TENNESSEE COMPTROLLER OF THE TREASURY

PERFORMANCE AUDIT REPORT

Department of Children's Services

December 2022

Jason E. Mumpower
Comptroller of the Treasury

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Jason E. Mumpower
Comptroller

December 13, 2022

The Honorable Randy McNally
Speaker of the Senate
The Honorable Cameron Sexton
Speaker of the House of Representatives
The Honorable Kerry Roberts, Chair
Senate Committee on Government Operations
The Honorable John D. Ragan, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Margie Quin, Commissioner
Department of Children's Services
315 Deaderick Street
UBS Tower, 10th Floor
Nashville, Tennessee 37238

Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Department of Children's Services for the period August 1, 2020, through August 31, 2022.[1] This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, *Tennessee Code Annotated*.

Our audit disclosed findings, conclusions, and recommendations in this report. Management of the Department of Children's Services has responded to the audit findings, conclusions, and recommendations, and we have included the responses in the respective sections. We will follow up the audit to examine management's corrective actions instituted because of the audit findings.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the Department of Children's Services should be continued, restructured, or terminated.

Sincerely,

Katherine J. Stickel, CPA, CGFM, Director
Division of State Audit

KJS/sp/ls
22/033

[1] For certain audit objectives, which can be found in **Appendix 1** under the Methodologies, our audit scope extended beyond this period.

DIVISION OF STATE AUDIT • PERFORMANCE AUDIT • DECEMBER 2022

DEPARTMENT OF CHILDREN'S SERVICES

AUDIT HIGHLIGHTS

Department of Children's Services' Mission

Provide high quality prevention and support services to children and families that promote safety, permanency and well-being.

Department of Children's Services' Vision

To create safe and healthy environments for children where they can live with supportive families and engaged communities.

The Department of Children's Services is struggling to provide support services to Tennessee's most vulnerable children and youth

Report Overview

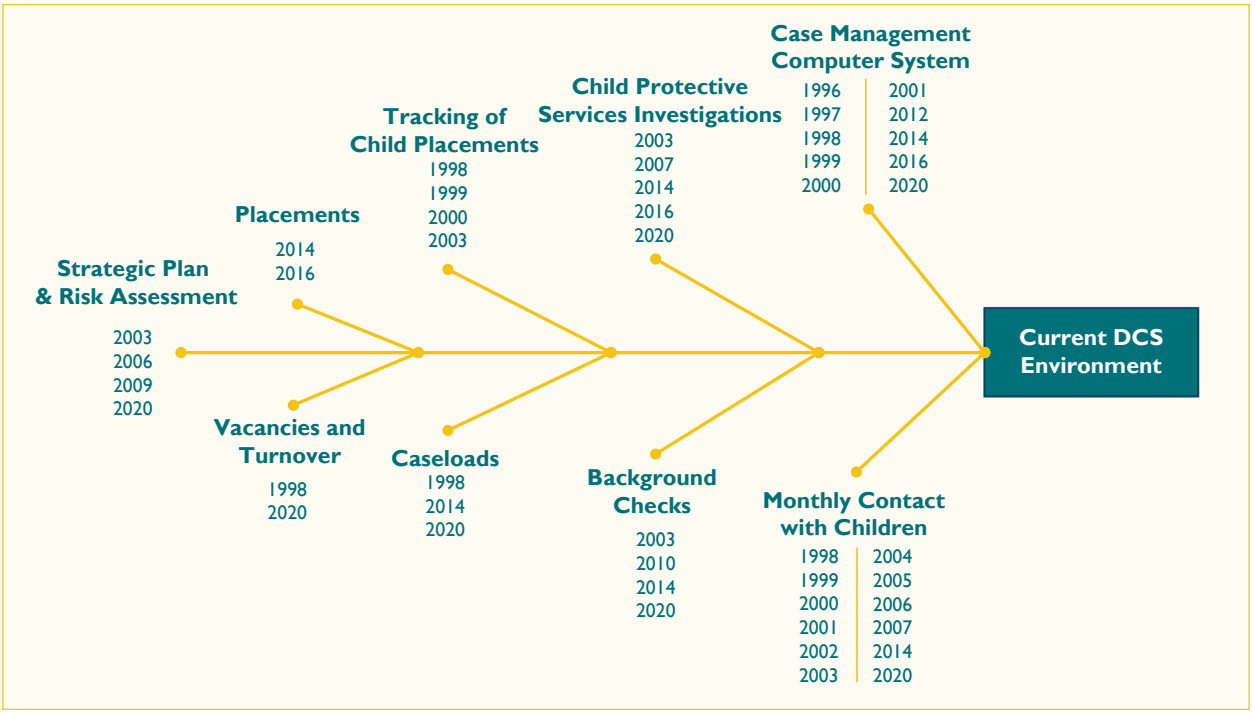
The safety, permanency, and well-being of Tennessee's most vulnerable children is in jeopardy by management's failure to

1. identify the risks DCS faces and develop an impactful strategic plan to address both long-standing and current issues;
2. curtail the escalating turnover of case managers, which has led to ever-increasing caseloads, and prioritize hiring strategies to fill case manager vacancies;
3. expand long-term placement options and set standards for consistent quality of facilities for children placed in temporary settings;
4. fully respond to child abuse and neglect allegations, including sexual abuse and sexual harassment, regardless of the child's placement, and especially in all residential facilities; and
5. ascertain ways to overcome a failing case management system.

In the time since the Department of Children's Services was created in 1996, DCS has faced recurring issues management has struggled to address. Over the years, our office's financial and performance audits of DCS have highlighted the following recurring issues, listed in **Figure 1**.

Scheduled Termination Date
June 30, 2023

Figure 1
Long-Standing Issues Covered in This Report



Source: Auditor created based on our review of prior financial and performance reports.

Key Takeaways

Background
Since 2020, DCS has had, on average, over 8,000 children in custody each month. These children are vulnerable and are often the victims of child abuse and neglect.

Purpose
Our goal was to determine what changes and improvements DCS can make to better promote the safety, permanency, and well-being of children and youth in DCS's care.

1. With the recent transition to new leadership, DCS management and top state leadership have the opportunity to step back and reevaluate DCS's approach to strategic planning and risk management to create impactful, lasting change that improves the lives of the families and children they serve. We found that DCS did not assess risks or develop controls in several areas that we have both previously reported and found in the current audit. Without committing to a robust strategic planning and risk assessment process, management hinders their ability to address the root cause of and to fix systemic issues that have plagued DCS for years.
2. Case managers are the backbone of DCS; without them, DCS cannot meet its mission to serve the state's most vulnerable citizens, the children of Tennessee. Case manager turnover and employee vacancies at DCS have reached crisis levels while the number of children going into DCS custody continues to rise. Top leadership must take more aggressive action to hire and retain case managers or risk the safety of vulnerable children who *slip through the cracks* because there is no one to help them.
3. When children are unable to safely stay in their own homes, DCS is responsible to provide placements that meet the children's emotional, physical, and social needs. The lack of available foster homes, rather than the needs of foster children, continues to present serious challenges to DCS's ability to make placement decisions. Case managers must find temporary placement locations such as state office buildings or transitional houses for extended durations. Additionally, DCS employees struggle to make quick placement decisions (for either long-term or temporary placements) because the case management system is not designed to capture child placement data and placement availability resulting in negative impacts on both children and department employees. The Commissioner must expedite efforts to retain placements and to expand the placement network. Management should continue to explore better alternatives to office buildings for temporary placements and set standards for consistent quality of facilities for temporary placements so case managers can efficiently place children in safe settings that meet their needs.
4. The most important responsibility of DCS is to keep children safe from harm. DCS was created as the statewide child welfare entity charged with the responsibility to remove children from environments that may cause them harm, to keep children safe while in state custody, and to investigate allegations of abuse or neglect. All allegations represent a child in a potentially unsafe environment. We found critical child safety incidents and risks in several of the department's processes. Specifically, we found that

- Children may have remained in unsafe situations because management has not met established timelines for key points of child abuse and neglect investigations.
- DCS did not ensure that reported allegations of sexual abuse, sexual harassment, or lack of supervision of custodial children living in residential facilities were investigated.
- DCS has not developed an effective and efficient process to respond to sexual abuse and harassment allegations to keep children in residential facilities safe.
- Deficiencies in management's Provider Quality Team (PQT) review process contributed to the PQT not identifying a questionable provider employee, to prevent his contact with children in state custody, and to avoid child endangerment.

We recommend the Commissioner and Deputy Commissioner of Child Safety take immediate action to prioritize these safety risks and take actions needed to eliminate unsafe environments for children in DCS care.

5. Ensuring that children and youth in DCS custody have the medical and dental services they need is critical to children's health. DCS determines what health services a child needs through medical and dental screenings. Management should automate the process for medical and dental screenings and supervisory reviews to ensure children and youth in custody receive timely health care services.
6. The DCS information system, TFACTS, is vital to DCS's ability to maintain case management information so that DCS management and case managers can make informed decisions about the children and families in DCS's care. TFACTS is the central point for all information regarding children and families DCS serves. Since TFACTS was implemented in 2010, DCS has been challenged with system functionality issues including delayed foster parents' payments, slow system processing, and unexpected user logouts. While DCS was able to implement the financial component in November 2021, and the enhancement improved DCS's ability to complete financial transactions to foster care families and providers, the new enhancement negatively impacted the system's non-financial functionality. These setbacks involved management and staff's inability to run needed program reports and to maintain data efficiency and accuracy. Given the long-standing issues with TFACTS, DCS management must decide the best course to ensure the case management system has the capability and functionality to help management effectively and efficiently care for the children in custody or at risk of custody and to provide the best automated resources and tools to DCS employees to achieve all of DCS's goals.

Recommendations

This report contains 13 findings, 1 observation, and 2 matters for legislative consideration with recommendations that address DCS's challenges with strategic planning and risk assessment, case manager turnover and caseloads, child placement, child safety, child health, and information systems.

AUDIT CONCLUSIONS

Findings

Strategic Planning and Risk Assessment

- Management's strategic plan and risk assessment processes fall short in developing goals, objectives, and controls to address long-standing issues and make lasting, permanent change to ensure the safety and well-being of children and families (page 8).

Case Manager Turnover and Caseloads

- Management's inability to fill vacant positions and failure to adequately address increasing turnover has created a staffing crisis and resulted in overworked and exhausted case managers serving children in a chaotic environment (page 14).
- Case managers' actual caseloads exceed the state maximum for average caseloads, and their workload does not allow them to provide the necessary attention and resources to the children and families for whom they are responsible (page 21).

Child Placement

- Tennessee faces a crisis-level shortage of long-term placement options to meet every child's needs, which has increased the number of children staying in temporary settings such as state office buildings and transitional houses (page 34).
- Children who stay in transitional homes or state office buildings across the state's temporary settings often experience inconsistent quality of facilities, resulting in unintended hardships for children (page 38).

Child Safety

- Children may have remained in unsafe situations because management did not meet certain key timelines for child abuse and neglect investigations (page 47).
- DCS did not ensure that reported allegations of sexual abuse, sexual harassment, or lack of supervision of custodial children living in residential facilities were investigated (page 50).
- DCS has not developed an effective and efficient process to respond to sexual abuse and harassment allegations to keep children in residential facilities safe (page 55).
- Deficiencies in management's PQT review process contributed to the PQT not identifying a questionable provider employee, to prevent his contact with children in state custody, and to avoid child endangerment (page 62).

- Rising turnover and caseloads have impacted juvenile justice case managers' ability to make the essential monthly supervision contacts with children, their families, schools, and service providers for children on probation and aftercare (page 70).

Child Health

- DCS cannot ensure timely dental and medical screenings given the reliance on paper forms and manual processes to complete, review, and follow up on children's medical and dental screenings; timely screenings are critical to identify potential health conditions and/or need for follow-up health services (page 74).

Tennessee Family and Child Tracking System (TFACTS)

- DCS cannot continue to rely on TFACTS as it currently exists, and management must carefully examine the costs and benefits between continuing to update TFACTS and implement necessary improvements or replacing TFACTS with a new system (page 80).
- As noted in the prior audit, DCS management and Strategic Technology Solutions management did not provide adequate internal controls in one area, increasing the risk of unauthorized access to sensitive data (page 84).

Observation

Child Safety

- Management needs to continue to improve the background check process to protect children from unsafe employees and volunteers (page 67).

Matters for Legislative Consideration

Case Manager Turnover and Caseloads

- The Commissioner should work with the General Assembly to assess and consider amending Section 37-5-132, *Tennessee Code Annotated*, to establish best practices and actual caseload sizes and bring much-needed relief to case managers' workloads (page 28).

Child Safety

- The General Assembly may wish to consider amending statutory language to define "person residing in the child's home" to clarify their intent for DCS's responsibility to investigate allegations of child-on-child sexual abuse between children ages 13 and 17 that occurred in a residential setting (page 53).

