Officials

FIA did not identify all complaints relating to suspected sexual abuse or sexual exploitation, and Program staff did not refer all suspected sexual abuse or sexual exploitation cases to law enforcement officials as required by the Law.

Section 8 of the Law requires that FIA, in the course of its investigation, seek the assistance of and cooperate with law enforcement officials within 24 hours after becoming aware that a child is the victim of suspected sexual abuse or sexual exploitation.

FIA did not have a system to identify all complaints of suspected CA/N involving sexual abuse or sexual exploitation. As a result, we could not determine to what extent FIA complied with this reporting requirement. In lieu of complaints, we selected a random sample of substantiated cases involving sexual abuse or sexual exploitation to review for compliance.

Our review of 77 substantiated sexual abuse or sexual exploitation cases in the 6 counties that we visited disclosed 3 cases (3.9%) that had not been referred to law enforcement officials. Also, we could not determine the status of referrals to law enforcement officials for 5 cases (6.6%) from 2 county offices because the county offices could not locate the files for our review.

Caseworkers and supervisors informed us that they did not always refer suspected sexual abuse and sexual exploitation cases to law enforcement officials. Services Manual procedure 712, page 8, states that "Only complaints that the department believes have 'basis in fact' are to be referred to the PA/LE (Prosecuting Attorney/Law Enforcement) for investigation." Section 8 of the Law does not give FIA discretion to only refer cases of suspected sexual abuse or sexual exploitation which they believe have a basis-in-fact.

The Children's Commission Report, issued in July 1996, noted that FIA was not in compliance with the Law which requires caseworkers to report suspected sexual abuse or sexual exploitation. Also, the 1995-96 Annual Report of the Children's Ombudsman noted that FIA did not require caseworkers to report suspected sexual abuse to law enforcement officials within 24 hours. FIA responded that "substantial abuse" must be reported to the police, not "suspected abuse."

Coordination with law enforcement officials helps ensure that the police have an opportunity to perform a comprehensive investigation and gather sufficient evidence to support the allegations in a criminal court proceeding. Failure to involve law enforcement officials in the investigation of suspected sexual abuse or sexual exploitation could result in continued risk of abuse or exploitation to the child if the caseworker does not perform a comprehensive investigation.

RECOMMENDATIONS

We recommend that FIA establish a system to identify all complaints relating to suspected sexual abuse or sexual exploitation.

We also recommend that the Program refer all suspected sexual abuse or sexual exploitation cases to law enforcement officials as required by the Law.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with these recommendations. FIA supports establishing a system which would classify all complaints received. This would

entail systems changes which will not be feasible in the near future. In the interim, a policy clarification will be sent to all Program staff which emphasizes the need to refer appropriate complaints to law enforcement.

SUBSTANTIATED CA/N CASES

COMMENT

Background: When sufficient and relevant evidence* of CA/N exists, caseworkers substantiate that abuse or neglect occurred, open a children's protective services case, assess risk to the child, and provide services to the family. In all substantiated cases of CA/N, the names of victims, family members, and perpetrators are placed on the Registry.

Audit Objective: To assess the Program's effectiveness and compliance with laws, regulations, policies, and procedures in coordinating and providing services for substantiated cases of CA/N.

Conclusion: We concluded that Program actions were sometimes not effective in protecting children at risk of further CA/N. Generally, the Program was in compliance with laws, regulations, policies, and procedures for substantiated cases of CA/N. However, our assessment disclosed one material condition. Based on our random

** See glossary on page 60 for definition.*

sample of substantiated cases from 6 county FIA offices, we determined that for 21 cases (11.7%) FIA did not take sufficient, appropriate, or timely action to protect the children involved.

Our assessment also disclosed other reportable conditions regarding notification of perpetrators on the Registry, Registry data integrity, and controls over access to the Registry.

FINDING

9. Actions Taken on Substantiated Cases

FIA did not take sufficient, appropriate, or timely action to protect the children involved in a number of substantiated cases.

FIA is responsible for protecting children who are abused or neglected by a parent or person responsible for the child's health or welfare. After CA/N has been substantiated, FIA procedures require that caseworkers take timely action to provide services to the family and to prevent further CA/N.

Our review of 180 substantiated cases in six counties disclosed:

a. Caseworkers did not take sufficient, appropriate, or timely action for 9 cases that involved repeated (chronic) substantiated and unsubstantiated complaints of CA/N to prevent further harm to the children.

   Chronic CA/N involves repeated instances of abuse or neglect over a period of time, often without significant improvement despite repeated attempts of caseworkers to provide services necessary to help reduce the risk of further physical or emotional harm.

