Office of the Auditor General
Performance Audit Report

Office of Children's Ombudsman

Department of Technology, Management, and Budget

April 2019

State of Michigan Auditor General
Doug A. Ringler, CPA, CIA

071-0176-17

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

The auditor general may make investigations pertinent to the conduct of audits.

Article IV, Section 53 of the Michigan Constitution

OAG
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Report Summary

Performance Audit

Office of Children's Ombudsman (OCO)

Department of Technology, Management, and Budget (DTMB)

Report Number:
071-0176-17

Released:
April 2019

OCO was established as an autonomous agency and is organizationally placed within DTMB. OCO's mission is to assure the safety and well-being of Michigan's children in need of foster care, adoption, and protective services and to promote public confidence in the child welfare system. OCO may independently investigate complaints alleging that the Michigan Department of Health and Human Services (MDHHS) and/or a private child placing agency violated law or policy concerning child welfare or made decisions harmful to a child's health or safety. OCO also must investigate child deaths that occur under circumstances specified in the Children's Ombudsman Act. From October 1, 2014 through September 30, 2018, OCO received approximately 4,600 complaints and other communications and opened approximately 680 investigations.

Audit Objective			Conclusion
Objective #1: To assess the effectiveness of OCO's efforts to properly address complaints and other communications received.			Effective
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
For over 30% of complaints that we reviewed, OCO did not contact the complainant within 5 business days to gather additional information and determine if there were risks to the child. In these instances, complainants were contacted from 6 to 19 business days after the complaint was received (Finding #1).		X	Agrees
Improved data encryption was needed for OCO's Web-based complaint form to reduce the risk that sensitive or confidential information from complainants could be inappropriately accessed, stolen, or tampered with (Finding #2).		X	Agrees

Audit Objective	Conclusion
Objective #2: To assess the sufficiency of OCO's efforts to conduct investigations of child welfare complaints and deaths.	Sufficient, with exceptions

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
OCO should enhance its procedures to independently identify child deaths requiring OCO investigation. OCO relied on MDHHS for notification of child deaths. Because of shortcomings in MDHHS's procedures, OCO did not receive timely notification of 206 child deaths (approximately 20%) recorded in MDHHS's system from 2014 through 2017 (Finding #3).	X		Agrees

Observations Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
Capacity and mandated investigations have limited the number of OCO investigations of child welfare complaints (Observation #1).	Not applicable for observations.		

Audit Objective	Conclusion
Objective #3: To assess whether OCO sufficiently reported selected information to designated parties.	Sufficient

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
None reported.	Not applicable.		

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April 30, 2019

Ms. Lisa McCormick, Children's Ombudsman
Director, Office of Children's Ombudsman
Department of Technology, Management, and Budget
Arbaugh Building
Lansing, Michigan
and
Ms. Tricia L. Foster, Director
Department of Technology, Management, and Budget
Lewis Cass Building
Lansing, Michigan

Dear Ms. McCormick and Ms. Foster:

This is our performance audit report on the Office of Children's Ombudsman, Department of Technology, Management, and Budget.

We organize our findings and observations by audit objective. Your agency provided preliminary responses to the recommendations at the end of our fieldwork. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and submit it to the State Budget Director upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

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

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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OFFICE OF CHILDREN'S OMBUDSMAN

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AUDIT OBJECTIVES, CONCLUSIONS, FINDINGS, AND OBSERVATIONS

ADDRESSING COMPLAINTS AND OTHER COMMUNICATIONS RECEIVED

BACKGROUND

The Children's Ombudsman* Act (Sections 722.921 - 722.932 of the *Michigan Compiled Laws*) requires the Office of Children's Ombudsman (OCO) to establish procedures for receiving and processing complaints from complainants* alleging that the Michigan Department of Health and Human Services (MDHHS) and/or a contracted private child placing agency violated law or policy or made decisions harmful to a child's health or safety.

OCO has established several ways to receive complaints and communications, most often from individuals via telephone calls and online submissions of a Web-based complaint form. OCO also receives communications through e-mail, fax, and the United States Postal Service and receives notifications of child deaths from MDHHS. OCO generally categorizes the communications that it receives as follows:

- ***Complaints*** - These are contacts that concern a child involved in Michigan's child welfare system where MDHHS or a private child placing agency may have violated State or federal laws, State rules, and/or MDHHS policies or where an alleged decision or action by MDHHS or a private child placing agency was harmful to a child's health, safety, or well-being.

  Complaints fall under the statutory authority of the Children's Ombudsman Act to investigate; however, a complaint may not always result in an OCO investigation. For example, complaints regarding events that occurred many years prior and where involvement by OCO would not serve any purpose or complaints about issues that have been addressed through new policy or State law are not opened for investigation. In addition, OCO does not open an investigation when a complainant is seeking an outcome that OCO has no authority to provide, such as making adoption decisions, returning a child to his or her home, or disciplining an MDHHS worker or child placing agency.