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INTRODUCTION

Audit Authority

We conducted this performance audit of the Department of Children's Services (DCS), pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated*. Under Section 4-29-244, DCS is scheduled to terminate June 30, 2023. Section 4-29-111 authorizes the Comptroller of the Treasury to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether DCS should be continued, restructured, or terminated.

Background

The Department of Children's Services was created by the General Assembly in July 1996 to, in partnership with the community, provide services to children who are unruly, delinquent, dependent, and neglected; at imminent risk and in need of services to prevent entry into state custody; or in state custody pending family reunification or other permanent placement. DCS focuses on services that support child safety, permanency, and well-being.

Child safety is supported through the Child Abuse Hotline and staff who conduct investigations of severe child abuse and neglect for children in their custody, as well as those in schools, daycares, and foster homes. DCS also serves adjudicated delinquent youth in custody, on aftercare, and on probation.

Child permanency services include foster care, adoption, family support, and child independent living. Tennessee strongly emphasizes keeping children in a family-like setting, and DCS strives to keep siblings together. While foster care is meant to be a temporary service until the child can be safely returned to their family, Tennessee foster parents are dually approved to adopt children who are unable to return to their immediate family.

Child well-being is managed through physical, emotional, behavioral, and educational health services. DCS also provides oversight, monitoring, and training for department staff, foster parents, and community partner employees.

For further background information on the department, see **Appendix 3** on department operations and **Appendix 4** for the department's organizational chart.

AUDIT SCOPE

We have audited the Department of Children's Services for the period August 1, 2020, through August 31, 2022. Our audit scope included assessments of program effectiveness, efficiency, internal controls, prospective analysis, and compliance with laws, regulations, policies, procedures, and provisions of contracts or grant agreements in the following areas:

- management's strategic planning and risk assessment to address the department's ongoing issues;
- management's response to case manager turnover and vacancies;
- management's process to find placements for children in DCS custody and management's use of temporary settings while they find appropriate placements;
- management's responsibility for child safety, including the investigation process for child abuse and neglect allegations;
- management's process for ensuring children in DCS custody receive child health and dental screenings; and
- management's enhancement of their case management system and the system's impact on case managers' ability to manage child cases.

We present more detailed information about our audit objectives, conclusions, and methodologies in Appendix 1 of this report.

We provide further information on internal control significant to our audit objectives in **Appendix 2**. In compliance with generally accepted government auditing standards, when internal control is significant within the context of our audit objectives, we include in the audit report (1) the scope of our work on internal control and (2) any deficiencies in internal control that are significant within the context of our audit objectives and based upon the audit work we performed.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient appropriate audit evidence to support the conclusions in our report. Although our sample results provide reasonable bases for drawing conclusions, the errors identified in these samples cannot be used to make statistically valid projections to the original populations.

We conducted our 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, recommendations, and conclusions based on

our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings, conclusions, and recommendations based on our audit objectives.

Department of Children's Services management is responsible for establishing and maintaining effective internal controls and for complying with applicable laws, regulations, policies, procedures, and provisions of contracts and grant agreements.

PRIOR AUDIT FINDINGS

Section 8-4-109(c), *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The prior audit report was dated December 2020 and contained 10 findings. According to our records, the Department of Children's Services (DCS) filed its report with the Comptroller of the Treasury on June 1, 2021. We conducted a follow-up of the prior audit findings as part of the current audit.

Status	Prior Audit Recommendations	Current Audit Results
Implemented 4	• Ensure monitors carefully document on the personnel tool all critical aspects of their reviews for provider background and safety checks, and identify background checks that were not completed before the provider employee started work • Ensure staff maintain documentation to support conclusions that juvenile detention centers complied with required staffing ratios • Ensure Wilder Youth Development Center's Prison Rape Elimination Act staffing plan assessment is completed each year • Ensure all of DCS's public records have Records Disposition Authorizations approved by the Public Records Commission and staff follow public records requirements; adhere to DCS's litigation hold; and follow requirements of the Records Management Division before destroying any public records	See **Appendix 1** for related conclusions
Partially Implemented 1	• Ensure Human Resources staff and volunteer coordinators keep accurate, complete volunteer records; conduct a comprehensive review of background check results for all existing DCS employees and volunteers; ensure all required background checks are completed as required; and implement controls to ensure staff accurately and completely document their review on the internal checklist	See **Observation 1**

Status	Prior Audit Recommendations	Current Audit Results
Corrective Action Not Implemented and Finding Repeated 5	• Ensure investigations are consistently and thoroughly conducted, documented, reviewed, and closed, and staff meet key investigative time benchmarks; and perform investigation quality reviews	See **Finding 6**
	• Ensure staff maintain documentation of dates and corrective actions providers took to address DCS's concerns; create a protocol that requires in-depth reviews or follow-up on Wilder employees named as an alleged perpetrator in multiple investigations; and document all in-depth reviews or monitoring and maintain that documentation	See **Finding 9**
	• Require team leaders to consistently document reviews of probation and aftercare cases; improve controls over supervisory review of staff over probation and aftercare; ensure staff are aware of and follow policy; require staff to use available reports as part of the supervisory review process; develop and instate new electronic monitoring division; and ensure staff document actions taken to resolve alert notifications	See **Finding 10**
	• Continue efforts to complete the TFACTS financial enhancement project to meet the expected go-live date	See **Finding 12**
	• Along with Strategic Technology Solutions, develop and consistently implement controls; assign staff to be responsible for ongoing monitoring of the risks and mitigating controls; and take action if deficiencies occur	See **Finding 13**

Strategic Planning and Risk Assessment

With the recent transition to new leadership, DCS management and top state leadership have the opportunity to step back and reevaluate DCS's approach to strategic planning and risk management to create impactful, lasting change that improves the lives of the families and children they serve.

We found that DCS did not assess risks or develop controls in several areas that we have both previously reported and found in the current audit. Without committing to a robust strategic planning and risk assessment process, management hinders their ability to address the root cause of and to fix systemic issues that have plagued DCS for years.

General Background

Tennessee's state agencies are statutorily required to complete strategic plans

A strategic plan is a set of goals and objectives that aims to guide the direction of an agency toward meeting its mission. The plan should include a description of the operational processes; skills and technology; and the human capital, information, and other resources required to achieve those goals and objectives. In Tennessee, state agencies are required by law to complete a strategic plan. According to Section 9-4-5602, *Tennessee Code Annotated*, which is part of the Tennessee Governmental Accountability Act of 2013,

A strategic plan is a set of goals and objectives that aims to guide the direction of an agency toward meeting its mission.

> The general assembly finds and declares that accountability in program performance is vital to effective and efficient delivery of governmental services, and to maintain public confidence and trust in government. To maximize accountability, a system of strategic planning, program performance measures, and performance audits should be implemented to measure the effectiveness and efficiency of governmental services. It is of paramount public importance that this system encourages full and candid participation by all agencies of state government. This system will generate information necessary to inform the public

fully and for the general assembly to make meaningful decisions about the allocation of scarce resources in meeting vital needs.

Each state agency is also required to develop a supplementary Customer Focused Government[2] plan each year, which supports an entity's overall strategic plan and includes key performance measures to track and monitor overall operation. A state agency's overall strategic plan and annual Customer Focused Government plans should help guide them toward meeting their mission by setting long-term overarching goals and short-term operational goals that track and monitor the agency's performance.

Each state agency must perform an annual risk assessment to identify risks to the organization and develop procedures to mitigate those risks

It is management's responsibility to provide a strong internal control system by identifying and evaluating what could go wrong and developing additional processes that mitigate those risks. This process is known as a risk assessment. To help state agencies prepare their risk assessments in compliance with the Financial Integrity Act of 1983,[3] the Tennessee Department of Finance and Administration provides guidance and resources, including "Management's Guide for Enterprise Risk Management and Internal Control," and incorporates the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book).[4] **Figure 2** provides a visual representation of the risk management process.

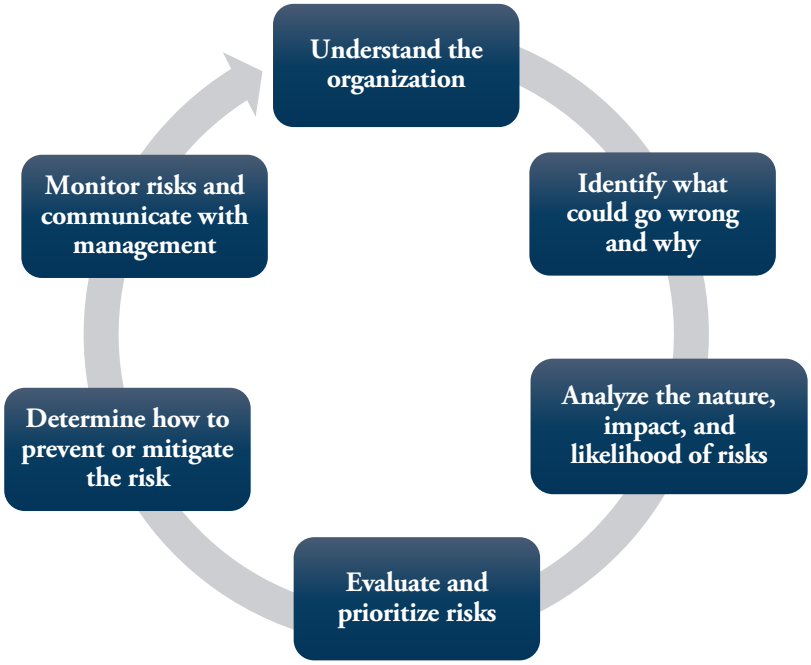
A risk assessment involves identifying and evaluating what could go wrong and developing additional processes to mitigate those risks.

[2] The Office of Customer Focused Government, under the Department of Finance and Administration, is responsible for overseeing and carrying out the requirements of the Governmental Accountability Act of 2013 in the form of annual Customer Focused Government plans.

[3] The Financial Integrity Act of 1983, located in Title 9, Chapter 18, *Tennessee Code Annotated*, requires each agency's management to annually perform a risk assessment and requires the head of each agency to issue an annual management report to the Department of Finance and Administration and the Comptroller of the Treasury.

[4] The Green Book defines the standards for internal controls through components and principles and explains why they are integral to the governmental entity's operations.

Figure 2
Risk Assessment Process



Source: Auditor created based on the Department of Finance and Administration's "Management's Guide for Enterprise Risk Management and Internal Control."

Together, the strategic plan, Customer Focused Government plan, and the risk assessment should guide management in their decision-making process to address the goals, objectives, and risks DCS faces.

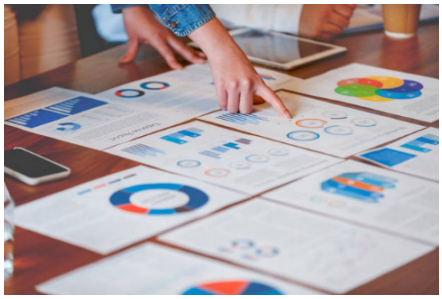
Finding 1

Management's strategic plan and risk assessment processes fall short in developing goals, objectives, and controls to address long-standing issues and make lasting, permanent change to ensure the safety and well-being of children and families

Management's strategic plan does not guide the direction of DCS toward meeting its mission and lacks urgency in finding solutions for problems DCS is facing now

We reviewed DCS's overall 2020–2024 strategic plan and found that while it does include a goal to "address workforce recruitment, training and retention," a major issue currently facing DCS, the objectives do not address the root causes for why DCS is struggling to recruit and retain qualified staff, including low pay, high caseloads, personal safety concerns, and a challenging work environment. Nor do they offer solutions for these issues.

We found that DCS did revise its strategic plan in April 2022 to include a new goal and related objectives intended to strengthen the development of their network of foster homes and residential facilities. While the objectives do seek to assess and strengthen DCS's current network of homes, the plan does not include steps to immediately decrease the reliance on temporary placements by expanding the long-term placement network.[5] Furthermore, the plan does not seek to address the underlying societal issues that drive the increased number of high-needs[6] children, nor does it address how that increase creates challenges to place children in the best environment for their situation.



We found that the strategic and customer focused plans were high-level, lacked clarity as to specific steps to address mission-critical issues, and lacked specificity as to how their goals and corresponding objectives would resolve long-standing issues. In addition, the plans did not include details of required resources (human capital, information, etc.) needed to achieve those goals and objectives. Without these fully developed plans, DCS, the Governor, and the General Assembly lack critical information to direct the state's limited resources to areas that promise the best return for the public's investment.

We also found that DCS's current strategic plan's objectives to achieve management's workforce recruitment, training, and retention goals are not expected to be fully implemented until June 2024, nearly two years in the future. DCS management faces a severe staffing shortage now, yet management's plans do not reflect a timeline that communicates a sense of urgency to deal with this issue.