   The failure of caseworkers to detect patterns of repeated abuse or neglect can result in long-term harm to the child. Services Manual procedure 712, page 55, requires that caseworkers consider filing a petition to terminate parental rights if agency efforts to improve family conditions have failed.

   Following are three examples of cases involving chronic CA/N:

   (1) A hospital nurse (a mandated reporter) reported that a child tested positive for cocaine at birth. The child remained at risk of CA/N because, even though five other children were removed from this parent, this child was not removed to a safe environment. FIA was aware for several weeks that the parent did not take the child to doctor's appointments; was not able to provide food, shelter, and diapers; and exhibited the same conduct that resulted in the removal of the five other children. Services Manual procedure 712, page 63, instructs caseworkers that a parent's treatment of one child is probative of how the parent may treat other children. FIA had credible and relevant evidence that this child was at risk and did not take actions to place this child in a safe environment.

FIA staff substantiated the case against the parent for knowingly placing the child at harm but allowed the parent to take the child home from the hospital. A caseworker documented that the parent did not have the funds to provide formula, shelter, or diapers for the child and documented that the parent missed two scheduled doctor appointments. A caseworker had face-to-face contact with the parent on three occasions within the first month. The case file noted that the child may be at risk of removal because of the parent's drug habits. The parent had an extensive history of drug abuse dating back to 1988.

(2) The CA/N reporter was one of several reporters who, over a seven-year period, indicated neglect of two children, ages 8 and 6. According to the reporter, the children were born with a medical condition known as PKU, a condition that results in severe developmental disabilities if a specific diet with limited protein is not followed.

FIA staff substantiated the case against the parents for physical abuse, mental injury, and medical neglect of both children in April 1996. The children were severely and permanently developmentally disabled because of the lack of a proper diet and were removed from the home. A caseworker concluded that the children were at risk of further damage because of the medical neglect and failure to provide the proper diet. However, FIA initially became aware of this family in 1989 when the first referral was substantiated for failing to follow the appropriate diet with the oldest child. The parents participated in some services but did not adhere to the required diet. Referrals in 1989, 1991, 1993, 1994, 1995, and 1996 were not substantiated even though the progression of developmental disabilities became more apparent in the children's conduct.

(3) A private agency social worker (a mandated reporter) stated that, when she had visited this family's home, there were 5 or 6 children (ages 2-8) sleeping on the floor in one room and the children crawled around in animal waste. She also reported that one child appeared to have medical problems and could not walk, but the parents would not seek medical attention. The reporter stated that family problems were getting worse and that the father is frequently drunk. This is the third complaint

of serious neglect for this family. The caseworker made a home call to the residence and noted that there was animal waste throughout the home, that there were not adequate beds for the children, and that the home was very dirty. The family was referred to a program to prevent placement of the children in foster care, for a second time. This program helped the family move to another county in a house next door to the maternal grandmother, and the case was closed. There was no evidence in the case file to document the living conditions at the time the case was closed. Also, the caseworker did not complete a service plan or quarterly reports as required by FIA policy. This indicates a lack of planning and monitoring of the family during this intervention.

b. In 12 cases, caseworkers did not take appropriate or timely action to provide services necessary to reduce the risk of further CA/N, or did not take appropriate or timely action against parents who refused to participate in services or cooperate with caseworkers.

Services Manual procedure 712, page 32, discusses requirements to assess the family situation, determine the risk of further CA/N, develop a service plan to reduce risk to the child, and evaluate the family's progress. In addition, Services Manual procedure 712, page 39, requires caseworkers to perform quarterly evaluations of the status of implementation of the service plans. FIA procedures require caseworkers to make initial and ongoing contacts and to follow up on the family.

Following are three examples of cases involving the lack of appropriate or timely action:

(1) A high school counselor (a mandated reporter) reported that a 14-year-old girl was physically abused by her father because she saved her lunch money. The child was visibly bruised. The child also reported to the counselor that her father had smashed a mirror and radio and had grabbed her with both hands around the neck.

FIA staff substantiated the case and reported that the father also punched holes in the walls of the home and that the mother would not intervene out of fear for the children. The girl reported that she and the other two siblings feared their father because he loses control when

angry. When interviewed by the caseworker, the father admitted that he became physically abusive toward his daughter and punched her in the back, arms, and face. The father was extremely resentful that the Program was involved with the family.

The case was substantiated, but was closed without services because of the uncooperative attitude of the father and unwillingness of the mother to take responsibility. In the closing narrative, the caseworker discussed that the father was extremely strict and unreceptive to counseling. The caseworker felt that further Program involvement would result in emotional harassment by the children's father. The case was closed with the statement that "if the father physically abuses another child in the future, a petition may be necessary."

