Office of the Auditor General
Follow-Up Report on Prior Audit Recommendations

Office of Children's Ombudsman
Department of Technology, Management, and Budget

January 2023

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

071-0176-17F

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

Article IV, Section 53 of the Michigan Constitution

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Report Summary

Follow-Up Report

Office of Children's Ombudsman (OCO)

Department of Technology, Management, and Budget (DTMB)

Report Number:
071-0176-17F

Released:
January 2023

We conducted this follow-up to determine whether OCO had taken appropriate corrective measures in response to the material condition noted in our April 2019 audit report.

Prior Audit Information	Follow-Up Results		
	Conclusion	Finding	Agency Preliminary Response
Finding 3 - Material condition Enhanced procedures needed to identify child deaths requiring OCO investigation. Agency agreed.	Complied	Not applicable.	

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January 6, 2023

Ms. Suzanna Shkreli, Children's Ombudsman
Director, Office of Children's Ombudsman
Department of Technology, Management, and Budget
George W. Romney Building
Lansing, Michigan
and
Ms. Michelle Lange, Director
Department of Technology, Management, and Budget
Elliott-Larsen Building
Lansing, Michigan

Dear Ms. Shkreli and Ms. Lange:

This is our follow-up report on the material condition (Finding 3) and corresponding recommendation reported in the performance audit of the Office of Children's Ombudsman, Department of Technology, Management, and Budget. That audit report was issued and distributed in April 2019. Additional copies are available on request or at audgen.michigan.gov.

We appreciate the courtesy and cooperation extended to us during our follow-up. If you have any questions, please call me or Laura J. Hirst, CPA, Deputy Auditor General.

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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OFFICE OF CHILDREN'S OMBUDSMAN

INTRODUCTION, PURPOSE OF FOLLOW-UP, AND AGENCY DESCRIPTION

INTRODUCTION

This report contains the results of our follow-up of the material condition* (Finding 3) and corresponding recommendation reported in our performance audit* of the Office of Children's Ombudsman (OCO), Department of Technology, Management, and Budget (DTMB), issued in April 2019.

PURPOSE OF FOLLOW-UP

To determine whether OCO had taken appropriate corrective measures to address our corresponding recommendation.

AGENCY DESCRIPTION

OCO was established as an autonomous* State agency by Act 204 of 1994 and is organizationally placed within DTMB. OCO's mission* is to help improve Michigan's child* welfare system through awareness, advocacy, public education, review, and recommendation. OCO accomplishes this through independently investigating complaints and child deaths, advocating for children, and recommending changes to law, policy, and practice to improve outcomes for children involved in Michigan's child welfare system.

The Children's Ombudsman* Act (Sections 722.921 - 722.932 of the *Michigan Compiled Laws*) requires OCO to conduct a preliminary investigation* of all child deaths that occurred or are alleged to have occurred because of abuse or neglect in the following situations:

- The child died during an active children's protective services (CPS) investigation* or an open services case.
- The child had history of a CPS complaint within two years.
- The child died while in foster care or while in an active foster care case.
- The child's death occurred within two years of closing a foster care case for the child or child's sibling.

The focus of an OCO child death investigation is to determine whether interventions by the Michigan Department of Health and Human Services (MDHHS) and/or a private child placing agency prior to the 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.

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

The Child Protection Law 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.

Accordingly, when a child's death occurs under these circumstances and is recorded in MDHHS's Michigan Statewide Automated Child Welfare Information System (MiSACWIS), OCO receives an automated notification from MiSACWIS regarding the child's death.

Also, in September 2021, OCO implemented a secondary child death alert process to help OCO independently identify deaths which may require an OCO investigation.

OCO evaluates notification information received and other relevant information to determine the circumstances under which the child died and whether a full OCO investigation must be conducted. For example, if a child dies while in foster care, the OCO would evaluate the cause and manner of death and the circumstances surrounding the death to determine if child abuse or neglect was involved in the death. If the child died from natural causes and not child abuse or neglect, an OCO investigation would not be required. According to OCO's most recently published annual report, OCO received a total of 319 alerts in calendar year 2021 and opened full investigations* for 60.

OCO employed 13 staff as of June 30, 2022, and its appropriations totaled $1.9 million and $2.1 million for fiscal years 2021 and 2022, respectively.

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

PRIOR AUDIT FINDING AND RECOMMENDATION, AGENCY PLAN TO COMPLY, AND FOLLOW-UP CONCLUSION

FINDING 3

Audit Finding Classification: Material condition.