Management's strategic plan also does not address long-standing problems for child safety, permanency, and well-being

We found DCS's 2020–2024 strategic plan does not address the internal and external factors that have contributed to long-standing problems such as

- the lack of a functional case management computer system,
- challenges with Child Protective Services' investigation timeliness and thoroughness,
- not completing monthly contact requirements with children, and
- issues completing background checks of employees and volunteers.

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[5] A temporary placement is a place, such as a state office building or a transitional house, where a child will stay when DCS cannot find any other placement available. See the **Child Placement** section for more information about temporary placements.

[6] According to management, DCS has the most challenge finding homes for children with mental health conditions, older teenagers, and juvenile delinquents.

DCS's strategic plan did not address the root cause of critical issues facing DCS right now. When these issues are not addressed, management and staff are unable to

- measure and determine if DCS is achieving its objectives,
- establish an effective internal control system,
- identify risks to the organization, or
- develop risk strategies around the organization's objectives.

A strategic plan should cover the overall approach that will be taken over the time period covered by the plan, including a schedule for significant actions and the needed resources.

Management did not fulfill their duty to conduct a comprehensive, entity-wide risk assessment

Management did not fully evaluate all program and operational areas within DCS in their risk assessment process in calendar year 2021, the most recent available. This included areas where we previously reported audit findings. Management's risk assessment process did not evaluate critical DCS operations for the offices of

- human resources,
- continuous quality improvement,
- information technology and support, and
- mental health and education programs.

We found that for the operational areas management did evaluate, either the identified risks were not specific enough to develop a well-defined control or the identified control was not specific enough for staff to know how to respond to the risk. For example, one of management's identified risks was simply stated as "PREA,"[7] and the related control listed was "reviews." Management did not sufficiently describe either the risk or the control so that staff responsible for this area knew what could go wrong and how they should prevent or mitigate these situations. Specifically, staff could not know whether management was referring to overall noncompliance with the PREA law, a risk of noncompliance with a subsection of the law such as timely investigations, an increase in sexual abuse in facilities, or any other topic because management did not explain what they meant by "PREA." As a result, management, staff, and we cannot be sure what they were trying to achieve. Because of PREA's importance to reduce sexual abuse of youth within

7 This is referring to the Prison Rape Elimination Act, which is a set of federal standards aimed at reducing the sexual abuse of youth within juvenile confinement facilities.

juvenile confinement facilities, the risk assessment must be crystal clear on what risks management identified to design and implement effective controls to avoid these situations happening to children.

Based on our discussions with management, DCS leadership did not fully understand their responsibility to develop a comprehensive risk assessment, which is the first step to achieving an effective internal control system. In addition, the former Commissioner did not hold program division and regional leadership accountable for evaluating risks in their areas of responsibility. As an example of this, we found that during the risk assessment process, not all of the divisions' leaders even responded to requests for risks identified within the division.

According to Green Book Principle 1.03, "Fundamental Concepts of Internal Control,"

> Internal control comprises the plans, methods, policies, and procedures used to fulfill the mission, strategic plan, goals, and objectives of the entity. Internal control serves as the first line of defense in safeguarding assets. In short, internal control helps managers achieve desired results through effective stewardship of public resources.

Without a comprehensive risk assessment process, management may not design and implement a robust internal control system to effectively achieve DCS's mission.

Recommendation

The Commissioner and DCS leadership should reevaluate their approach to strategic planning and embark on a robust risk assessment process. This starts with the Commissioner and top management ensuring all levels of management understand their responsibilities for strategic plan development. Ultimately the DCS Commissioner and leadership must ensure the strategic plan identifies goals and objectives that are aimed at the root cause of systemic issues and must also identify and mitigate risks across the department that threaten the department's ability to meet its mission.

The risk assessment should identify risks within every program area and should include effective controls to mitigate the identified risks. Additionally, management should continue to address the critical risks we have noted in each new or repeated finding or observation in this report, update the risk assessment as necessary, assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur.

Management's Comment

We concur with both parts of this finding.

For the risk assessment part TCA (9-18-02) mandates that each agency of state government annually perform a management assessment of risk. While we do have a quarterly process for monitoring key risks to the organization, we agree that it falls short of what a truly robust risk assessment process should look like. Management's Guide for Enterprise Risk Management and Internal Control and the Tennessee Department of Finance and Administration both provide excellent support that we have begun leveraging to remediate this finding. As of the date of this response, management has completed a new risk assessment for the major program areas Programs, Child Safety, Child Health, and Juvenile Justice as well as some of the divisions not previously looked at including Office of Continuous Quality Improvement, Human Resources, and IT Support. Interviews have been scheduled with the remaining area leaders with the full expectation that the risk assessment is completed by the time this report is finalized.

DCS has a Strategic Plan that we developed based in consultation with the Governor's administration. A revised Strategic Plan will be submitted to the Administration in the first quarter of 2023 based on the roadmap provided by the Comptroller audit. The Strategic Plan is reviewed quarterly with Customer Focused Government staff and updates are provided. DCS will continue to update the plan as needed.

Case Manager Turnover and Caseloads

Case managers are the backbone of the Department of Children's Services (DCS); without them, DCS cannot meet its mission to serve the state's most vulnerable citizens, the children of Tennessee.

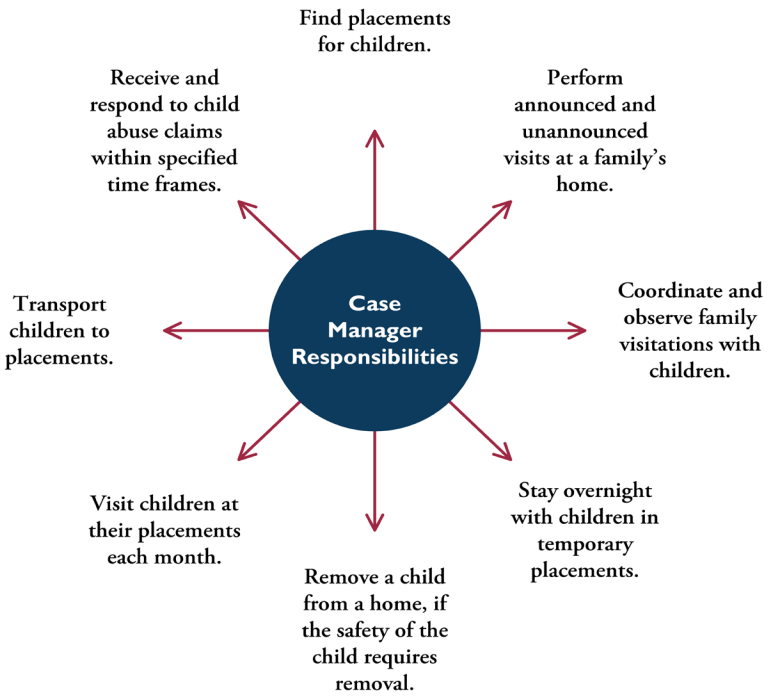
Case manager turnover and employee vacancies at DCS have reached crisis levels while the number of children entering DCS custody continues to rise. Top leadership must take more aggressive action to hire and retain case managers or risk the safety of vulnerable children who *slip through the cracks* because there is no one to help them.

General Background

Case managers provide the critical services fundamental to DCS and its mission

DCS's core responsibility, to see to the safety and well-being of children and their families, is carried out by case managers. They work various types of cases including child abuse allegations, foster care, and delinquent youth, and their responsibilities are crucial to DCS's mission (see **Figure 3**).

Figure 3
Examples of Case Managers' Responsibilities



Source: Auditor creation based on discussion with management and review of job descriptions.

Case managers account for **71%** of DCS's entire number of budgeted positions, and they typically work in one of three offices: Child Programs, Child Safety, or Juvenile Justice. There are four levels of case managers—new case managers start as a Case Manager 1 and receive increased responsibilities as they move up each level; Case Manager 4 is a supervisor position.

Each child served by DCS, whether in custody or at risk of coming into DCS custody, is represented by a case, and those cases have steadily increased over the past several years. As of July 2022, there were **9,041** children in DCS custody, a 7% increase from over 4 years ago. Furthermore, the number of filled case manager positions has declined by 17% over the same time period.

Finding 2

Management's inability to fill vacant positions and failure to adequately address increasing turnover has created a staffing crisis and resulted in overworked and exhausted case managers serving children in a chaotic environment

Case manager turnover rates have steadily risen to alarming levels

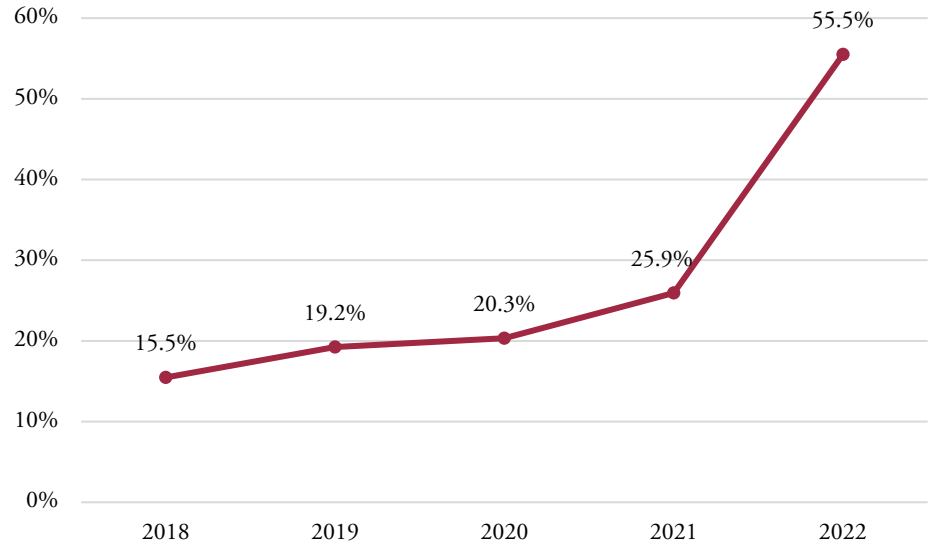
Each child is assigned a case manager upon entering DCS custody; however, those children are served by overworked case managers who are leaving DCS in high numbers. In fiscal year 2022, DCS's statewide turnover rate was 56%, as shown in **Chart 1**;[8] its Davidson County regional office's turnover was alarmingly higher at 127%, with 104 average employees experiencing 132 separations during the year.[9] At this rate of turnover, DCS is losing people faster than they can hire them. More than 20% of all case manager positions across the state were unfilled as of July 1, 2022, as shown in **Chart 2**. We provide further information on turnover and vacancy rates in **Appendix** 7.

The number of children in DCS custody has increased 7% from January 2018 to July 2022.

[8] According to the U.S. Bureau of Labor Statistics, for calendar year 2021 the average separation rate for state and local governments, excluding education, was 20%.

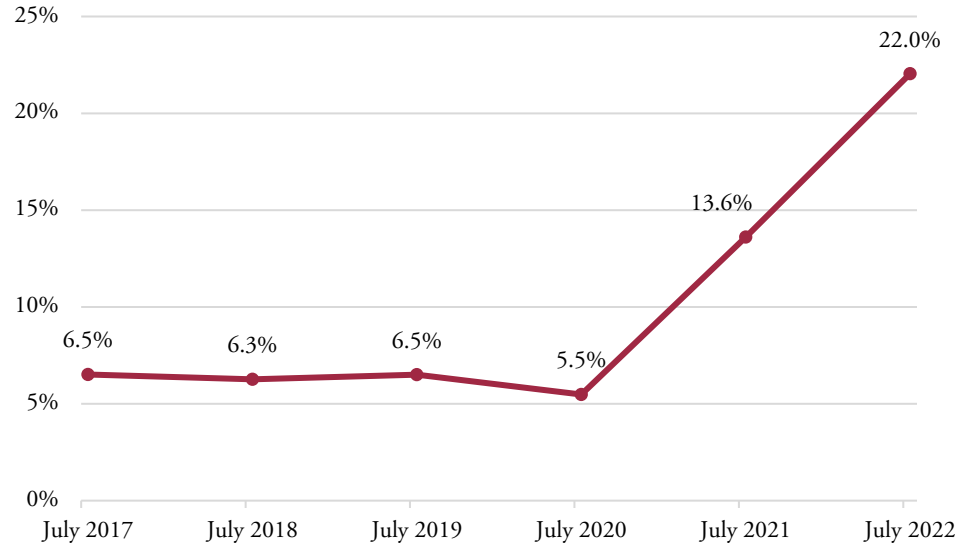
[9] The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) sets internal control standards and is considered best practice for nonfederal entities. Principle 4.05, "Recruitment, Development, and Retention of Individuals," states, "Management recruits, develops, and retains competent personnel to achieve the entity's objectives." Furthermore, Principle 5.07 and 5.08, "Consideration of Excessive Pressures," states, "Management adjusts excessive pressures on personnel in the entity. Pressure can appear in an entity because of goals established by management to meet objectives or cyclical demands of various processes . . . Excessive pressure can result in personnel 'cutting corners' to meet the established goals. Management is responsible for evaluating pressure on personnel to help personnel fulfill their assigned responsibilities in accordance with the entity's standards of conduct. Management can adjust excessive pressures using many different tools, such as rebalancing workloads or increasing resource levels."