(2) A hospital employee (mandated reporter) reported that there was evidence that a 5-year-old child was sexually abused.

FIA staff substantiated the case against the father for sexual abuse. A caseworker prepared handwritten notes of contacts two days after the referral date. There was no additional contact with the family or follow-up other than a closing report 8 1/2 months later which stated that a previously assigned caseworker was no longer employed with FIA, and the case was being closed as no additional complaints had been received.

(3) An adjacent county FIA caseworker reported that a 14-year-old boy, who had been abandoned by his parents, was placed with his grandmother. The grandmother placed the child with his 18-year-old cousin in the county of the complaint. The cousin was in the process of moving back to the other county. The child was not attending school and would not have a place to live.

The case file did not document any attempts to locate the parents of the child or to contact the grandmother or courts to determine who had legal jurisdiction of this child. There were no documented contacts with law enforcement officials to help locate the child. This child had a history of running away.

The case was substantiated for abandonment and improper supervision of the child, but was closed without services because FIA could not locate the child. In the case file, the caseworker discussed concerns that this case should be a delinquency case and probably should have been handled by the referring county; however, no one had jurisdiction over the child and could not control his tendency to run away.

As a result of FIA's failure to take sufficient, appropriate, or timely action to protect children in 21 cases (11.7%), FIA did not reasonably protect these children from risk of further CA/N.

The 1995-96 Annual Report of the Children's Ombudsman also noted that FIA did not take timely action to prevent CA/N in cases in which parents refused to participate in services. The Ombudsman noted that FIA procedures do not require caseworkers to refer cases to law enforcement officials when a parent refuses to make themselves available for services.

RECOMMENDATION

We recommend that caseworkers take sufficient, appropriate, or timely action to reduce the risk of additional abuse and neglect for substantiated CA/N cases.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with this recommendation. FIA has developed and is in the process of implementing policies, procedures, and protocols such as Structured Decision Making and improvements in staff training to help ensure that sufficient and appropriate interventions are made in substantiated cases. The Child Safety Assessment Project will provide a method to monitor implementation of these changes.

FINDING

10. Notification of Perpetrators on the Central Registry

FIA's perpetrator notification practices sometimes were not effective in providing perpetrators with appropriate due process regarding their placement on the Registry.

FIA maintains the Registry, which is an automated record system of CA/N perpetrators. Information on the Registry is used by a number of agencies and entities to investigate complaints of CA/N and to screen applications for licensed child care organizations, foster care home operators, and adoptions. FIA also established the Historical Registry* as part of the Registry for information regarding perpetrators placed on the Registry prior to August 1, 1992.

Act 393, P.A. 1994, effective December 29, 1994, requires FIA to notify all perpetrators placed on the Registry of their placement on the Registry within 30 days, of their right to request expungement of the record, and of their right to a hearing if FIA denies the request to expunge. The intent of the policy changes and the legislation is to provide a due process system for perpetrators placed on the Registry.

** See glossary on page 60 for definition.*

Our review of FIA's notification of perpetrators placed on the Registry disclosed:

a. Caseworkers did not notify some perpetrators on the Historical Registry of their rights as required by the law when their names were subsequently accessed on the system in relation to a current CA/N complaint or in conjunction with a request to screen applicants for certain licenses and adoptions.

   To comply with the Law, FIA procedures require that caseworkers notify perpetrators on the Historical Registry when the perpetrator's name is subsequently accessed as a result of a current CA/N complaint. In our review of 175 investigations, we identified 7 (4%) cases in which FIA did not comply with these notification requirements and inform the perpetrators of their rights.

b. FIA did not establish effective controls to ensure that due process was provided to individuals previously determined by FIA to be a perpetrator and placed on the Historical Registry.

   The Law does not address the notification of persons previously determined to be a perpetrator by FIA and placed on the Historical Registry. As of December 6, 1996, FIA had not notified approximately 147,000 perpetrators that they had been placed on the Historical Registry prior to August 1, 1992.

Therefore, these perpetrators have not been afforded due process regarding such placement.

Although notification of all perpetrators on the Historical Registry would be an administrative burden, such notification would help safeguard the rights of these individuals and improve the overall accuracy of the Registry.