- ***Child death alerts*** - These are notifications to OCO that MDHHS's Michigan Statewide Automated Child Welfare Information System (MiSACWIS) has received information that a child died. Not all child death alerts require an OCO investigation. OCO must evaluate death alert information to determine the circumstances under which the child died and whether an OCO investigation must be conducted. For example, if a

** See glossary at end of report for definition.*

child in foster care died of a natural cause and there had been no prior children's protective services (CPS) or licensing complaints concerning the foster care home, an OCO investigation would not be required.

- ***Consumer contacts**** - These include inquiries that are not about a child in the child welfare system, such as questions about how to become a licensed foster parent or adopt a child in Michigan, complaints from other states about a child not in Michigan's child welfare system, or general requests for information. Consumer contacts also include inquiries about child-related issues that OCO does not have jurisdiction to investigate, such as Friend of the Court or child custody matters and truancy or school concerns.

  Consumer contacts also include referrals that are concerns about a child involved in the child welfare system but may involve actions of an entity or a person that OCO is not authorized to investigate, such as the court, law enforcement, or an attorney.

OCO's intake process for addressing complaints and other communications includes, but is not limited to:

- Documenting pertinent information related to the communication and categorizing the contact in OCO's database.

- Conducting follow-up with complainants to obtain additional information and assess whether there are current safety concerns or risks to the child.

- Evaluating complaint and child death alert information and making a determination regarding whether an OCO investigation will be opened.

- Notifying complainants and MDHHS when OCO opens an investigation.

- Providing relevant referral information to resolve consumer contacts.

Between October 1, 2014 and September 30, 2018, OCO received a total of 4,597 consumer contacts, complaints, and child death alerts and opened a total of 681 investigations.

** See glossary at end of report for definition.*

AUDIT OBJECTIVE

To assess the effectiveness* of OCO's efforts to properly address complaints and other communications received.

CONCLUSION

Effective.

FACTORS IMPACTING CONCLUSION

- OCO's category determinations for 133 sampled complaints and other communications met policy criteria and were sufficiently documented, including OCO's determination to open or decline an investigation.
- OCO properly notified complainants and MDHHS that it had opened an investigation, as required, for all of the complaints that we reviewed.
- OCO posted an informational video on its Internet Web site as outreach to educate the public about OCO's responsibilities and activities and to provide assistance for filing a complaint.
- Reportable conditions* related to timely contact with complainants and improved data encryption for the Web-based complaint form (Findings #1 and #2).

** See glossary at end of report for definition.*

FINDING #1

Improvement needed to ensure timely contact with complainants.

OCO did not always contact complainants in a timely manner after receiving a complaint. Untimely responses could delay the discovery of immediate threats to children.

OCO's procedures require the intake analyst to contact complainants within five business days of receiving the complaint. This contact is necessary for the intake analyst to understand the complainant's concerns, gather information about the complaint, and determine if the associated child is safe or at risk.

We reviewed 78 complaints and determined that in 26 (33%) instances OCO did not contact the complainant within the required 5 business days in accordance with OCO procedures. In these instances, OCO contacted the complainants ranging from 6 to 19 business days after receiving the complaint, averaging 10 business days.

OCO informed us that staffing issues contributed to delayed contacts.

RECOMMENDATION

We recommend that OCO contact complainants in a timely manner after receiving a complaint.

AGENCY PRELIMINARY RESPONSE

OCO provided us with the following response:

OCO agrees with and will comply with the recommendation. OCO is establishing a backup procedure that in the event there is a staff vacancy, or a staff member is on medical leave, OCO will be able to contact complainants within the required 5 business days.

FINDING #2

Improved data encryption needed for OCO's Web-based complaint form.

OCO did not ensure that its Web-based form for submission of complaints utilized appropriate data encryption to reduce the risk that sensitive or confidential information could be accessed, stolen, or tampered with.

State of Michigan (SOM) Technical Standard 1340.00.170.03 requires that data that is in transit should be encrypted to minimize the likelihood that sensitive or confidential SOM information is inadvertently disclosed or accessed during transmission. Data in transit includes Web traffic, e-mail, and connections to the SOM wireless network.

Our review noted that prior to November 2017, OCO used a Web-based complaint form without an appropriate level of data encryption. OCO received approximately 160 complaints through its Web-based form annually during our audit period and informed us that it was not aware of any instances of inappropriate access to, theft of, or tampering with complaints that were submitted using its Web-based form.

OCO was not aware that its Web-based complaint form was established without the appropriate data encryption and was not adequately secure. Upon notification, OCO immediately notified the Department of Technology, Management, and Budget (DTMB) Information Technology Support Division and it promptly changed the online complaint form to a secure encryption method.

RECOMMENDATION

We recommend that OCO continue to ensure that its Web-based form for submission of complaints utilizes appropriate data encryption.

AGENCY PRELIMINARY RESPONSE

OCO provided us with the following response:

OCO agrees with and has complied with the recommendation. Upon notification of the issue, OCO worked with DTMB to immediately upgrade the online complaint form's security to a more secure encryption method.