Chart 1
Annual Case Manager Turnover Rate
Fiscal Years 2018 Through 2022



Source: Auditor analysis of Edison employment data.

Chart 2
Statewide Case Manager Vacancy Rates
As of Each July From 2017 Through 2022



Source: Auditor analysis of Edison employment data.

To help us understand the difficulties that case managers face and the areas that may contribute to high employee turnover, we conducted a survey of current case managers as of April 26, 2022. The anonymous survey was open from May 3, 2022, to May 23, 2022. We report the results of our survey throughout this report. See **Appendix 8** for the complete survey questions and results.

The nature of the case manager job is inherently stressful

Case managers regularly work with traumatized children and families in distressing environments and the worst of circumstances. This can involve removing children from illegal activities, abusive families, and uninhabitable environments or homes. This work takes a toll on mental health and plays a key factor in a case manager's decision to remain in the profession. Case managers expressed significant, recurring personal safety concerns such as staying overnight to care for children staying in state office buildings and transitional houses;[10] transporting children who have exhibited violent behaviors; and making home visits, especially at night or in areas with no cell phone service. Case managers also reported being physically and verbally attacked by children and family members.

Case managers worked longer hours to meet increasing caseload demands

Based on our review, we noted that **80%** of case managers worked overtime in fiscal year 2022, and each case manager generally reported about 15 hours of overtime each month. However, some case managers stated that, at the request of their supervisors, they frequently did not report overtime, so the actual number of overtime hours worked could be much higher. Exhausted case managers were required to work their designated shift, then stay at a transitional house or office building at least part of the night with children, and still report to work the next day. This lack of work-life balance contributed to already exhausted case managers leaving their jobs.

In response to our survey, case managers overwhelmingly identified the need to hire more case managers and reduce caseloads so they can have a greater impact on the youth and families DCS serves. Case managers also suggested the tools and resources in **Figure 4** would make their jobs easier.

[10] Transitional houses are community partner-owned spaces where the community partner allows DCS to use the space for children awaiting long-term placement, so that the child does not have to stay in a state office building. Community partners can include Isaiah House, houses of worship, and other nonprofits. We discuss transitional houses in more detail in the **Child Placement** section of the report.

Figure 4
Case Manager Responses to "What tools or resources would make your job easier?"

having **someone other than case managers to sit overnight with children** in offices or transitional houses

greater availability of foster homes and other placements so that children do not have to stay in office buildings or transitional houses

"assistants" that could handle the administrative tasks of entering information into the department's information system, or tools that would automate data entry

better equipment, such as phones, tablets, and computers that hold a charge or can scan documents

more transportation options for children to prevent case managers from having to transport children long distances—sometimes hours away—and to reduce wear and tear on their personal vehicles

Source: Auditor created based on case manager survey responses.

Low pay is a contributing factor to case manager turnover

According to case manager survey results and interviews we conducted, salary is not the most important factor in deciding to continue or leave the profession. However, case managers reported that low pay was a contributing factor for case managers who left DCS. Each level of the case manager position has a starting salary and a maximum salary that is the same across all 12 DCS regions. Prior to August 2022, case managers' starting salary was $34,967 for the entry-level title, and DCS paid 95% of Case Manager 1s within 5% of the starting salary, as of May 2022.

Further, 25% of all case managers are at or above their position's maximum pay and not eligible to receive pay increases without specific exceptions from the Department of Human Resources.

Case managers that were at or above the maximum salary for their job position did not consistently receive pay increases as intended.

Case managers received three pay increases from July 2021 to August 2022. However, case managers who were at or above the maximum salary for their job position ***did not*** receive the July 2021 4.25% pay increase; did receive the December 2021 3.58% pay increase as a one-time bonus; and were granted a one-time exception by the Department of Human Resources for the 5% pay increase in August 2022[11] to go above the maximum pay amount for their job position. **Table 1** has the average and maximum annual salary for each of the four case manager positions, as of May 2022, which is prior to the third pay increase that raised the starting salary to $40,000.

[11] All case managers received at least a 5% increase. This pay increase also raised the minimum salary for case managers to $40,000 annually for a Case Manager 1, and some case managers received more than a 5% increase to be paid the new minimum salary.

Table 1
Average and Maximum Annual Salary for Each Case Manager Position
As of May 2022

Position	Average Annual Salary	Maximum Annual Salary
Case Manager 1	$35,713	$50,640
Case Manager 2	$47,286	$53,160
Case Manager 3	$51,694	$58,620
Case Manager 4 (supervisor)	$58,919	$61,524

Source: Auditor analysis of Edison salary data and Department of Human Resources salary information.

Vacancies and turnover increased caseloads and placed an extra burden on the remaining case managers to provide the same level of service for all children

Turnover has increased dramatically among case managers across the state over the past five years, as shown in **Chart 1**. In fact, from August 2020 to May 2022, case manager caseloads have increased by **63%**. Case managers in the Office of Child Safety's Child Protective Services have the highest number of cases.

The average number of caseloads for each region fluctuates and is greatly impacted by the number of staff vacancies in the region. Davidson, Mid-Cumberland, and South Central regions had some of the highest vacancy percentages, and subsequently those case managers had some of the highest caseloads. Our analysis of caseloads can be found in **Finding 3**.

No matter the caseload, case managers were expected to provide the level of care and attention each child needed. Given the increasing number of children entering DCS custody, increasing vacancies, and high caseloads, this expectation has set case managers up for failure and only hurts the children when case managers cannot provide children with high-quality support services. As evident in **Findings 6, 7,** and **10,** support services and even DCS operations were delayed and, in some cases, not provided to children.

Management's efforts to retain and hire more case managers and reduce caseloads have not provided relief to case managers

Management has made incremental efforts to both hire more case managers and increase retention of case managers. In March 2021, DCS completed a safety culture survey of all staff. This survey was an organizational assessment that examined factors such as how safe employees feel in the office and work environment, whether employees feel accepted and respected (psychological safety), and how teams support one another. Survey responses indicated that employees were overworked due to caseloads, did not feel supported and appreciated by DCS leadership, had safety concerns about visiting homes alone, and felt that the pay was low. In addition to the contributing factors that surveyed case managers reported for turnover, management has cited the COVID-19 pandemic and the general economic environment, where employers in all industries struggle to hire employees, as contributing factors for turnover and vacancies.

Furthermore, in summer and fall 2021, management held a "listening tour" in each of DCS's 12 regions to hear from case managers what their challenges were and why they were leaving. In the following months, management implemented some of the case managers' ideas from the listening tour; they increased salaries, created additional team leader positions, and hired a recruitment specialist to focus on staff recruitment and retention.

Table 2 shows other actions management has taken to hire and retain more case managers.

Table 2
Management's Actions to Reduce Case Manager Turnover

Actions to Hire More Case Managers	• created three recruiting job positions to help recruit and hire case managers • increased the use of recruiting websites, such as ZipRecruiter and LinkedIn • hosted in-person hiring events • established and increased the use of part-time work • increased case manager starting salaries
Actions to Retain Case Managers	• increased training for case manager supervisors • supplied training coaches to provide better support to new employees • created specialized training to help case managers and their supervisors address secondary trauma and mental health • increased the use of simulations to help case managers work through difficult real-world scenarios • conducted listening sessions with staff in each region to identify issues • increased case manager salaries • assigned administrative tasks to non-case managers • redistributed cases to regions with lower caseloads

Source: Auditor creation based on interviews with DCS employees.

Despite management's efforts in both of these areas, management has continued to have difficulty hiring and retaining case managers. Newly hired case managers are limited to five cases during training, which lasts seven to nine weeks, and must complete their training program before they are allowed to carry a full caseload. Although training is necessary, newly hired case managers provide minimal relief from high caseloads for more experienced case managers. Furthermore, our review of turnover data revealed that **97%**[12] of Case Manager 1s left DCS in calendar year 2021.

[12] Auditor analysis of the State of Tennessee Turnover report.

Case Manager 1s are typically new case managers during their first year of employment, so this figure indicates that DCS is not retaining new recruits.

If management is not able to recruit and retain case managers, and lower the turnover levels at DCS, management risks the safety of vulnerable children who slip through the cracks because there are no case managers to help them. Further, when turnover increases, the number of cases that the remaining case managers must work increases, as we discuss in **Finding 3**, making it more difficult for case managers to provide the needed services to children and families who rely on DCS.

Recommendation

The DCS Commissioner must work with the Tennessee General Assembly, the Governor's Office, and other state agencies to get case managers the resources they need to help them perform the critical duties necessary to protect children.

As noted in **Finding 1**, management must develop a realistic strategic plan that identifies the root causes of chronic issues such as case manager workloads and turnover. The plan should also lay out comprehensive, aggressive actions to bring fundamental change.

Management's Comment

We concur with this finding.

The U.S. is facing a shortage of social workers. The Tennessee Department of Children's Services is not immune to this crisis. Management has already taken steps such as the creation of 5 permanent positions focused on recruiting and an increased presence online and at in-person hiring events. Budget requests were submitted for $15.8 million to increase the case manager salaries within the Department for FY 2023/2024. Management is also focused on increasing retention through increased training, mentoring, and field supports. In an article published on October 26th by the Child Welfare Monitor entitled The Placement Crisis For High-Needs Kids: It is Residential Facilities, Not Foster Homes that are Lacking, "In Colorado, Florida, Kentucky, Maryland, Massachusetts, Michigan, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, and Washington, the stories are similar. State and local agencies are unable to find appropriate placements for foster children and youth with the most severe behavioral health needs. As a result, they are being warehoused in inappropriate settings, such as temporary shelters, hotels, offices, or state-leased houses staffed by social workers; sent far away for residential care, or being left in psychiatric hospitals and detention centers after being cleared for release." The issues are not just germane to Tennessee; all states are faced with children with increased needs, low staffing, and fewer placement options. Tennessee's plan to address these issues is to increase salaries,

develop a robust case manager training program, increase the network provider rate (Budget request submitted $30.3 million) to increase the available beds for high needs children, and work with providers to develop the programs youth today need.

Finding 3

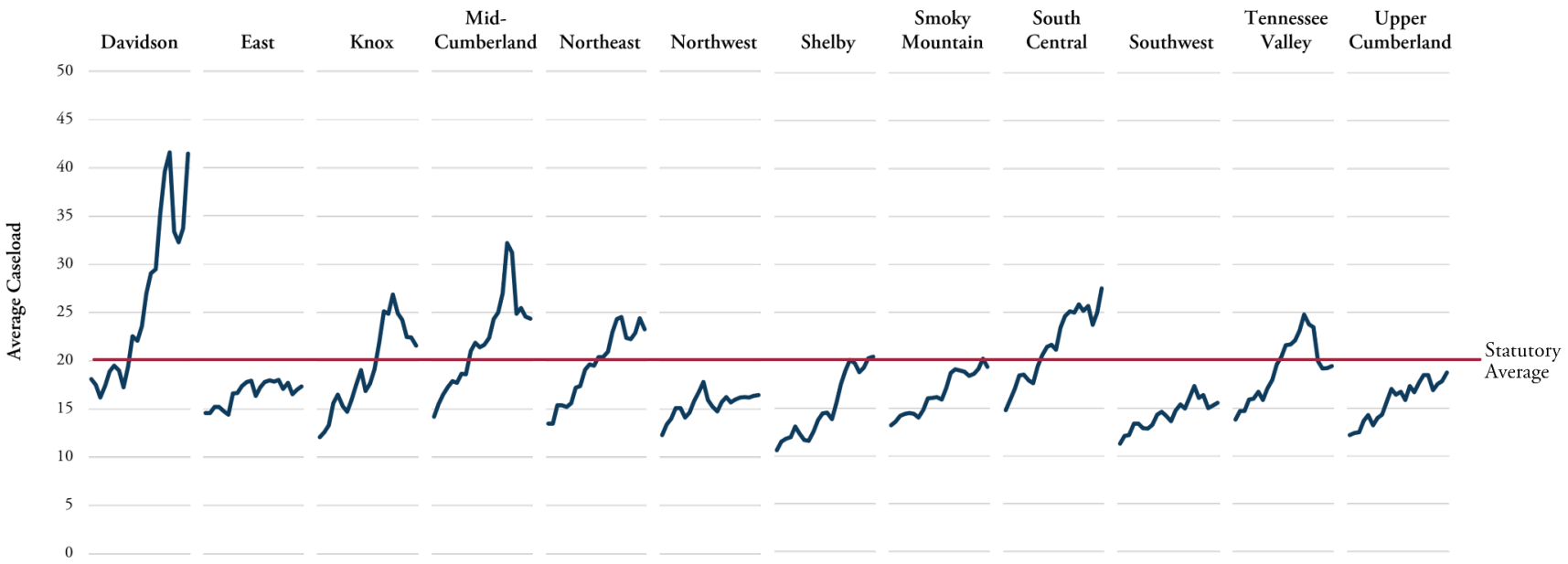
Case managers' actual caseloads exceed the state maximum for average caseloads, and their workload does not allow them to provide the necessary attention and resources to the children and families for whom they are responsible

DCS has not achieved compliance with the state's caseload law since April 2021

Section 37-5-132(a), *Tennessee Code Annotated*, requires DCS to maintain staff within each region to ensure that each region's caseloads do not exceed an average of 20 cases per case manager, to be calculated at least monthly.[13] According to management, DCS determines compliance with this statute by analyzing caseloads within each region and calculating an average caseload based on 2 days for each month. Since April 2021, at least 1 region has been out of compliance with the state's caseload law, exceeding an average of 20 cases, with as many as 8 of DCS's 12 regions exceeding an average of 20 cases, in both December 2021 and April 2022. Furthermore, the Davidson region's average caseloads were more than double the statutorily required average, at an average of 41.6 cases in January 2022 and 41.5 cases in May 2022. See **Chart 3** for each region's caseload averages. We present further information on average caseloads in **Appendix 7**.