FIA informed us that its staff consulted with the Legislature prior to implementation of Act 393 regarding the administrative burden of notifying all perpetrators listed on the Historical Registry. As a result, FIA established internal controls to provide for the proper notification to perpetrators as their names are accessed in connection with a new investigation of alleged CA/N or in conjunction with a review of the Registry relating to license requests and adoptions.
However, as stated in part a. of this Finding and in Finding 12, FIA's controls were not always effective. As a result, the current control system did not provide reasonable assurance that perpetrators on the Historical Registry whose names were accessed were notified of their due process rights.

c. Caseworkers did not notify perpetrators who were convicted in a criminal court or adjudicated in Probate Court.

FIA Services Manual procedure 712, page 26, states that perpetrator notification is not required when the allegations substantiated in a CA/N complaint are essentially the same as those for which the perpetrator is convicted in criminal court or adjudicated in Probate Court. However, neither the Probate nor Circuit Courts notify convicted perpetrators of their identification as perpetrators on the Registry and of their rights as required by the Law.

We identified 9 (5%) of 177 perpetrators in our sample of the Registry and 12 (7%) of 180 perpetrators in our sample of substantiated cases from six county FIA offices who were convicted in court and placed on the Registry without notification.

d. FIA often did not document that perpetrators were notified of their placement on the Registry and often did not notify perpetrators of their placement on the Registry on a timely basis.

Our review of 177 randomly selected cases of perpetrators for compliance with Registry notification requirements disclosed:

(1) FIA could not document that written notification was provided to 68 (38%) of the 177 perpetrators reviewed.

(2) FIA notified 109 perpetrators; however, FIA did not notify 17 (10%) of the 177 perpetrators in our sample within 30 days as required by the Law.

RECOMMENDATIONS

We recommend that FIA notify all perpetrators of their placement on the Registry, document such notifications, and issue notifications on a timely basis.

We also recommend that FIA improve its internal control system to provide for notification to perpetrators on the Historical Registry.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with these recommendations.

FIA will continue to require notification to all new perpetrators of their placement on the Central Registry, will continue to require documentation that notifications were completed on a timely basis, and plans to monitor performance with policy on new perpetrator notifications. FIA plans to revise its policy on notification of perpetrators convicted in criminal court or adjudicated in Probate Court to require written notification in these situations.

Also, FIA plans to strengthen the internal control system for notifying perpetrators on the Historical Registry to help ensure that they are properly notified when a perpetrator's name is accessed in conjunction with a current Protective Services complaint or in conjunction with a request to screen an applicant for certain licenses and adoptions. The Child Safety Assessment Project will provide a method to monitor implementation of controls by the local FIA offices.

FINDING

11. Registry Data Integrity

FIA had not established effective controls to help ensure that Registry data is complete and accurate. As a result, the effectiveness of the Registry as a repository of CA/N perpetrators is reduced.

Section 7 of the Law requires FIA to maintain a Registry that includes records of all known perpetrators of CA/N. Registry information is used by a number of agencies and entities to investigate complaints of CA/N and to screen applicants for licensed child care organizations, foster care home operators, and adoptions.
Our review of Registry records in six county FIA offices disclosed:

a. Caseworkers often did not record known perpetrators on the Registry.

Section 7 of the Law requires that FIA record the identity of all known CA/N perpetrators on the Registry. However, Services Manual procedure 715B, page 6, states that a caseworker may record "no perpetrator" when a child is without proper custody or guardianship and may record "unknown perpetrator" when there is insufficient information to determine which adult was the perpetrator.

Our review of 119 randomly selected cases with "no perpetrator" or "unknown perpetrator" recorded on the Registry disclosed that case files identified the perpetrator in 48 (40.3%) of the 119 cases.

We were informed that caseworkers often use "no perpetrator" or "unknown perpetrator" rather than the perpetrator's name in order to obtain cooperation during the investigation and while providing services to the family.

b. FIA did not establish procedures to help ensure that teachers and teachers' aides convicted in court of child abuse are placed on the Registry.

Section 2 of the Law defines child abuse as harm to a child by a parent, legal guardian, teacher, or teacher's aide. Without a method to include teachers and teacher's aides, the Registry does not contain a list of all perpetrators of CA/N as required by the Law.

RECOMMENDATION

We recommend that FIA establish effective controls to help ensure that Registry data is accurate and complete.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the recommendation. The Child Assessment Project will provide performance checks to help ensure that Central Registry data is accurate and complete.

FINDING

12. Controls Over Access to the Registry

FIA had not established internal controls to effectively monitor access to the Registry. As a result, there was little assurance that confidential information on the Registry was being controlled as numerous unauthorized individuals had the ability to access, edit, and expunge Registry information.

Section 7 of the Law limits the release of Registry information for specific purposes and requires that FIA protect the identity of the reporting person. Unauthorized release of sensitive information is a misdemeanor and could result in legal action for noncompliance with the Law's confidentiality requirements.