INVESTIGATING CHILD WELFARE COMPLAINTS AND DEATHS

BACKGROUND

The Children's Ombudsman Act provides OCO with the authority to investigate complaints of MDHHS and child placing agencies to ensure compliance with relevant statutes, rules, and policies pertaining to CPS and the placement of children in foster care and adoptive homes. The Act also provides the Children's Ombudsman with the sole discretion to determine whether a complaint is investigated. In addition, the Act requires that the Children's Ombudsman investigate ***all*** child deaths that occurred, or are alleged to have occurred, because of abuse or neglect in the following situations: (1) the child died during an active CPS investigation or an open services case, (2) the child had history of a CPS complaint within two years, (3) the child died while in foster care or while an active foster care case, or (4) the child's death occurred within two years of closing a foster care case.

When OCO determines that it will open a complaint or child death investigation, the case is assigned to an investigator who must begin the investigation within 10 business days. During the investigation, the investigator performs investigatory steps to reach a conclusion and takes actions as appropriate that include, but are not limited to:

- Accessing and evaluating MiSACWIS and other agency case records as necessary to reach conclusions.
- Interviewing agency personnel, law enforcement personnel, attorneys, medical personnel, or school officials.
- Issuing a request for action* (RFA) letter to MDHHS when an investigation identifies a situation that requires immediate action to protect a child. The letter details the situation and requests that MDHHS take certain action(s) and respond to OCO within 5 business days.
- Issuing a report to MDHHS affirming the agency's actions if no violations or poor decisions are identified or a findings and recommendations (F&R) report to MDHHS when an investigation identifies violations of law, rule, or policy or poor decisions.
- Evaluating MDHHS's responses to RFA letters and F&R reports to ensure that corrective action was implemented and performing follow-up for outstanding recommended corrective actions.
- Submitting completed investigation reports for an internal peer review process and the OCO chief investigator's review, approval, and closure of the investigation.

** See glossary at end of report for definition.*

The Act requires OCO to complete child death investigations within 12 months; however, the Act does not establish a required time frame for completion of complaint investigations. In addition, the Child Protection Law (CPL), Sections 722.621 - 722.638 of the *Michigan Compiled Laws*, requires MDHHS to notify OCO no later than one business day when a child dies and:

- The child died during an active CPS investigation or an open CPS case.
- MDHHS received a prior CPS complaint concerning the child's caretaker.
- The child's death may have resulted from child abuse or neglect.

MDHHS's Office of Family Advocate (OFA) used an automated alert process in MiSACWIS to identify child deaths and notify OCO via a child death alert. Prior to November 2017, MDHHS's OFA staff would evaluate the alerts and then notify OCO of the child deaths that it determined to be applicable according to specifications in the CPL. As of November 2017, the process changed and OCO began receiving automatic and direct notification from MiSACWIS of all child deaths.

The focus of an OCO child death investigation is to determine whether interventions by MDHHS and/or a private child placing agency prior to a child's death complied with law or policy. OCO also determines whether a correlation existed between previous agency involvement with the family and the circumstances that led to the child's death.

Between October 2014 and September 2017, OCO conducted and closed a total of 88 child welfare complaint investigations and 342 child death investigations.

AUDIT OBJECTIVE

To assess the sufficiency of OCO's efforts to conduct investigations of child welfare complaints and deaths.

CONCLUSION

Sufficient, with exceptions.

FACTORS IMPACTING CONCLUSION

- OCO's investigation conclusions, including issuance of the applicable report(s) to MDHHS, were appropriately supported and documented for all investigations that we reviewed.
- OCO completed 97% of investigations within 12 months of the receipt of the child welfare complaint or child death alert.

- OCO documented that its internal peer review process had been utilized for all investigations that we reviewed.

- OCO issued timely RFA letters to MDHHS when it detected issues that required immediate action to protect a child.

- OCO investigators had direct system access to MDHHS's electronic child welfare case files for conducting investigations.

- OCO had established processes with MDHHS for corrective action communication, follow-up of investigation findings and recommendations, and child death alerts.

- Material condition* related to OCO's lack of independent identification of child deaths requiring OCO investigation.

** See glossary at end of report for definition.*

FINDING #3

Continued improvement needed in identifying child deaths that require OCO investigation.

OCO should enhance its procedures to independently identify child deaths that require OCO investigation. OCO's primary reliance on MDHHS's child death alert process significantly hindered OCO's ability to fulfill its statutory obligation to complete timely investigations of child deaths and to fully carry out its mission* to assure the safety and well-being of Michigan's children in need of foster care, adoption, and protective services.

The Act requires OCO to:

- Investigate all child deaths that occurred, or are alleged to have occurred, because of abuse or neglect, including deaths that occurred during an active CPS investigation or an open services case; if the child had history of a CPS complaint within two years; if the child died while in foster care or while an active foster care case; or if the child's death occurred within two years of closing a foster care case.