[13] Specifically, Section 37-5-132, *Tennessee Code Annotated*, states, "(a)The department shall maintain staffing levels of case managers so that each region has enough case managers to allow caseloads not to exceed an average, to be calculated at least monthly, of: (1) Twenty (20) active cases relating to initial assessments, including investigations of an allegation of child abuse or neglect; or (2) Twenty (20) children monitored and supervised in active cases relating to ongoing services. (b) The department shall comply with the maximum caseload ratios described in subsection (a)."

Chart 3
Average Regional Caseloads
August 2020 Through May 2022



Source: Auditor creation based on DCS's Caseload Compliance and Averages reports.

Case managers' actual caseloads fluctuate well above averages

In reality, the actual number of cases assigned to a case manager fluctuates depending on the number of case managers in a region and the number of children entering and leaving custody. We found that actual caseloads for case managers could be as high as 108 or as few as 1 on any given day. The maximum number of cases result from the regions that are understaffed. See **Table 3** for statewide caseloads and **Appendix 7** for regional caseloads.

Table 3
Number of Cases Assigned to Case Managers Statewide*
As of May 2022

Minimum†	Average	Maximum
1	22	108

* These do not include Interstate Compact on the Placement of Children, Resource Linkage, Order of Reference, Permanency Specialist, or Special Investigations Unit cases.

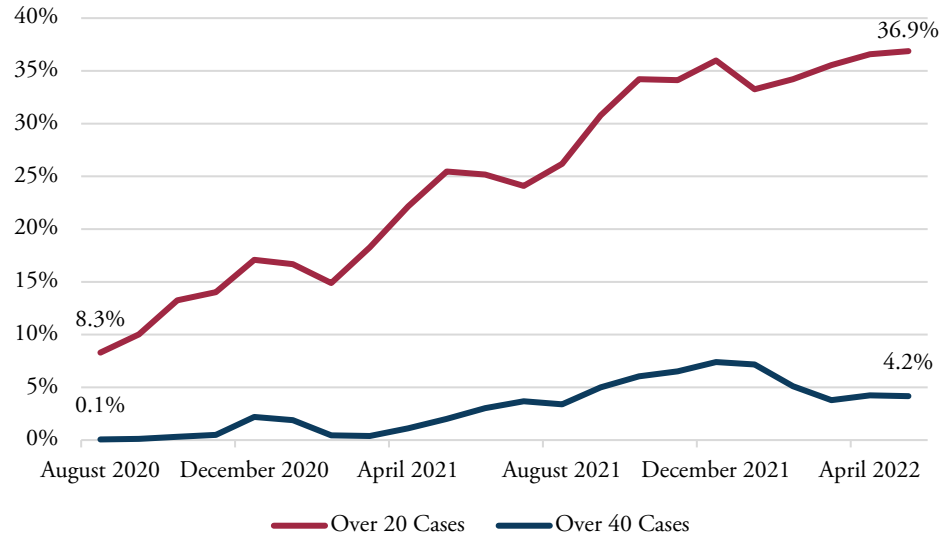
† The low minimum cases are generally representative of new case managers (who cannot carry a full caseload) or supervisors carrying cases.

Source: Auditor analysis of DCS's Caseload Compliance and Averages report.

While the fluctuation of the actual case count per case managers is expected, we found that the duration of how long a case manager may have excessively large numbers of actual cases has exacerbated the frustrations of overworked case managers. We found that in August 2020 there were 137 case managers[14] (8%) across the state with more than 20 cases. This number increased to 469 case managers (37%) working more than 20 cases in May 2022, as shown in **Chart 4** and **Table 4**. Further, between August 2020 and May 2022, we found that there were 22 case managers that carried more than 20 cases for at least 18 months, 149 case managers that carried more than 20 cases for at least 12 months, and 469 case managers that carried more than 20 cases for at least 6 months. There were even 5 case managers that carried more than 60 cases for at least 6 months. With these high caseloads for long periods, staff cannot provide the time and attention needed by the children and families they serve.

[14] In our analysis, we only used individuals in the Case Manager 1 through 3 positions, since those are the only positions that should normally be carrying cases.

Chart 4
Percentage of Case Managers With More Than 20 and 40 Cases in a Month
August 2020 Through May 2022



Source: Auditor analysis of DCS's caseload compliance and averages reports.

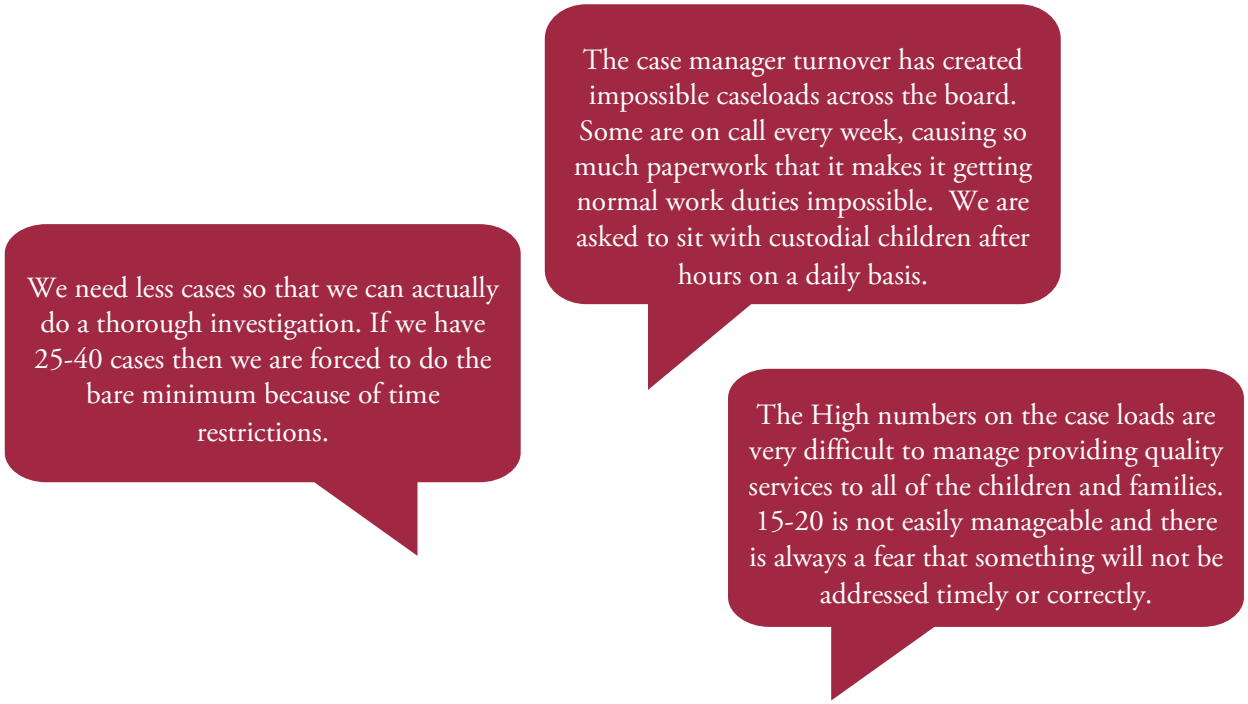
Table 4
Percentage of Case Managers With More Than 20 Cases in a Month
August 2020 Through May 2022

Month	Total Case Managers	Case Managers Over 20 Cases	Percentage of Case Managers Over 20 Cases
August 2020	1,652	137	8.3%
September 2020	1,657	166	10.0%
October 2020	1,646	218	13.2%
November 2020	1,619	227	14.0%
December 2020	1,592	272	17.1%
January 2021	1,589	265	16.7%
February 2021	1,578	235	14.9%
March 2021	1,566	286	18.3%
April 2021	1,526	338	22.1%
May 2021	1,489	379	25.5%
June 2021	1,490	375	25.2%
July 2021	1,440	347	24.1%
August 2021	1,386	363	26.2%
September 2021	1,361	419	30.8%
October 2021	1,339	458	34.2%
November 2021	1,319	450	34.1%
December 2021	1,298	467	36.0%

Month	Total Case Managers	Case Managers Over 20 Cases	Percentage of Case Managers Over 20 Cases
January 2022	1,284	427	33.3%
February 2022	1,292	442	34.2%
March 2022	1,297	461	35.5%
April 2022	1,274	466	36.6%
May 2022	1,272	469	36.9%

Source: Auditor analysis of DCS's caseload compliance and averages reports.

Figure 5
Case Manager Survey Responses Regarding Caseloads



Source: Auditor created based on case manager survey responses.

Council on Accreditation standards recommend caseloads of 10 to 15 cases

As the current statute requires, management uses a **20-case-average measurement**, rather than an actual count of cases for each case manager. As noted above, this means that case managers frequently carry more than **20 actual cases**, and in some regions, significantly more than 20 actual cases. The Council on Accreditation (COA) provides best practices for entities utilizing case management services and recommends in its best practice standards that "Caseload sizes range between 10 and 15 cases depending on the needs of individuals and families, the goals sought by the intervention, and the frequency of contact." COA also issued a standard stating, "Caseload sizes are sufficiently small to permit case managers to respond flexibly to differing service needs of individuals

and families, including frequency of contact, and to support the achievement of client outcomes."[15] The important difference between current state statute and the COA standard is that the COA best practice standard addresses actual cases for each case manager, not an average of cases for the region.

We discussed our concerns with DCS management, who commented that they cannot meet the current statute of the average 20-caseload requirements for all regions without more staff.

A fully staffed DCS could meet current statute requirements

Our analysis revealed that if all 2,155 case manager positions that worked in DCS's 12 regional offices as of March 15, 2022, were filled, each region's caseload average per case manager would comply with the existing statute. See **Table 5**.

Table 5
Comparison of Actual Average Regional Caseloads to the Average if All Positions Were Filled
As of March 2022

Region	Actual Average Caseload	Potential Average Caseload if All Positions Were Filled
Davidson Region	32.3	11.0
Mid-Cumberland Region	25.5	13.0
South Central Region	23.7	14.4
Northeast Region	22.9	14.8
Knox Region	22.4	11.5
Shelby Region	19.2	11.0
TN Valley Region	19.2	10.2
Smoky Mountain Region	19.1	10.8
Upper Cumberland Region	17.5	11.3
East Tennessee Region	16.5	10.9
Northwest Region	16.2	11.4
Southwest Region	15.0	8.7

Source: Auditor analysis of Edison employee data and DCS's caseload compliance and averages report. The table only includes case managers that work at one of the DCS's 12 regional offices.

When case managers have a significant number of cases, and more than a total of 10 to 15 actual cases, case managers cannot provide the time and attention that the children and families need.

[15] Council on Accreditation's Case Management Standard 5.03 and Standard 2, respectively.

Recommendation

DCS should strive to provide the best care for the children with whom they interact, which includes allowing case managers the time to work cases. The Commissioner should evaluate all possible avenues to reduce caseloads and fully support DCS children and case managers.

Specifically, management must find solutions to the hiring and staff retention challenges while also addressing high caseloads, evaluating the current caseload statute, and considering the COA's best practice guidance for caseload goals. Management should develop attainable workload expectations to enable case managers to meet the needs of children in their care.

Additionally, the Commissioner should work with the General Assembly to study state statute and revise as necessary to establish realistic caseload goals which align with best practices of 10 to 15 actual cases. This change would allow case managers to spend the necessary amount of time with children to provide the support they need. Implementing this recommendation may also help management address its staffing and turnover crisis, which we discuss further in **Finding 2**.