As of May 1996, 566 individuals Statewide had passwords allowing them to enter, edit, and expunge confidential Registry information, and an additional 82 individuals had passwords allowing them to view confidential information.

Our review of Registry access controls in six county FIA offices disclosed:

a. County FIA office policies regarding Registry access were inconsistent.

   County office personnel who were allowed access ranged from only Program data entry clerks to the entire Program staff.

b. Program supervisors often could not confirm the appropriateness of authorizations for individuals within their county office. Our review of 141 individuals authorized access to enter, edit, and expunge Registry data in the six county offices visited disclosed that supervisors:

(1) Could not identify 26 (18.4%) of the 141 individuals.

(2) Identified 13 (9.2%) of the 141 individuals as former Program employees.

(3) Identified 31 (22.0%) of the 141 individuals as no longer being in a position that requires them to have such access.

Supervisors in the county offices informed us that they do not routinely monitor Registry access and were not aware of how many unauthorized individuals had access to the Registry.

Our prior audit report also noted weaknesses in internal controls over access to the Registry. FIA indicated that it would review central and local office practices related to the Registry and take appropriate action. However, FIA had not improved internal controls over access to the Registry.

RECOMMENDATION

We recommend that FIA establish internal controls to effectively monitor access to the Registry.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the recommendation by implementing a new system for assigning access to the Central Registry. This system will void passwords not changed within specified time periods. This is expected to be completed by September 1999.

OTHER PERTINENT ISSUES

COMMENT

Audit Objective: To assess other pertinent issues related to the Program.

Conclusion: Our assessment disclosed one material condition. FIA had not established a comprehensive continuous quality improvement process to monitor and improve the Program's effectiveness in protecting children. In addition, we identified other reportable conditions in the areas of implementation of training for caseworkers,

contracting and competitive bidding for purchased services, and the confidentiality of Program information.

Noteworthy Accomplishments: Our assessment of other pertinent issues related to the Program disclosed significant improvements in the training of Program staff and contracting procedures for the Program. The Office of Foster Care Management (OFCM) and county offices, which are responsible for the administration of Program contractual services, implemented significant improvements in the process used to purchase medical and psychological services. Our prior audit contained 12 audit findings and 16 corresponding recommendations regarding the administration of contracted services. OFCM established procedures to improve competitive bidding, monitoring, and documentation of contracted services. The county offices significantly improved functions to help ensure adequate separation of duties and implemented most procedures established by OFCM. As a result, we identified only 1 finding and recommendation related to the administration of contracted services.

FINDING

13. Continuous Quality Improvement Process

FIA had not established a comprehensive continuous quality improvement process to monitor and improve the Program's effectiveness in protecting children.

The mission of the Program, which has been identified by FIA as one of its core responsibilities, is to protect children who are at risk of CA/N. FIA expended approximately $48.1 million in fiscal year 1995-96 on the Program.

Program effectiveness can often be improved by establishing a continuous quality improvement process. Such a process should include: performance indicators* for measuring outputs and outcomes*; performance standards* or goals* that describe the desired level of outcomes based on management expectations, peer group performance, and/or historical performance; a management information system to accurately gather outcome data; a comparison of outcome data to desired outcomes; a reporting of the comparison results to management; and recommendations to improve effectiveness.

Other than the gathering of certain annual data for statistical reporting, the Program had not developed a continuous quality improvement process. Some

examples of performance indicators that the program could use in a quality improvement process include a reduction in:

a. Chronic CA/N cases.

** See glossary on page 60 for definition.*

b. The incidence of violence between teens and their parents.

c. Infant deaths caused by CA/N.

Performance indicators could be useful to evaluate the overall effectiveness of the Program in protecting children. Also, the State Legislature and Governor are increasingly demanding (for example, in various appropriations acts and in Executive Directive No. 1996-1) that State programs use quality improvement processes to manage the use of limited State resources.

We reported on the lack of an effective system for monitoring the Program in our prior audit report. FIA responded that it was implementing a monitoring and evaluation system for the Program, but FIA did not implement such a system.

RECOMMENDATION

We recommend that FIA establish a comprehensive continuous quality improvement process to monitor and improve the Program's effectiveness in protecting children.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the recommendation. The Child Safety Assessment Project will establish a continuous quality improvement process to monitor and improve program effectiveness.

FINDING

14. Implementation of Training for Caseworkers

FIA had not fully implemented a comprehensive training program for all caseworkers.