- Establish procedures for receiving complaints and conducting investigations.

The CPL requires MDHHS to notify OCO within one business day when a child dies:

- While under the court's jurisdiction under Section 2(b) of Chapter XIIA of the Probate Code of 1939, Public Act 288 of 1939, Section 712A.2 of the *Michigan Compiled Laws*.

- During an active CPS investigation or an open CPS case.

- And MDHHS received a prior CPS complaint concerning the child's caretaker.

- And the child's death may have resulted from child abuse or neglect.

OCO relied on MDHHS for child death notifications; however, notifications for 206 child deaths were not received during 2014 through 2017.

OCO indicated that because of MDHHS's CPL requirement, child death notifications were solely MDHHS's responsibility and OCO relied on MDHHS for child death notifications. However, the Act does not require or specify that OCO should rely on, and only receive, child death notifications from MDHHS.

In July 2017, MDHHS notified OCO that it had identified child deaths that occurred in 2016 for which it had not provided a child death alert; therefore, OCO could not investigate as required. In August and September 2017, MDHHS conducted additional procedures and identified a total of 206 (approximately 20%) child deaths that occurred during 2014 through 2017 with no associated alert. OCO received an average of 267 child death alerts annually during fiscal years 2014 through 2016.

** See glossary at end of report for definition.*

MDHHS determined that the missed alerts resulted from human error because the "child death box" in MiSACWIS was not appropriately checked by child welfare personnel. In response, MDHHS implemented an ancillary weekly procedure to capture child death information documented in other MiSACWIS records in an effort to identify missed alerts. Despite the corrective action, a risk still exists that OCO's primary reliance on MDHHS will not ensure that it receives timely notifications of all child deaths subject to OCO's investigation requirement. Our concerns are as follows:

- MiSACWIS is dependent on human input for a check box and case record information in order for a child death to be identified.

- MDHHS's weekly procedure to identify missed child death alerts does not meet the CPL requirement to send OCO a notification within one business day of a child's death.

- MDHHS screens the child deaths identified in its weekly procedure prior to sending an alert to OCO. Determination of whether a child's death warrants OCO investigation is the responsibility of OCO, not MDHHS. We determined that MDHHS did not notify OCO of 93 of the 206 missed child deaths because its screening concluded that the deaths did not meet criteria to send to OCO. We reviewed 38 of the 93 and determined that 8 (21%) should have been sent to OCO according to the CPL. OCO informed us that 2 of the 8 did warrant its investigation.

OCO should implement additional independent procedures to identify child deaths.

Because of the shortcomings in MDHHS's child death alert process and the ever present risk of human input error, OCO should implement additional independent procedures, such as routinely comparing State death records to MiSACWIS, to identify child deaths that warrant OCO investigation.

We determined this to be a material condition because of the significant number of child death alerts that OCO did not receive in a timely manner during fiscal years 2014 through 2017; the magnitude of the untimeliness of the missed alerts; the potential consequences of risk of harm to other surviving children; and the inability of OCO to fully meet its statutory obligations or to fully carry out its mission in relation to child death investigations.

RECOMMENDATION

We recommend that OCO enhance its procedures to independently identify child deaths that require OCO investigations.

AGENCY PRELIMINARY RESPONSE

OCO provided us with the following response:

OCO agrees with and will comply with the recommendation. OCO takes all child welfare complaints seriously. The office is committed to reviewing and investigating complaints regarding

children involved with MDHHS, foster care services, adoption services and the juvenile justice system.

Currently, OCO relies on MDHHS to send child death alerts. This process is mandated in the Child Protection Law. When a child dies, MiSACWIS is utilized to send a death alert to OCO. This process requires a member of MDHHS staff to check a box in MiSACWIS. Due to this human element, some alerts were missed. Once it was determined that some alerts were missed, OCO worked with MDHHS to review all missed cases.

In order to address any future cases, MDHHS is currently doing a second check based on its records to determine if the box was not checked. If MDHHS identifies a case where the box was not checked, MDHHS emails OCO of the child death so OCO can decide whether opening an investigation is warranted. OCO is committed to looking at the most effective and efficient way to merge the data from MiSACWIS and other databases to conduct an independent review to determine whether a child death case should be opened.

OBSERVATION #1

Limitations exist that constrain OCO's investigation of child welfare complaints and diminish its opportunity to identify emerging issues.

Resource limitations exist that constrain OCO's investigation of child welfare complaints and diminish its opportunity to identify emerging issues to better effect changes in policies and legislation and to educate the public.

The Children's Ombudsman Act established OCO as a means to:

- Effect changes in policy, procedure, and legislation.
- Educate the public.
- Investigate and review actions of MDHHS, child placing agencies, or child caring institutions.
- Monitor and ensure compliance with relevant statutes, rules, and policies pertaining to CPS and the placement, supervision, and treatment of children.
- Improve the delivery of care of children in foster care and adoptive homes.