Management's Comment

We concur with this finding.

Management is taking a multi-tiered approach to address this problem. Budget requests to substantially increase salaries for case managers in fiscal year 2023/2024 should enable the Department to attract personnel. Budget requests were submitted for $15.8 million to increase the case manager series within the Department for FY 2023/2024. Additional training and field support strategies to be implemented in mid-year 2023 will impact retention. Retention has been a focus through increased mentorship and training programs. DCS management will also review work assigned to case managers to determine what can be reassigned elsewhere. Finally, DCS management will focus on balancing workload of caseloads from regions that are higher in caseloads to those that have fewer to manage.

Matter for Legislative Consideration

The Commissioner should work with the General Assembly to assess and consider amending Section 37-5-132, *Tennessee Code Annotated*, to establish best practices and **actual caseload sizes** and bring much-needed relief to case managers' workloads.

Management's Comment

Management had no comments.

Child Placement

When children are unable to safely stay in their own homes, the Department of Children's Services (DCS) is responsible to provide placements that meet the children's emotional, physical, and social needs. The lack of available foster homes, rather than the needs of foster children, continues to present serious challenges to DCS's ability to make placement decisions. Case managers must find temporary placement locations such as state office buildings or transitional houses for extended durations.

Additionally, DCS employees struggle to make quick placement decisions (for either long-term or temporary placements) because the case management system is not designed to capture child placement data and placement availability resulting in negative impacts on both children and department employees.

The Commissioner must expedite efforts to retain placements and to expand the placement network. Management should continue to explore better alternatives to office buildings for temporary placements and set standards for consistent quality of facilities for temporary placements so case managers can efficiently place children in safe settings that meet their needs.

General Background

A child enters DCS custody through neglect, abuse, delinquency, or disobedience

A child enters DCS custody through three main paths:[16]

- If the child is found to be **neglected or abused** [typically through allegations to the Child Abuse Hotline];
- If the child is found to be **delinquent**, also referred to as a juvenile justice child who has been found by the Court to have committed an offense which would be considered a crime if it had been committed by an adult; or
- The child is **unruly**, which refers to a child who is in need of treatment or rehabilitation and who habitually, and without justification, is truant from school; is habitually

[16] This information is from DCS's "Client's Rights Handbook."

disobedient to the degree that his or her health and safety is endangered; and/or is a runaway.

Staff assign the child a level of care based on the child's needs

Many of the children entering DCS custody have service needs related to emotional and physical trauma as well as behavioral and mental health issues, all of which impact placement decisions. Based on these needs, DCS staff assign the child one of four levels of care:

- **Level 1** – family-based care, usually a foster home, with no need for additional services;
- **Level 2** – inclusive of foster-care services in Level 1 but includes additional services such as support services for medically fragile children;
- **Level 3** – psychiatric care and residential treatment facilities; or
- **Level 4** – intense psychiatric stabilization treatment below hospital level but for children with intense and immediate needs.

Children are placed in foster homes, treatment facilities, secure residential facilities, or temporary placements

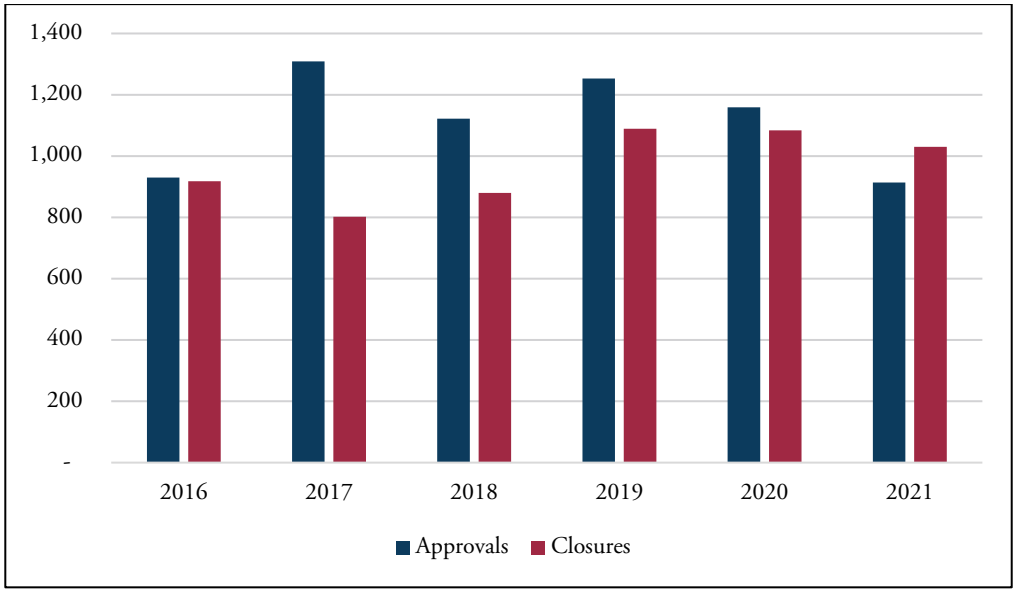
When a child enters DCS custody, case managers work to place them in a foster home or, if the child has behavioral or mental health issues, in a treatment or residential facility. For delinquent children that need greater security, case managers first try to place them in secure facilities, in a detention center or staff-secure or hardware-secure facility.[17] These placements may also be outside Tennessee; as of September 16, 2022, DCS had **371 children placed out of state.**

If none of these options are immediately available, the child must be placed in a temporary setting. DCS uses transitional houses, which are community-based, home-like settings supervised by DCS staff. If a transitional house is not available, DCS houses children in state office buildings with case manager oversight as a last resort.

Based on information DCS reported, **Chart 5** shows the number of foster homes DCS approved and closed from 2016 through 2021. As of September 16, 2022, in Tennessee and out of state, DCS had 2,846 approved foster homes and partnered with private providers for another 2,275 approved foster homes. See **Table 13** in **Appendix 9** for data on regional foster homes and children.

[17] See the **Sexual Abuse/Harassment Investigations and the Prison Rape Elimination Act** section for additional information on these facilities.

Chart 5
DCS-Operated Foster Home Approvals and Closures*
Calendar Years 2016 Through 2021



* This data only includes homes closed in good standing, not those DCS closed for failure to maintain requirements, including more severe noncompliance such as substantiated abuse.
Source: Auditor created based on data provided by Deputy Commissioner of the Office of Child Programs and Director of Network Development.

Foster families can decline to accept placements requested by case managers

When a family has been approved as a foster home for DCS, the family is only approved for certain types of child placements—specific ages, genders, and needs—and can still decline to accept a child when DCS requests to place a child with them. When regional staff need to place a child, they must contact every foster family in their region, then contact the private providers and staff in other DCS regions. To further illustrate, **Figure 6** displays Mid-Cumberland region staff notes from their contact of all 49 foster families in 1 of the 8 counties in their region. In this instance, there was nowhere for the child to go, and the child had to stay in a temporary setting. Staff repeat this process each day until they find a placement.

Figure 6
Mid-Cumberland Region Staff Efforts to Place a Teenage Male: Responses From Foster Home Families* in One County

1: Declined, struggling with current teen	27: Full and doesn't take teens
2: Voicemail & text x2	28: Full- Hope to be able to assist with teens in the future. Cannot right now.
3: Declined due to teen boy	29: Declined only has room for a youth to share a room with 2-year-old
4: Very sick at this time	30: No sorry
5: SIU†	31: SIU†
6: Only wanting younger females	32: Declined, switching to Omni
7: Declined due to having teen girl	33: Declined, very full and no room even with alt sleeping arrangements
8: Not interested in taking teens at this time	34: No sorry
9: Voicemail & text x2	35: Declined- Hands full with 2 foster babies and 2 full time jobs
10: Declined has 2 current youth in the home	36: Declined, home is full at this point
11: SIU†	37: Voicemail & text x2
12: Declined, cannot take teen boys due to having teen girls	38: On hold until May
13: No teen boys due to having teen daughter	39: Declined, only taking under 12 months
14: Not taking teen boys right now	40: Voicemail & text x2
15: declined due to behaviors and teen boys are tough for them	41: Husband is not ready for any children at this time
16: Declined, has another youth, not wanting another	42: No sorry
17: Voicemail & text x2	43: Declined- Currently have 3 littles
18: Voicemail & text x2	44: Declined full no additional sleeping arrangements
19: Declined, will be closing her home	45: Declined Full at this time
20: Declined due to age	46: Cannot assist as current placements are fighting
21: Wanting ages under 6	47: Not wanting to assist with teenagers
22: Declined, doesn't take teen boys	48: Unable to assist at this time with teenagers
23: Declined, aren't taking any placements	49: Can't take teenagers, sorry
24: Declined only has a crib	
25: Declined due to behaviors	
26: Declined- Has newborn to focus on right now	

* We replaced family names with numbers.
† These families were not considered because they were involved in a Special Investigations Unit (SIU) investigation.
Source: Mid-Cumberland region placement staff.

Since 2019, DCS has established partnerships with transitional houses, which are used as a last resort given these placements are only intended for temporary placement

If regional staff have exhausted all possible locations for long-term placement of a child, staff must use temporary locations for the child to spend the night or nights until a long-term location can be found. These temporary settings include a transitional house or state office building while staff continue to search for and find a long-term placement for the child. Neither state statute nor DCS policy prohibits management's use of temporary settings, as it is sometimes the only option for placing a child; however, according to management, they try to minimize the duration the child spends in these temporary settings.

DCS does not own the transitional houses; instead, a community partner owns the space and allows DCS to use the space for children awaiting long-term placement. Community partners include Isaiah House,[18] places of worship, and other nonprofit organizations. DCS does not compensate community partners to use their space, and a DCS case manager must remain with children in the transitional houses. See **Appendix 9** for a map of the state's transitional houses.

Management faces ongoing challenges to address both the state's and the public's concerns

We have provided audits to management, and DCS has received substantial media attention focused on some of the same recurring issues from our audit reports and/or based on their own investigative reporting. Often external reporters initiate audits or investigations based on information obtained through tips and open records requests. In recent years, the tips and concerns have involved the lack of transparency DCS provides to potential foster families regarding a child's history, including behavioral concerns, when DCS seeks child placement with these foster parents; untenable conditions[19] of state office buildings when children must stay overnight; and the case manager staffing issues within DCS (see also **Finding 2** and **Finding 3** in the **Case Manager Turnover and Caseloads** section and **Finding 5** below).

News articles and televised stories highlighted the urgent need for foster homes while also covering stories about foster parents' weariness from ongoing calls from DCS asking the families to take more children than they are approved to care for simply because the state does not have enough foster homes to place children. Additionally, foster parents reported a lack of support and communication from DCS once a child was placed in the foster home.

[18] Isaiah House is a privately owned and operated safe home that seeks to provide safety and comfort while meeting each child's needs.

[19] The untenable conditions involved lack of adequate sleeping arrangements and lack of adequate supervision (children known to have run away from the state office buildings and inappropriate contact between children).

Finding 4

Tennessee faces a crisis-level shortage of long-term placement options to meet every child's needs, which has increased the number of children staying in temporary settings such as state office buildings and transitional houses

Management's actions have not prepared DCS for the placement crisis

From January 2018 to July 2022, the number of children in DCS custody has increased by 7%. As noted in **Finding 1**, management did not plan for and anticipate the risk of a shortage of foster homes, treatment facilities, or secure residential facilities. While DCS has taken action to expand placement options for children, management did not take sufficient action to prepare for a problem that now hinders their ability to properly care for children in their custody.

The Council on Accreditation provides best practices for entities utilizing child and family services and recommends in its best practice standards that the agency "recruits a diverse array of families to maximize opportunities for children to be placed in a family setting that effectively meets their needs" and "promotes resource family development and retention . . . to ensure that children receive safe, consistent, and nurturing care."[20]

DCS regional staff have historically developed foster home recruitment and retention plans based upon the demographic needs of each region and focused on increasing the number of relative and foster homes, as well as supporting and retaining current homes. These plans used characteristics of each region's foster care population and current foster homes to identify the number and type of foster homes needed. Each region developed a set of goals, strategies, and action steps needed to improve foster home recruitment and retention. DCS did not meet its recruitment goal of having more approved foster homes than closed foster homes in calendar year 2021; see **Chart 5**. As of July 1, 2022, DCS decided to contract out its efforts to recruit and retain foster homes.

DCS is facing challenges to place children in foster care homes and secure facilities, impacting both children and case managers

In our survey of case managers across the state, one theme that emerged in their responses was the challenge that they had finding long-term placements for children, especially those with a higher level of need. Case managers across the state expressed similar statements to those in **Figure 7**.

[20] The Council on Accreditation's (COA) Child and Family Services (PA-CFS) Standard 22, "Resource Family Recruitment," and Standard 26, "Resource Family Development, Support, and Retention."