Section 9 of the Law requires FIA to provide a continuing education program for caseworkers and supervisors that includes caseworker responsibilities, obligations, and powers and methods for diagnosing and treating CA/N. A comprehensive training program would help caseworkers to develop and maintain knowledge and skills necessary to safeguard and enhance the welfare of children.

Caseworkers, who are generally trained as social workers, perform a number of functions, such as investigating allegations, managing crisis situations, providing services to families, and working with the criminal and civil court systems. As a result, caseworkers need comprehensive training related to implementing Program policies and procedures, identifying substance and sexual abuse, and working with law enforcement officials and the courts.

At the time of our audit, FIA had developed, but not fully implemented, a comprehensive training program for caseworkers called the Child Welfare Institute. Institute training, which is designed to significantly enhance child welfare training in Michigan, is a positive step toward providing a comprehensive training program for all caseworkers. FIA, through the Institute, is assessing the training needs of existing caseworkers and plans to offer a comprehensive training program to both new and existing caseworkers.

The 1995-96 Annual Report of the Children's Ombudsman concluded that the lack of training resulted in differences in investigations, decisions, and policy implementation by the county FIA offices. The report recommended more training to increase caseworker fact finding and investigation skills. The report also noted a lack of training in interviewing skills and lack of preparation for court and administrative hearings. The Children's Commission Report also identified the lack of investigative training as a barrier to recognizing CA/N soon enough to protect children and prevent further CA/N.

RECOMMENDATION

We recommend that FIA continue its efforts to implement a comprehensive training program for all caseworkers.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the recommendation. The eight-week Child Welfare Training Institute Program was implemented in January 1997. All workers new to the position must attend the Institute and current workers must also attend

as space is available. Assessment of the training needs of staff will be completed. The workers and supervisors will be required to attend the sections of the curriculum which address areas of weakness.

FINDING

15. Contracting and Competitive Bidding for Purchased Services

County office staff did not comply with FIA procedures regarding contracting and competitive bidding for purchased psychological and medical services.

FIA contracting instructions require county office staff to enter into a contract when purchased services from an individual contractor will exceed $5,000 in a 12-month period. The instructions also require that county offices obtain such services through a competitive bid process when expected purchases for a type of service will exceed $10,000 in a 12-month period.

In fiscal year 1994-95, FIA paid $471,609 for psychological and medical services to 43 vendors who billed over $5,000 including 15 vendors who billed over $10,000 without obtaining contracts and competitive bids. Also, in the first eight months of fiscal year 1995-96, FIA paid $127,002 for psychological and medical services to 15 vendors who billed over $5,000 including 5 vendors who billed over $10,000 without obtaining contracts and competitive bids.

Competitive bidding helps ensure that services are purchased at a reasonable price. Also, contracts help to ensure Program accountability.

RECOMMENDATION

We recommend that county office staff comply with FIA procedures regarding contracting and competitive bidding for purchased psychological and medical services.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the recommendation. FIA completed a comprehensive review of the bid process and has adopted a fair market value rate setting process. The only area where bidding or fair market value rates do not apply is the purchase of psychological and medical assessments. FIA is hoping to make program policy specific enough to permit the establishment of fair market rates for psychological assessments. At that point, staff would be able to purchase

psychological assessments through master contracts that are being established for other fair market rate services. FIA also plans to determine the feasibility of establishing fair market rates for medical services.

FINDING

16. Confidentiality of Program Information

FIA had not established controls to help prevent the unauthorized release of confidential Program case information.

Program case information regarding suspected and substantiated CA/N is confidential information. Section 7 of the Law outlines specific individuals and groups who are allowed access to information contained in the Registry. Section 13(3) of the Law states that a person who disseminates, or who permits or encourages the dissemination of, information contained in the Registry and in reports and records made pursuant to the Law is guilty of a misdemeanor and is civilly liable for the damages proximately caused by the dissemination.

We identified two conditions which could result in release of confidential information in violation of the Law:

a. Caseworkers use cellular phones when investigating reports of CA/N. Cellular phone conversations are transmitted over public airwaves which could result in the release of confidential information. FIA had not established written policies and procedures regarding the use of cellular phones involving confidential Program information.

b. FIA accounting records for purchased services include the names of children involved in CA/N. Neither the central office nor the county offices had established procedures regarding the review or release of this confidential information accessed through automated accounting records which could be requested under the Freedom of Information Act.

RECOMMENDATION

We recommend that FIA establish controls to help prevent the unauthorized release of confidential Program case information.

AGENCY PRELIMINARY RESPONSE

FIA agreed and will comply with the recommendation. FIA policy prohibits employees from revealing confidential information, including family names and case specific information. FIA will issue an instructional letter to staff which provides guidelines on the use of cellular phones.