The Act mandates that OCO investigate certain child deaths, while providing the Children's Ombudsman with the sole discretion and authority to determine if non-death related child welfare complaints fall within his or her duties and power to investigate. We noted:

OCO dedicates a majority of its limited resources to conducting mandated child death investigations.

a. Almost 85% of the investigations that OCO conducted from October 1, 2014 through September 30, 2018 were mandated child death investigations.

b. OCO did not conduct investigations for a significant number of the child welfare complaints that it received. Of 133 complaints and other communications that we reviewed, 40 were child death notifications that required an OCO investigation and 23 met the criteria for a child welfare complaint investigation. OCO conducted investigations for the 40 child death notifications and for 10 of the child welfare complaints. However, OCO did not conduct investigations for 13 (57%) of the child welfare complaints.

c. OCO did not dedicate resources toward formally evaluating commonalities or trends that may exist in the significant number of child welfare complaints that are not accepted for investigation to facilitate identification of potential emerging issues within the complaints.

OCO's resource limitations, mandate for conducting child death investigations, and sole discretion for accepting child welfare complaints for investigation is concerning because:

- Limited options exist for complainants to seek an independent examination of child welfare complaints.
- OCO's ability to identify potential emerging issues and pursue improvements for the benefit of child welfare outcomes is diminished.

OCO's resource limitations, mandate for conducting child death investigations, and sole discretion regarding the acceptance of child welfare complaints for investigation is concerning because OCO is the only option within the State for individuals to seek an impartial examination of child welfare complaints regarding children involved with CPS, foster care services, adoption services, and the juvenile justice system. Although individuals may file complaints with MDHHS's OFA, MDHHS's Child Welfare Licensing Division, and/or child placing agencies, these entities are under the control and supervision of MDHHS and are not independent. In addition, OCO's ability to vigorously identify potential emerging issues and pursue improvements in law, policy, and practice for the benefit of child welfare outcomes is diminished.

The Children's Ombudsman informed us that she shares our concerns because OCO should be in the forefront of improving the lives of Michigan's children through its independent investigations of complaints, timely identification of emerging issues, and recommendations for changes that improve law, policy, and practice. OCO management informed us that OCO cannot conduct investigations into all of the child welfare complaints that it receives because the majority of its limited capacity is directed toward conducting mandated child death investigations and investigations when OCO determines that a child is in danger. OCO management also indicated that it believes that OCO is operating with 2 investigators below an optimum level.

Effectively addressing OCO's limitations will require input from the Governor, the Legislature, the Children's Ombudsman, and OCO management. We encourage the relevant parties to begin those discussions.

REPORTING SELECTED INFORMATION

BACKGROUND

The Children's Ombudsman Act requires OCO to prepare and submit an annual report to the Governor, the Legislature, and MDHHS to provide an account of OCO's operations and overall recommendations regarding needed legislation or changes in rules or policies.

In addition, each month OCO reports on the timeliness of its investigations and complainant communications as a part of Michigan's MiScorecard*.

OCO also reports the results of investigations to complainants. The information that OCO reports is dependent on the relationship of the complainant to the case. OCO may report its findings and recommendations, the agency's response to both, and any epilogue(s) to the Ombudsman's report and the department's response, if the complainant is any one of the following:

- The child, if he or she is able to articulate a complaint.
- A biological parent of the child.
- A foster parent of the child.
- An adoptive parent or a prospective adoptive parent of the child.
- A legally appointed guardian of the child.
- A guardian ad litem of the child.
- An adult who is related to the child within the fifth degree by marriage, blood, or adoption, as defined in Section 22 of the Michigan Adoption Code, Section 710.22 of the *Michigan Compiled Laws*.
- A Michigan legislator.
- An individual required to report child abuse or child neglect under Section 3 of the CPL, Public Act 238 of 1975, Section 722.623 of the *Michigan Compiled Laws*.
- An attorney for any individual described in Sections 722.925(a) - 722.925(g) of the *Michigan Compiled Laws*.

If a complainant is not an individual listed above, OCO may only report its recommendations, the agency's response to those recommendations, and any epilogue to the Ombudsman's report and the department's response.