Figure 7
Case Manager Survey Responses Regarding Placement Availability

Source: Auditor created based on case manager survey responses.

The Deputy Commissioner for Child Programs believes that children staying overnight in temporary settings are due to providers' reduced willingness to accept children with greater needs. She added that there is also a lack of resources available for providers to be able to properly staff their facilities as necessary for higher-needs children, which contributes to children having to stay overnight in temporary settings.

In March 2021, Governor Bill Lee and other stakeholders recognized the need for more foster families and created the Tennessee Fosters Hope initiative, which is a statewide collaborative campaign engaging state agencies, community organizations, the business community, and places of worship to elevate high-quality care and opportunities for children and families impacted by foster care and adoption. In addition, DCS contracted with Chapin Hall, a child welfare research institute group, who issued a needs assessment report to DCS in June 2021, which projected that DCS would need to increase capacity to accommodate expected growth in the population based on data through June 30, 2020. Given the changing economic climate since this study, the needs are even greater as the number of children entering custody has increased and available placements for those children has decreased.

In an October 2022 legislative discussion,[21] the newly appointed Commissioner explained that DCS also lacks placements for delinquent children. Juvenile detention centers are meant to be short-term secure placements, but she explained that staff-secure and hardware-secure facilities are 100

[21] October 5, 2022, Joint Ad Hoc Committee to Review the Adequacy of the Supervision, Investigation, and Release of Criminal Defendants.

percent filled and therefore cannot take these children. Case managers may place lower-level delinquent children in foster homes if the home can meet the child's needs; however, foster families do not have to accept placement requests. Local officials may call DCS to remove a disruptive child from their juvenile detention center, and case managers then must search for a new placement, which at times must be a temporary setting. DCS staff then must stay overnight with these delinquent children, who are often high-needs, combative, or violent, in an office building without the necessary training to properly care for these youth. She explained that this additional duty leads to traumatized employees and children. Furthermore, the increased use of temporary settings has created more work demands on case managers, who must stay up all night with children in temporary settings.

See **Finding 2** regarding case manager turnover.

The processes to place a child and track their location when in either long-term or temporary placements are cumbersome and inefficient

Because TFACTS does not have the functionality to assist staff in finding placement availability in the foster homes and other residential facilities, case managers resorted to making phone calls, sending emails, and using various tracking spreadsheets to search for placement locations.

To track where children were placed in temporary settings, TFACTS can only record a child's placement as a *regional state office;* therefore, each region must maintain this information in Excel spreadsheets. Even though regional management increased child placement in temporary settings since 2019, top management was not aware of the number and location of all children staying in temporary settings. In **April 2022,** the Commissioner required daily reporting by the regions of all temporary child placements.

TFACTS is not capable of providing current information for staff to be able to determine which foster homes or facilities may be an appropriate placement for a child. See **Finding 12**.

Given placement shortages, the use of temporary settings when no other long-term placements can be found has transitioned from a rare emergency occurrence to an increasingly necessary department practice. We analyzed management's data and found that in every region, between April 22, 2022, and July 4, 2022, foster care children stayed overnight in temporary settings at least 1 night, with 1 region having a child in a transitional house for 38 nights and another region having a child in an office building for 24 nights. In addition, a juvenile justice youth stayed in a transitional house for up to 18 nights and in an office building for up to 11 nights. See **Table 6** for details on the number of and duration of children staying overnight[22] in temporary settings, beginning April 2022.

[22] DCS considers it an overnight stay in an office when "any child who is removed prior to midnight and remains in the office after 4 a.m. the following day," according to DCS's Guide to Placement Exception Categories, a supplement to DCS Policy 16.46, "Child/Youth Referral and Placement."

Table 6
Details of Overnight Stays in Temporary Settings
April 22, 2022, Through July 4, 2022

represents an office building

represents a transitional house

Region		No. of Overnight Stays	Minimum Nights	Average Nights	Maximum Nights	Total Unique Count of Children*
Mid-Cumberland		56	1	5	16	67
		20	1	9	35	
Northeast		17	1	5	12	53
		47	1	8	38	
Juvenile Justice		33	1	2	11	39
		13	1	4	18	
Knox		6	1	1	1	35
		31	1	3	11	
Smoky		29	1	3	24	35
		13	1	4	19	
Davidson		21	1	5	28	21
South Central		15	1	2	5	19
		7	1	4	15	
TN Valley		19	1	5	19	19
Shelby†		15	1	4	14	15
East		5	1	3	9	9
		4	1	1	1	
Northwest		5	1	2	3	5
Upper Cumberland†		4	1	1	2	4
Southwest		1	1	1	1	1

* The number of overnight stays of children may not equal the sum of the unique count of children in office buildings and transitional houses for the region, because in some instances one child may stay in both an office building and transitional house over a period of time.

† This region does not have transitional houses that can be utilized.

Source: Auditor analysis of DCS's Youth in Office or Transitional (Safe) House Overnight spreadsheet.

The lack of available foster homes, rather than the needs of foster children, continues to present serious challenges to DCS's ability to make placement decisions. Without crucial data to ascertain ongoing foster placement needs, opportunities for increased placements in current foster homes, and the availability of temporary transitional homes, management cannot fully understand the scope of the problems and challenges they face to expedite solutions to address the placement shortages.

Recommendation

The Commissioner must expedite efforts to obtain and retain placements and explore alternatives to office buildings for temporary placements based on complete and accurate data. To do so, management must evaluate regions' current placement needs, and implement reasonable recruitment and retention strategies suggested from research groups or contractors.

Management's Comment

We concur with the finding.

DCS entered into a contract effective July 1, 2022 with an external partner to enhance and expand outreach and marketing capacity in the recruitment and certification of foster homes. DCS management has also expanded work with the Governor's Faith-Based Communities Director to put together an initiative to recruit foster care families throughout the state. DCS continues to work with residential providers to increase the number of Tennessee youth that can be placed within their facilities to receive proper treatment with the goal of finding permanency. If the General Assembly approves the budget requests, the provider network will realize a $30 million increase, which will enable DCS to increase the continuum of beds for higher needs children. It is important to increase capacity where the needs exist. Tennessee doesn't have a bed shortage, it has a funding shortage. When children step down from treatment facilities, there need to be foster homes or DIDD [Department of Intellectual and Developmental Disabilities] supported homes available to house these youth. DCS is working on both fronts to increase the capacity, but will rely on the General Assembly for the funding to realize this.

Finding 5

Children who stay in transitional homes or state office buildings across the state's temporary settings often experience inconsistent quality of facilities, resulting in unintended hardships for children

We found inconsistencies in amenities for children at temporary settings

DCS Policy 16.46, "Child/Youth Referral and Placement," states, "DCS placements are made in a home-like, least restrictive setting that meets the unique needs of children/youth." Temporary placements, however, are not designed to provide long-term stability for children and may not meet the unique needs of the children who stay there, which can negatively impact the child's safety and quality of life.

In April, May, and June 2022, we performed on-site visits at four regional and county office buildings and two transitional houses across the state to determine the level of care and amenities children received in transitional houses and office buildings. We found inconsistent quality in the facilities where the children stayed and the amenities that children received. For example, a child who stays in an office building could spend time in an office cubicle designed for work, but a child who stays in a transitional house will have space comparable to a living room. As another example, a child who stays overnight at an office building may not have a bed, but a child who stays overnight at an Isaiah House will have a bed. Since DCS had no policies or written guidance, each region's staff had to determine how to implement and provide for each child's care. See **Figure 8** and **Appendix 9** for details and photos of temporary settings.

Figure 8

Photo of an Office Cubicle With a Child's Belongings Shelby Region Office Building

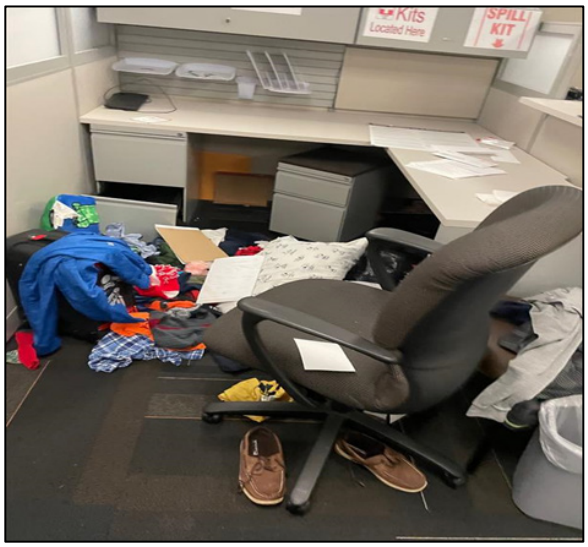


Photo of Sleeping Area Montgomery County Office Building

Source: Auditor photographs.

Management did not implement formal guidance addressing transitional houses until **July 2022**. Before this, staff had to prepare the temporary settings without guidance on how to meet the immediate needs of children who were removed from their homes and had no long-term housing, such as family or a foster home. While the new July 2022 protocol addresses how staff can use transitional houses and how to supervise children in them, it does not address amenities in temporary settings. As noted above, children are required to stay in these temporary settings when a long-term placement is not available; therefore, it is critical that management ensures those children will still have their basic needs met with amenities such as food, bedding, clothing, and hygiene care. Based on our case manager survey, respondents indicated that the children in temporary settings do not always have

food, clothes, beds, or a shower.[23] During our site visits, regional staff stated temporary settings are often supplied and supported by community members; thus, one region's temporary settings may be better equipped with the amenities needed to care for children than another.

Without formal written guidance or clear expectations about the aspects of care for children while in a temporary setting, such as the transitional houses or state office buildings, management and staff did not consistently equip each location to ensure that children received the highest possible quality of care and amenities.

Recommendation

To ensure children staying in all transitional houses and office buildings receive the highest quality of care possible, the Commissioner should provide written guidance to staff for what amenities children should receive while in temporary placements and ensure staff have the resources they need to provide the amenities to children. Management should minimize the use of state office buildings when possible but should also seek state and federal funding to supply temporary settings as needed to support children that must stay there.

Management's Comment

We concur with the finding.

With the unforeseen pandemic and the unintended consequences that resulted in national staffing and funding related placement shortages, the department progressively partnered with community resources across the state to develop transitional alternatives. Management has developed and implemented a common set of protocols and continues to work to develop and refine policies and procedures to guide what amenities must be provided to youth staying in temporary settings. The budget request includes 48 new beds for assessment purposes which will enable children and youth who come into custody with high needs, who cannot be placed immediately into foster homes, to be placed in assessment homes where they will reside for up to 30 days to be assessed. They will have immediate access to education, medical, and psychiatric services including individual and group therapies. Children and youth will be supported in the Assessment Homes where clinical assessments will be conducted to ascertain the most appropriate long-term care for the youth. These 48 beds will be available regionally and will aid the Department in making appropriate first placement for high needs youth.

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[23] The *Standards for Internal Control in the Federal Government* (Green Book) sets internal control standards and is considered the best practice for nonfederal entities. According to Green Book Principle 10, "Design Control Activities," "Management should design control activities to achieve objectives and respond to risks." Additionally, Green Book Principle 12, "Implement Control Activities," states, "Management should implement control activities through policies."

Child Safety

The most important responsibility of the Department of Children's Services (DCS) is to keep children safe from harm. DCS was created as the statewide child welfare entity charged with the responsibility to remove children from environments that may cause them harm, to keep children safe while in state custody, and to investigate allegations of abuse or neglect. All allegations represent a child in a potentially unsafe environment.

We found critical child safety incidents and risks in several of the department's processes. Specifically, we found that

- Children may have remained in unsafe situations because management has not met established timelines for key points of child abuse and neglect investigations.
- DCS did not ensure that reported allegations of sexual abuse, sexual harassment, or lack of supervision of custodial children living in residential facilities were investigated.
- DCS has not developed an effective and efficient process to respond to sexual abuse and harassment allegations to keep children in residential facilities safe.
- Deficiencies in management's PQT review process contributed to the PQT not identifying a questionable provider employee, to prevent his contact with children in state custody, and to avoid child endangerment.

We recommend the Commissioner and Deputy Commissioner of Child Safety take immediate action to prioritize these safety risks and take actions needed to eliminate unsafe environments for children in DCS care.

General Background

Tennessee is a mandatory reporting state. Section 37-1-403, *Tennessee Code Annotated,* states that it is the duty of all Tennessee residents to report any instance of neglect or abuse of a child, and failure to report these instances can result in civil liability. DCS's Office of Child Safety operates the Child Abuse Hotline (hotline) 24 hours a day, 7 days a week for Tennesseans to report any signs of

From February 1, 2021, through July 31, 2022, the hotline received over 200,000 allegations ranging from severe physical abuse to unclean homes.

child abuse or neglect by phone, email, or online. During our audit scope, the hotline staff had to work over 200,000 allegations and assign/route each allegation to the proper next steps in the allegation resolution process.