Also, the payment process has been revised to eliminate the need to record the name of clients receiving services on the payment voucher and is no longer entered on the Michigan Administrative Information Network (MAIN) system.

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SUPPLEMENTAL INFORMATION

Proposed Projects and Policy Changes Initiated by FIA

1. Child Safety Assessment Project - This Project includes ongoing evaluations of local office performance in Children's Protective Services. Local offices will be evaluated against key quality standards and will receive technical assistance to develop strategies to address areas of weakness.

2. Child Death Review Teams - As of August 1997, 32 counties implemented Child Death Review Teams. An additional 27 counties will be added in fiscal year 1997-98, and all counties will have Child Death Review Teams by fiscal year 1998-99.

3. Child Protection Assessment Tool - A valid and reliable assessment tool is being developed to assist Program and Foster Care workers to assess child safety. The assessment tool and protocol for using it are currently being tested.

4. Forensic Interviewing - A program developed to standardize interviewing techniques and improve the quality of information obtained during investigations to help ensure that the Program can determine if the allegations are true. Development of the protocol began in fall 1996, and the program was implemented on a test basis in July 1997.

5. Solution-Focused Interventions - Solution-focused interventions will assist caseworkers to obtain more information from children and their families in a more efficient manner and will enhance the capacity of the Program to produce behavioral change in families. Statewide implementation will begin in fiscal year 1997-98.

6. Training on Domestic Violence - FIA, in conjunction with the National Violence Prevention Fund, in recognition that child abuse and domestic violence coexist in the same families in 20% to 40% of abuse and neglect cases, developed a national curriculum for Program workers. This training program was completed in fiscal year 1996-97, and training of all existing Program staff will be completed in fall 1998.

7. Complaint Screening Protocol - A joint project with the Lieutenant Governor and The National Council on Crime and Delinquency. FIA initiated a review and revision of policies and procedures used to determine whether to accept a

complaint for investigation and to determine timeliness standards for initiating face-to-face contact.

8. Structured Decision Making - This risk-based assessment tool is designed to help improve the consistency of case services provided to families with substantiated cases of CA/N.

9. Services Worker Support System - This computerized case file documentation and support system is designed to provide improved accountability, consistency, and better access to case information for county offices.

10. Children's Protective Services Training Program - This Program, started in October 1996, is intended to reinforce the State's philosophy and goals for children and families, to establish minimum qualification levels for child welfare staff, and to assess the training needs of staff.

11. Additional Staffing - The fiscal year 1996-97 Appropriations Act included funding for up to 125 additional program staff to partially fund a projected shortfall of caseworkers identified in a recent FIA study of case trends. These 125 additional positions were allocated to the county offices as of April 1997.

12. Proposed Revisions to the Child Protection Law - Revisions to the Law include changes to confidentiality requirements and the creation of an additional category of "Families in Need of Services."

Glossary of Acronyms and Terms

basis-in-fact	Direct, personal knowledge on the part of an individual reporting child abuse or neglect that is specific and concrete and reasonably indicates harm or threatened harm to a child's health or welfare.
CA/N	Child abuse and/or child neglect.
Central Registry (the Registry)	The automated data system maintained and used by FIA to keep a record of all reports filed with FIA pursuant to the Child Protection Law in which a preponderance of relevant and accurate evidence of child abuse or neglect is found to exist.
child(ren)	A person(s) under 18 years of age.
child abuse	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 or by a teacher or teacher's aide that occurs through nonaccidental physical or mental injury; sexual abuse; sexual exploitation; or maltreatment.
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: (i) Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care, or (ii) 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 the risk when that person is able to do so and has, or should have, knowledge of the risk.
Child Protection Law	Act 238, P.A. 1975, as amended (Sections 722.621 -

(the Law)	722.636 of the *Michigan Compiled Laws*).
Child Safety Assessment Project	This Project includes ongoing evaluations of local office performance in Children's Protective Services. Local offices will be evaluated against key quality standards and will receive technical assistance to develop strategies to address areas of weakness.
Children's Commission	An agency in the Lieutenant Governor's office established by Executive Order 1995-12 to review current laws, programs, procedures, policies, and training procedures that affect children and to create recommendations to help improve the quality of life for Michigan's children.
Children's Ombudsman	A government official created by Act 204, P.A. 1994, to monitor and ensure compliance with relevant statutes, rules, and policies pertaining to children's protective services and the placement, supervision, and treatment of children in foster care and adoptive homes.
Children's Protective Services	Program services designed to rectify conditions that threaten the health and safety of children because of the actions or inactions of those responsible for their care. These services include investigating a report, determining the danger to the child and taking immediate steps to remove the danger, providing or arranging for needed services for the child and family, and when appropriate initiating legal action to protect the child.
collateral contacts	Contacts with other community agencies (e.g., schools, law enforcement officials, and medical facilities) which may have additional information regarding the condition of the child or the situation.
complaint	Communication to FIA of an allegation of child abuse or neglect. The term "complaint" as used in this audit report is