** See glossary at end of report for definition.*

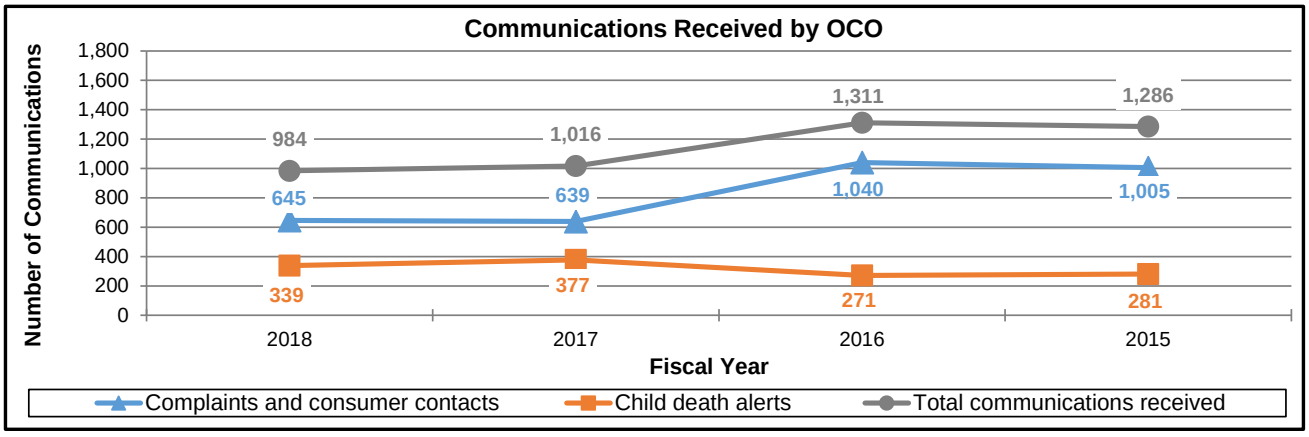
AUDIT OBJECTIVE	To assess whether OCO sufficiently reported selected information to designated parties.
CONCLUSION	Sufficient.
FACTORS IMPACTING CONCLUSION	• OCO consistently prepared and submitted annual reports to the Governor, the Legislature, and MDHHS on its operations and recommendations. • OCO published MiScorecard reports each month throughout our audit period indicating its performance in meeting targets for investigation timeliness and initial contact with complainants. • OCO had documented its evaluation of the relationship of complainants to ensure appropriate reporting of investigation results for the investigation cases that we reviewed.

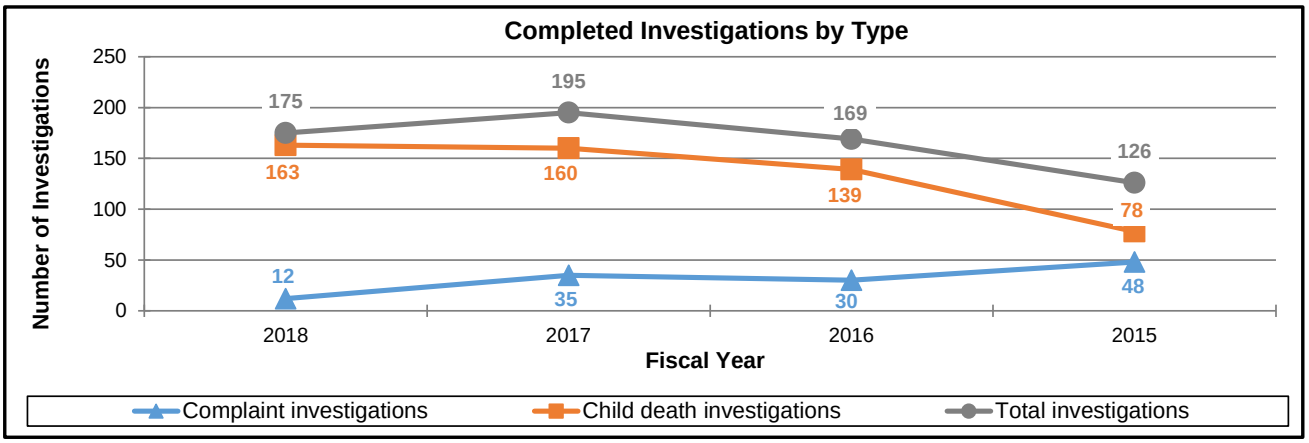
SUPPLEMENTAL INFORMATION

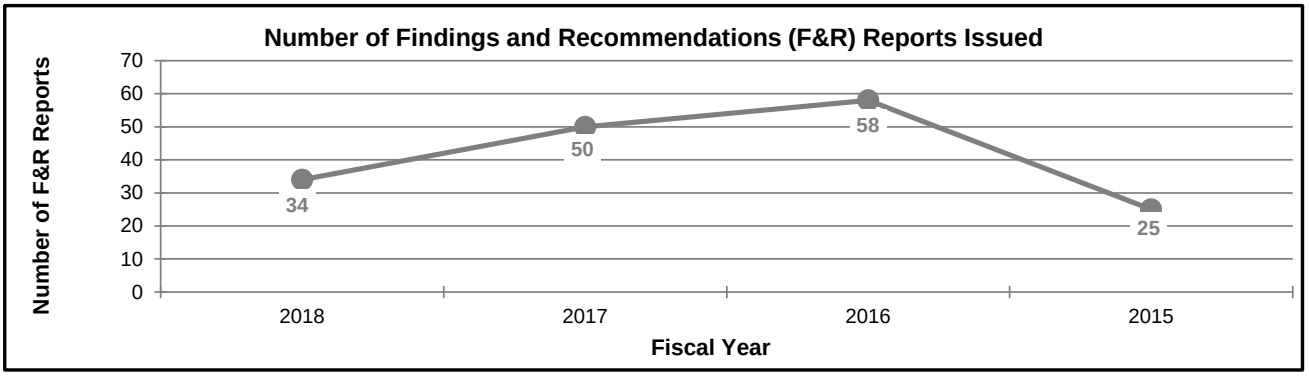
UNAUDITED

OFFICE OF CHILDREN'S OMBUDSMAN
Department of Technology, Management, and Budget

OCO Historical Data
For Fiscal Years 2015 Through 2018







Source: The OAG prepared this exhibit using data from OCO's database.

