Legislative Analysis

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CHILDREN'S OMBUDSMAN FINDINGS AND PRELIMINARY INVESTIGATIONS

House Bill 5248 (H-2) as reported from committee
Sponsor: Rep. Matt Hall

House Bill 5249 as reported from committee
Sponsor: Rep. Andrea K. Schroeder

1st Committee: Families, Children and Seniors
2nd Committee: Ways and Means
Complete to 5-31-20 ***(Enacted as Public Acts 185 and 186 of 2020)***

SUMMARY:

House Bills 5248 and 5249 would amend the Children's Ombudsman Act to require the ombudsman to release certain findings and recommendations to the public and to require the ombudsman to conduct a preliminary investigation into certain child fatality cases before determining whether a full investigation is needed.

House Bill 5248 would require that, no later than 30 days after the closure date of a case investigated by the Office of Children's Ombudsman (OCO), the ombudsman must release his or her findings, recommendations, and the agency responses, if any, to the public. The ombudsman would have to redact confidential information consistent with state and federal law.

Under the act, if the ombudsman identifies action or inaction by the state that failed to protect children, he or she must provide findings and recommendations to the agency affected and make those findings available to the complainant and the legislature upon request, to the extent consistent with law. In general, a record of the OCO is confidential, is not subject to court subpoena, is not discoverable in a legal proceeding, and is exempt from disclosure under the Freedom of Information Act. Section 9 prescribes further conditions under which the ombudsman may, and may not, release certain records or information under the act.

MCL 722.929

House Bill 5249
Currently, the OCO is required to investigate all child fatality cases that occurred or are alleged to have occurred due to child abuse or child neglect in the following situations:

- A child died during an active Child Protective Services (CPS) investigation or open case or there was an assigned or rejected CPS complaint within the 24 months preceding the child's death.
- A child died while in foster care, unless the death was from natural causes and there were no prior CPS or licensing complaints concerning the foster home.

- A child was returned home from foster care and there is an active foster care case.
- The foster care case involving the dead child or sibling was closed within the 24 months preceding the child's death.

The bill would instead require the OCO to conduct a ***preliminary investigation*** into all child fatality cases that occurred or were alleged to have occurred due to child abuse or child neglect in one or more of the situations described above.

Preliminary investigation would mean 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 or systematic issue is identified that would cause the ombudsman to open a full investigation.

Upon completing a preliminary investigation, the OCO would have to determine whether a ***full investigation*** was necessary and, if so, open a full investigation.

Full investigation would mean an act of fact finding, document review, or systematic inquiry or examination that occurs after the completion of a preliminary investigation.

Subject to state appropriations, a full investigation would have to be completed within 12 months after the OCO opened it. (This is the same time frame within which an investigation must be completed, subject to appropriations, under current law.)

MCL 722.922 and 722.926

BACKGROUND:

The Office of Children's Ombudsman was established in 1994 as an autonomous state agency charged with investigating complaints concerning the safety or welfare of children who need protective services, foster care, or adoption. The OCO is required to investigate all child fatality cases that occurred in the circumstances described above (HB 5249). The OCO also may recommend changes to rules or the law concerning child welfare issues. The ombudsman is appointed by the governor with the advice and consent of the Senate.[1]

In April 2019 the Office of the Auditor General released its performance audit report on the operations of the OCO.[2] Among other things, the report found that resource limitations, combined with the mandate to investigate child fatalities as described above, served to restrict the number of investigations the OCO could conduct of other complaints it received concerning child safety or welfare. (According to the report, "Almost 85% of the investigations that OCO conducted from October 1, 2014 through September 30, 2018 were mandated child death investigations.")

The House Committee on Oversight held hearings on the audit report in 2019 and unanimously referred a report of its legislative recommendations to the House Committee

[1] 2019 OCO annual report: https://www.michigan.gov/documents/oco/Annual_Report_2019_686899_7.pdf
[2] https://audgen.michigan.gov/wp-content/uploads/2019/04/r071017617-4312.pdf

on Families, Children and Seniors.[3] The committee's report contains two legislative proposals, quoted below:

- "Require or allow the OCO to publicly release its findings and recommendations and an agency's written responses to those findings and recommendations in all child death investigations. Currently, these findings must remain confidential."
- "Allow the OCO some discretion with regard to investigations in child death cases. Full investigations may not be necessary in all cases in which the OCO becomes involved. Allowing preliminary investigations in certain circumstances may free up time to allow the OCO to devote more time and resources to investigating other complaints."

These proposals are respectively reflected in HBs 5248 and 5249. According to committee testimony, requiring the OCO to publicly release its findings and recommendations and an agency's response to them, as HB 5248 would do, could help uncover trends in child fatalities or issues with the child welfare system and ultimately provide for greater transparency, public awareness, agency accountability, and child safety. The rationale for HB 5249 is described in the second bulleted item above.

FISCAL IMPACT:

House Bills 5248 and 5249 would have minimal fiscal impact on the State of Michigan and no fiscal impact on local units of government. HB 5249 would change the current statutory provisions requiring the OCO to investigate all child fatality cases that occurred from child abuse or child neglect to requiring that the OCO conduct a preliminary investigation into all these cases. After the preliminary investigation, the OCO shall determine whether a full investigation is then needed. In FY 2017-18, the OCO received 338 child death complaints. Of those, an investigation was opened in 141. It might be that fewer full investigations would be conducted under the bill's provisions.

POSITIONS:

The Michigan Press Association indicated support for the bills. (3-4-20)

A representative of the Office of Children's Ombudsman testified with no position on the bills. (3-4-20)

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■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.

[3] https://www.house.mi.gov/MHRPublic/CommitteeDoc.aspx?uri=api/integration/committee_documents/content/?revno=-1&apn=2019_2020_session/committee/house/standing/families,_children,_and_seniors/meetings/2020-03-04-1/documents/testimony/Rep.%20Matt%20Hall,%20Oversight%20Chair.pdf