	interchangeable with the term "report" as used in the Child Protection Law.
credible evidence	Facts that are both relevant and accurate and support a conclusion that there is a causal relationship between the perpetrator's behavior and the child's situation or condition.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical for the amount of resources applied or minimizing the amount of resources required to attain a certain level of outputs or outcomes.
expunction/ expungement	To physically remove or eliminate and destroy a record or report.
FIA	Family Independence Agency.
goals	The agency's intended outcomes or impacts for a program to accomplish its mission.
Historical Registry	Record of perpetrators placed on the Central Registry prior to August 1, 1992.
internal control structure	The management control environment, management information system, and control policies and procedures established by management to provide reasonable assurance that goals are met; that resources are used in compliance with laws and regulations; and that valid and reliable performance related information is obtained and reported.
investigation	An intense time-limited process of gathering and evaluating information to assess the level of risk to a child and to reach a disposition regarding complaint allegations.

living-together-partner (LTP)	An unmarried person of the opposite sex (commonly a boyfriend) who resides, for any length of time, in the same home with the parent of a child involved in child abuse and/or neglect.
mandated reporter	Person required to report to FIA child abuse or neglect, including a physician, coroner, dentist, registered dental hygienist, medical examiner, nurse, a person licensed to provide emergency medical care, audiologist, psychologist, marriage and family therapist, licensed professional counselor, certified social worker, social worker, social work technician, school administrator, school counselor or teacher, law enforcement officer, or regulated child care provider who has reasonable cause to suspect child abuse or neglect.
material condition	A serious reportable condition which could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the opinion of an interested person concerning the effectiveness and efficiency of the program.
mission	The agency's main purpose or the reason the agency was established.
OFCM	Office of Foster Care Management.
outcome(s)	The actual impact(s) of a program. Outcomes should positively impact the purpose for which a program was established.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.

performance indicators

Information of a quantitative or qualitative nature indicating program outcomes, outputs (products or services produces by the program), or inputs (resources that a program consumes). Performance indicators are typically used to assess achievement of goals and/or objectives.

performance standards

A desired level of output or outcome as identified in statutes, regulations, contracts, management goals, industry practices, peer groups, or historical performance.

perpetrator

Person who committed child abuse or neglect.

person responsible for the child's health or welfare

A parent, legal guardian, person 18 years of age or older who resides for any length of time in the same home in which the child resides, or an owner, operator, volunteer, or employee of the following:

(i) A licensed or unlicensed child care organization, as defined in Section 1, Act 116, P.A. 1973, being Section 722.111 of the *Michigan Compiled Laws*.

(ii) A licensed or unlicensed adult foster care family home or adult foster care small group home as defined in Section 3, Act 218, P.A. 1979 (the Adult Foster Care Facility Licensing Act), being Section 400.703 of the *Michigan Compiled Laws*.

preponderance of evidence

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

Protective Services Management Information System (PSMIS)

An automated management information system used by FIA to track reported, investigated, and substantiated cases involving child abuse and child neglect.

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.
reportable condition	A matter coming to the auditor's attention that, in his/her judgment, should be communicated because it represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
Services Manual	FIA Children and Youth Services Manual.
Services Workers Support System	A computerized case file documentation and support system designed to provide improved accountability, consistency, and better access to case information for county offices.
sexual abuse	Engaging in sexual contact or sexual penetration, as defined in Section 750.520a of the *Michigan Compiled Laws*, with a child.
sexual exploitation	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 defined in Section 750.145c of the *Michigan Compiled Laws*.
Solution-Focused Interventions	This program will assist caseworkers to obtain more information from children and their families in a more efficient manner and will enhance the capacity of the Program to produce behavioral change in families. Statewide implementation began in fiscal year 1997-98.
Structured Decision Making	A risk-based assessment tool designed to help improve the consistency of case services provided to families with substantiated cases of child abuse or neglect.
substantiated	A complaint of child abuse or neglect made pursuant to the Child Protection Law in which a preponderance of evidence

(credible evidence prior to September 20, 1996) of child abuse or neglect is found following the investigation.