AGENCY DESCRIPTION

OCO was established as an autonomous* State agency by Act 204 of 1994. Organizationally, OCO is placed within DTMB.

OCO's mission is to assure the safety and well-being of Michigan's children in need of foster care, adoption, and protective services and to promote public confidence in the child welfare system. OCO accomplishes this through independently investigating child welfare complaints and child deaths, advocating for children, and recommending changes to improve law, policy, and practice to improve outcomes for children who for reasons of child abuse or neglect are under the jurisdiction, control, or supervision of MDHHS or its contracted private child placing agencies, the Michigan Children's Institute, the family division of the circuit court, or a child caring institution.

As of September 30, 2018, OCO employed 6 investigators, 2 intake staff, 1 chief investigator, 1 executive assistant to the Children's Ombudsman, and the Children's Ombudsman.

OCO's appropriations totaled $1,801,600 and $1,814,900 for fiscal years 2017 and 2018, respectively.

** See glossary at end of report for definition.*

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine the activities and records of OCO. We conducted this performance audit* in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our audit was not directed toward reaching a conclusion regarding the accuracy or completeness of data in MiSACWIS. Accordingly, we provide no such conclusion. We released a performance audit report on the Michigan Statewide Automated Child Welfare Information System (MiSACWIS), Michigan Department of Health and Human Services and Department of Technology, Management, and Budget, in June 2017. Copies of that report are available at audgen.michigan.gov.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered October 1, 2014 through September 30, 2017; however, our testing of selected attributes related to OCO's efforts to properly address complaints and other communications received covered October 1, 2014 through September 30, 2018.

METHODOLOGY

We conducted a preliminary survey to gain an understanding of OCO's operations and activities in order to establish our audit objectives, scope, and methodology. During our preliminary survey, we:

- Interviewed OCO management and staff to obtain an overall understanding of OCO's operations and activities.
- Reviewed OCO policies and procedures and applicable laws.
- Examined OCO's annual reports, MiScorecard reports, and other publicly available information.
- Analyzed OCO's expenditure, contact, and investigation data from October 1, 2014 through September 30, 2017.
- Performed limited preliminary testing of OCO's intake procedures for complaints and other communications and investigations.

** See glossary at end of report for definition.*

OBJECTIVE #1

To assess the effectiveness of OCO's efforts to properly address complaints and other communications received.

To accomplish this objective, we:

- Judgmentally and randomly sampled 83 complaints and other communications, from a population of 3,906 that OCO did not open for investigation between October 2014 and September 2018, to assess whether OCO's categorization of the communication, related actions, and decision to decline an investigation were reasonable, supported, and in compliance with applicable laws and OCO policy.

- Randomly sampled 50 investigations, from a population of 589 cases that OCO opened between October 2014 and September 2018, to assess whether OCO's determination to open an investigation was reasonable, supported, and in compliance with applicable laws and OCO policy and whether OCO appropriately notified MDHHS of its intention to conduct the investigation.

- Judgmentally and randomly sampled 78 child welfare complaints, from a population of 2,681 received between October 2014 and September 2017, to assess the timeliness of OCO's initial contact with the complainants.

- Performed limited review of security over OCO's Web-based complaint form.

- Conducted a telephone questionnaire of 13 other states' children ombudsman offices to obtain an understanding of how other ombudsman offices received, addressed, and recorded incoming complaints and other communications.

Our random samples were selected to eliminate any bias and enable us to project the results to the population. We selected other samples judgmentally and, therefore, could not project those results to the respective populations.

OBJECTIVE #2

To assess the sufficiency of OCO's efforts to conduct investigations of child welfare complaints and deaths.

To accomplish this objective, we:

- Randomly and judgmentally sampled 30 investigations, from the population of 430 investigations completed between October 2014 and September 2017, to verify that OCO's conclusions were appropriately supported by the related MDHHS case file information in MiSACWIS.

- Reviewed a random sample of 12 F&R reports, from the population of 118 issued between October 2014 and

September 2017, to determine if OCO appropriately verified that MDHHS implemented corrective actions related to the recommendations.

- Reviewed the 10 RFA letters OCO issued to MDHHS between October 2014 and September 2017 to determine the timeliness of OCO's identification of the issues that required immediate action to protect children and its reporting of the issues to MDHHS.

- Compared investigation assignment and completion dates for the population of 490 investigations completed between October 2014 and September 2017 to determine the timeliness of OCO's completion of investigations.