Summary of the April 2019 Finding:
OCO placed primary reliance on MDHHS's child death alert process to identify child deaths which may require OCO investigation. In July 2017, MDHHS notified OCO it had identified deaths that occurred in 2016 for which it had not provided an 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 from 2014 through 2017 with no associated alert to OCO. In response, MDHHS implemented an ancillary weekly procedure to capture death information documented in other MiSACWIS records in an effort to identify missed alerts. However, a risk still existed that OCO's primary reliance on MDHHS would not ensure it received timely notifications of all child deaths subject to OCO's investigation requirement.

Recommendation Reported in April 2019:
We recommended that OCO enhance its procedures to independently identify child deaths that require OCO investigations.

AGENCY PLAN TO COMPLY*

On December 26, 2019, OCO indicated it had worked with MDHHS to create a project to match State vital record* child death certificates to MiSACWIS. If there was a name match, OCO planned to receive an automated alert and review the child death to determine whether OCO should open an investigation.

FOLLOW-UP CONCLUSION

Complied.

Our review noted:

- OCO implemented an automated electronic secondary alert process on September 27, 2021 to independently identify child deaths which may require OCO investigation. This daily process matches State vital record child death certificates to MiSACWIS child welfare records and notifies OCO of any resulting matches. In addition:
    - OCO is the business owner of the script that executes the secondary match. This provides OCO control over future script revisions which may be necessary to ensure OCO captures all necessary child deaths pursuant to its statutory obligations.

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

- OCO devoted resources to support the secondary alert process, including creating and staffing an analyst position to process secondary alerts.

- OCO developed policy and procedures, including relevant controls, for the receipt and processing of secondary alerts.

- During our review, we identified 25 child deaths not captured by OCO's secondary alert process because a script* error occurred in the execution of the daily match process. Subsequent to our notification, OCO asserted it corrected the script error on September 9, 2022, conducted a preliminary investigation for each of the 25 child deaths, and determined none required a full investigation under OCO's statutory requirements.

- OCO implemented additional informal processes, such as receiving online news media alerts, to further identify child deaths which may require an investigation.

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

FOLLOW-UP METHODOLOGY AND PERIOD

METHODOLOGY

We reviewed OCO's corrective action plan and conducted interviews with management to obtain an understanding of OCO's procedures to independently identify child deaths that require OCO investigations. In addition, we:

- Performed an independent match of all child deaths occurring from October 1, 2021 through June 13, 2022 which were recorded in the State's vital records to MiSACWIS child welfare records and compared the resulting identified child deaths with OCO's records to verify OCO had received notification of all potential child deaths relating to child abuse or neglect through its child death alert processes.

- Reviewed OCO's secondary death alert e-mail inbox to verify OCO regularly received secondary child death alerts beginning September 27, 2021 through the end of our review period on June 30, 2022.

- Confirmed OCO is the business owner of the script that executes the secondary child death alert match via our communication with the applicable IT team.

- Verified OCO filled an analyst position in March 2022 to process secondary child death alerts through our review of OCO's organizational chart, position description documentation, and OCO records demonstrating the individual processed secondary child death alerts.

- Validated OCO developed and implemented policy and procedures for the receipt and processing of secondary child death alerts.

- Randomly and judgmentally selected 32 unduplicated secondary child death alerts from the population of 89 that OCO received from October 6, 2021 through July 5, 2022 and reviewed OCO records to verify OCO processed the alerts in accordance with its established policy and procedures.

- Observed OCO's receipt of applicable online news media alerts.

PERIOD

Our follow-up generally covered October 1, 2021 through June 30, 2022.

GLOSSARY OF ABBREVIATIONS AND TERMS

agency plan to comply	The response required by Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100). The audited agency is required to develop a plan to comply with Office of the Auditor General audit recommendations and to submit the plan to the State Budget Office 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.
autonomous	Not controlled by others or by outside forces; independent.
child	An individual under the age of 18.
CPS	children's protective services.
DTMB	Department of Technology, Management, and Budget.
full investigation	An act of fact finding, document review, or systematic inquiry or examination that occurs after the completion of a preliminary investigation.
investigation	Either a preliminary investigation or a full investigation.
IT	information technology.
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.

mission	The main purpose of a program or an entity or the reason the program or the entity was established.
OCO	Office of Children's Ombudsman.
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.
preliminary investigation	An act of fact finding, document review, or systematic inquiry or examination to determine if there is a correlation between an administrative act and the death of a child or to determine if a trend of systematic issue is identified that would cause the ombudsman to open a full investigation.
script	A set of commands executed by an operating system or application.
vital records	Register of death, birth, marriage, and divorce certificates for all events that occur in Michigan, with records dating back to 1867.

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