- Examined OCO's peer review procedures for investigations and verfied that OCO's investigation documentation supported that the process was utilized for the 30 randomly sampled investigations that we reviewed.

- Reconciled OCO's record of child death alerts received from MDHHS to MDHHS's log of child death alerts sent to OCO, from January 2015 through August 2017, to determine whether OCO's records contained all child death alerts sent from MDHHS.

- Tested a judgmental sample of 38, from a population of 93 child deaths not sent to OCO and identified through MDHHS's procedures between July 2017 and September 2017, to determine if the 38 deaths should have been alerts sent to OCO and investigated by OCO.

- Verified that OCO staff had direct access to MDHHS's MiSACWIS records to complete investigations.

We used random sampling to eliminate any bias and enable us to project the results to the entire population. The results from our judgmental samples could not be projected to the respective populations.

OBJECTIVE #3

To assess whether OCO sufficiently reported selected information to designated parties.

To accomplish this objective, we:

- Reviewed OCO's annual reports to the Governor, Legislature, and MDHHS for fiscal years 2015 and 2016 and verified the accuracy of judgmentally selected key figures from those reports.

- Verified that OCO consistently submitted MiScorecard information throughout the audit period to report performance on the timeliness of investigations and initial contact with complainants.

- Randomly and judgmentally sampled 43 investigations, from the population of 430 investigations completed between October 2014 and September 2017 to determine compliance with policy for release of information and reporting of findings to intended parties.

We used random sampling to eliminate any bias and enable us to project the results to the entire population. The results from our judgmental sample could not be projected to the population.

CONCLUSIONS

We base our conclusions on our audit efforts and any resulting material conditions or reportable conditions.

When selecting activities or programs for audit, we direct our efforts based on risk and opportunities to improve State government operations. Consequently, we prepare our performance audit reports on an exception basis.

AGENCY RESPONSES

Our audit report contains 3 findings and 3 corresponding recommendations. OCO's preliminary response indicates that it agrees with all of the recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion at the end of our fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require an audited agency to develop a plan to comply with the recommendations and to submit it to the State Budget Director upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

PRIOR AUDIT FOLLOW-UP

Following is the status of the reported findings from our January 2013 performance audit of the Office of Children's Ombudsman, Department of Technology, Management, and Budget (071-0176-12):

Prior Audit Finding Number	Topic Area	Current Status	Current Finding Number
1	Access to MDHHS's Computer Networks	Complied	Not applicable
2	Timeliness of Investigations	Rewritten*	3
3	Follow-Up of Corrective Actions	Complied	Not applicable

SUPPLEMENTAL INFORMATION

Our audit report includes supplemental information. Our audit was not directed toward expressing a conclusion on this information.

** See glossary at end of report for definition.*

GLOSSARY OF ABBREVIATIONS AND TERMS

autonomous	Not controlled by others or by outside forces; independent.
complainant	An individual who makes a complaint to the Children's Ombudsman with respect to a particular child, alleging that an administrative act is contrary to law, rule, or policy; imposed without adequate statement or reason; or based on irrelevant immaterial, or erroneous grounds.
consumer contacts	Issues that are not about a child in the child welfare system, such as how to become a licensed foster parent or adopt a child in Michigan; complaints from other states about a child not in Michigan's child welfare system; or requests for information. In addition, consumer contacts include complaints involving child-related issues that OCO does not have jurisdiction to investigate, such as Friend of the Court or child custody matters, cash assistance, and truancy or school concerns. Consumer contacts also include referrals that are concerns about a child involved in the child welfare system but may involve actions of an entity or a person that OCO is not authorized to investigate, such as the court, law enforcement, or an attorney.
CPL	Child Protection Law.
CPS	children's protective services.
DTMB	Department of Technology, Management, and Budget.
effectiveness	Success in achieving mission and goals.
F&R	findings and recommendations.
material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program. Our assessment of materiality is in relation to the respective audit objective.
MDHHS	Michigan Department of Health and Human Services.

MiSACWIS	Michigan Statewide Automated Child Welfare Information System.
MiScorecard	Part of the State of Michigan's goal to increase accountability and transparency. The monthly MiScorecard reports current performance levels for certain areas within the various departments and serves as an internal management tool for decision-makers.
mission	The main purpose of a program or an entity or the reason that the program or the entity was established.
observation	A commentary that highlights certain details or events that may be of interest to users of the report. An observation may not include the attributes (condition, effect, criteria, cause, and recommendation) that are presented in an audit finding.
OCO	Office of Children's Ombudsman.
OFA	Office of Family Advocate.
ombudsman	A Swedish term for an appointed government official who investigates complaints, reports findings, and helps achieve solutions.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision-making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
request for action (RFA)	A situation that an investigator identifies which requires MDHHS's immediate action to protect a child.

rewritten	The recurrence of similar conditions reported in a prior audit in combination with current conditions that warrant the prior audit recommendation to be revised for the circumstances.
SOM	State of Michigan.

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