Child Abuse Hotline allegations are evaluated to decide if the report of child abuse and neglect should be assigned to the next responsible area for investigation

Child Abuse Hotline staff are responsible for making the first evaluation of an allegation received through the hotline. Hotline staff evaluate each allegation, known as the screen-in or screen-out process,[24] based on various criteria shown in the decision-making tool in **Appendix 10, Figure 25**. Allegations can be screened out if there is a duplicate allegation (there is already an open Child Protective Services case specific to the allegation); if the allegation did not contain enough details for follow-up (the allegation is promptly closed); if the allegation occurred out of state (the allegation is referred to the appropriate state); or if the allegation does not meet the definition of abuse or neglect in Tennessee. Hotline staff can also "screen out" allegations to the department's Statewide PREA Coordinator and/or to external law enforcement depending on specific circumstances. All other allegations are screened in and assigned to internal groups (see next section for the groups) for follow-up/investigation. The decision-making process followed by the hotline staff is handled in TFACTS.

Hotline staff refer the screened-in allegations to the appropriate DCS group for follow-up actions

Hotline staff categorize screened-in allegations to one of the following categories so that the responsible group can take action.

- **Resource linkage:** The allegation involves a family whose children are at risk of coming into DCS custody. In such cases, case managers in the Office of Child Programs can provide short-term intervention services to keep the child safe and the family together.
- **Assessment:** Assessment cases are non-severe allegations that may include environmental neglect such as lack of food, lack of supervision, unclean homes, or other safety issues.
- **Investigation:** Investigation cases involve severe allegations such as physical abuse.
- **Special Investigations Unit (SIU) investigation:** These allegations involve abuse or neglect by an individual functioning in an official capacity, such as a teacher, residential facility staff, or foster parent.

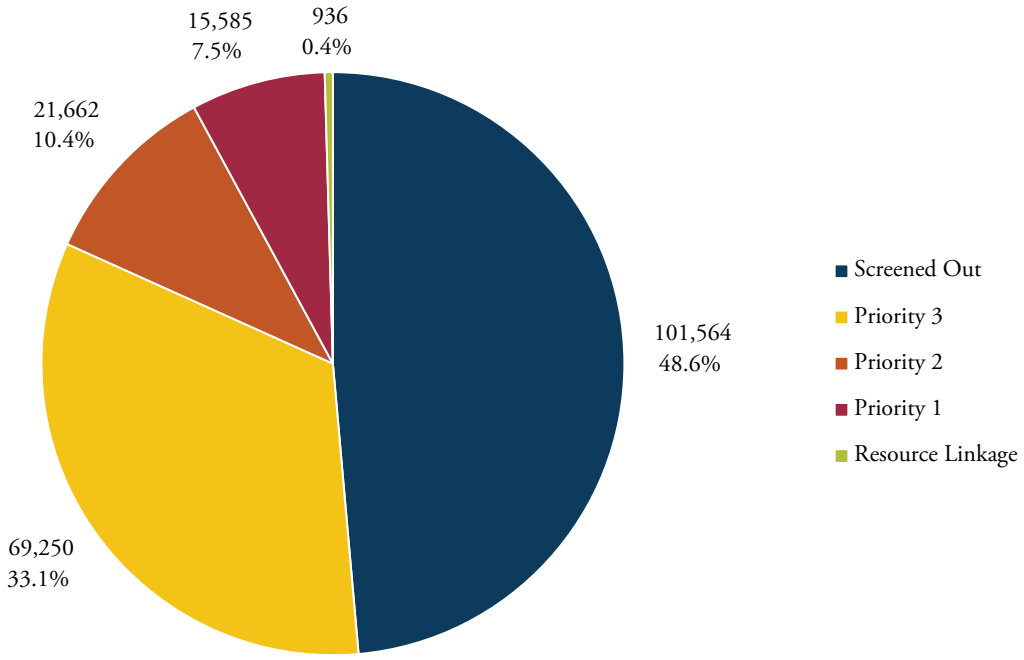
Resource linkage, assessment, and investigation cases are assigned to non-SIU Child Protective Services (CPS) case managers in the related region. SIU allegations are assigned to the SIU unit for investigation.

[24] According to DCS Policy 14.1, "Child Abuse Hotline," screened-in refers to "alleged child abuse/neglect reports received from the community that meets the established criteria for a CPS case" and screened-out means "alleged child abuse/neglect reports coming from the community that does not meet the state criteria for CPS involvement."

When hotline staff categorize an allegation as an assessment, investigation, or SIU investigation, they also assign an initial priority level that is based on the severity of the allegation:

- **Priority 1** cases allege that children may be in imminent danger;
- **Priority 2** cases allege injuries or risk of injuries that are not imminent or life threatening, or do not require immediate care; and
- **Priority 3** cases allege situations or incidents that pose a low risk of harm to the child.

Chart 6
Child Abuse Hotline Allegations by Priority Level
February 1, 2021, Through July 31, 2022



This chart includes intake records recorded with a priority level, screened out, or resource linkage (a program to help families find resources in their community). The records excluded are created to begin a case in TFACTS and include out-of-state and court referrals.
Source: Auditor created using TFACTS data.

Hotline staff refer the screened-out allegations to the DCS PREA group or local law enforcement for the appropriate follow-up actions

Based on our understanding, we determined that when DCS hotline staff make the determination that an allegation does not meet the criteria for a CPS investigation (or does not require a referral to another state agency), hotline staff screen these reports out. If the allegation was screened out because the referent did not provide enough information or there was already an open investigation

for the same allegation, then the hotline closes the allegation, and no further action is required. If the screened-out allegation pertains to children living in residential facilities and involves potential sexual abuse or sexual harassment, hotline staff assign the allegation to the Prison Rape Elimination Act (PREA) group for investigation and to law enforcement.

Allegations sent to the PREA group involve sexual abuse and sexual harassment allegations against children who reside in facilities **that primarily house juvenile delinquents**. Allegations of sexual abuse and sexual harassment where both the alleged victim and alleged perpetrator are children 13 to 17 years old and are placed in residential facilities **that do NOT primarily house juvenile delinquents** are not investigated by DCS but are instead reported to law enforcement for investigation. Also, management does not track or follow up on allegations which are referred to law enforcement.

Residential facility staff report safety concerns to DCS through the TFACTS incident response application

In addition to the Child Abuse Hotline, DCS requires residential facility staff to enter incidents, including sexual abuse and sexual harassment allegations, into the TFACTS incident reporting application. For any incidents that involve child abuse, including physical abuse and sexual abuse, facility staff are required to also report them to the Child Abuse Hotline for evaluation. Incidents reported to the hotline are subject to the allegation evaluation process discussed above. Since the incidents could occur at a residential facility that primarily houses juvenile delinquents, the Statewide PREA Coordinator reviews each incident that is sexual in nature to ensure the incident is reported to the Child Abuse Hotline and screened out (referred) to the PREA group.

DCS established a Provider Quality Team review process to review closed SIU and closed PREA cases

As discussed above, SIU cases involve abuse or neglect by an individual functioning in an official capacity, such as a teacher, residential facility staff, or a foster parent. DCS established the Office of Continuous Quality Improvement Provider Quality Team (PQT) process to review closed investigation cases (including SIU and PREA investigations) to determine whether provider employees or Wilder Youth Development Center employees had patterns of habitual misconduct involving children in their care, thus posing extreme safety risks to the children at those facilities. PQT also responds to other contract-provider concerns which come into the DCS central office.

Current Audit

We focused our audit on management's responsibility to protect children while in or at risk of state custody. We evaluated management's fulfillment of mission goals to ensure children's safety within the following DCS processes:

Child Protective Services' Child Abuse and Neglect Investigations

CPS Investigations Background

Once hotline staff assign a priority level to the allegation, they refer the case to the local regional office, where a case manager is assigned to the case. According to Section 37-1-406, *Tennessee Code Annotated*, it is the case manager's duty to thoroughly investigate any allegation of child abuse or neglect to ensure the safety of the children involved.

The case manager contacts the child based on the initial priority level and to gather information regarding the allegation and the safety of the child. As part of that investigation, staff use the Family Advocacy and Support Tool (FAST) to help identify safety concerns, underlying risks, needs, and strengths of families involved with DCS. The safety assessment component of the FAST focuses on the child's immediate safety and reassesses the priority level assigned by hotline staff. The FAST also helps staff determine if immediate intervention is needed. If an allegation is severe, the case manager must also immediately convene the Child Protective Investigative Team (CPIT) and document subsequent discussion of the allegation on the "CS-0561, Child Protective Investigative Team Review."

Case managers then use evidence obtained during the investigation and discussions to either substantiate or refute the allegation in order to classify the case. At the discretion of the department, investigations and SIU investigations are classified in one of seven classifications and assessments in one of six classifications, as shown in **Table 7.**

Table 7
Investigation and Assessment Classifications

Investigations and SIU Investigations
1. Allegation Substantiated, Perpetrator Substantiated
2. Allegation Substantiated, Perpetrator Unsubstantiated
3. Allegation Substantiated, Perpetrator Unknown
4. Allegation Unsubstantiated, Perpetrator Unsubstantiated
5. Allegation Unsubstantiated, Child with Sexual Behavior Problems
6. Unable to Complete
7. Administrative Closure
Assessments
1. No Services Needed
2. Services Recommended
3. Services Needed
4. Services Needed, Court Ordered
5. Unable to Complete
6. Administrative Closure

Source: DCS Policy 14.7, "Child Protective Services Investigation Track," and Policy 14.26, "Child Protective Services Assessment Track."

If necessary, case managers may transfer cases to other department offices so that the child or family can receive other support services from the department or for the department to take the child into the department's custody. Policy 14.7, "Child Protective Services Investigation Track," requires case managers to close investigations within 60 days or for supervisors to document monthly reviews explaining the delay. Assessments, usually less severe than investigations, still go through the same investigative process as an investigation; however, an assessment allows 90 days to close a case from case opening.

Prior Audit Results

In both the November 2016 and December 2020 performance audit reports, we reported that case managers struggled to meet child abuse and neglect investigation timelines. In addition to other corrective action, management reported that they made improvements to their administrative review policies and procedures. These improvements, however, were not sufficient to ensure staff completed the critical investigation milestones within established timeframes.

Current Audit

In the prior audits, we reviewed Priority 1 investigations; however, we expanded our scope in the current audit to review all three priority levels for both investigations and assessments because staff may identify additional information after intake that increases the risk involved in any case, regardless of its priority level at intake. We conducted testwork to assess the effectiveness of corrective actions taken after the prior audit.

Repeat Finding

Finding 6

Children may have remained in unsafe situations because management did not meet certain key timelines for child abuse and neglect investigations

Case managers continue to struggle to complete timely investigations

Management developed a timeline for investigations[25] to guide Child Protective Services (CPS) case managers to make quick and appropriate decisions regarding a child's safety. DCS, however, is currently faced with a significant staffing shortage in many regions, which directly impacts staff's ability to conduct thorough and timely investigations of child abuse and neglect. According to management, the staffing need is so urgent that supervisors and regional leadership have had to step in and carry investigation caseloads just to get investigations done. As supervisors stepped in to help with the investigation process, they were unable to complete quality reviews of investigations to identify when case managers were not moving investigations through the process timely.

See **Finding 2** for additional information on the impact of staffing shortages on case managers.

In the current audit, we followed up on the prior finding and reviewed investigation case files.[26] We again noted that DCS case managers did not complete required documentation or meet key timeline benchmarks while conducting investigations. For **4%** of cases we reviewed, the case manager did not make contact with the child victim within the required days to initiate the investigation. According to the department's Policy 14.3, "Screening, Priority Response and Assignment of Child Protective Services Cases," Priority 2 cases "are initiated by face-to-face contact with the [alleged child victim (ACV)] within two (2) business days" and Priority 3 cases "are initiated by face-to-face contact

[25] In this finding, we are including the investigations, assessments, and SIU investigations paths when we discuss investigations.

[26] We selected a random sample of 75 investigation, assessment, and Special Investigation Unit investigation case types at all priority levels referred to DCS from January 2021 through February 2022.

with the ACV within three (3) business days." In **three** of the cases we reviewed, it took case managers 8 business days to make contact with the child victim in a Priority 2 case, and 11 business days and 24 business days to make contact with the child victim in two Priority 3 cases.

In addition, we found that for **43%** of cases we reviewed, case managers experienced safety assessment issues.[27] We found

- for 4 cases, case managers did not perform the safety assessment;
- for 8 cases, case managers did not submit the safety assessment within the required 5 business days; and
- for 20 cases, we could not determine if case managers submitted and reviewed the safety assessment timely because the submission date was not recorded.

See **Table 14** in **Appendix 10** for other results noted from our review.

When CPS does not complete important steps of an investigation and does not to adhere to critical timeframes, vulnerable children remain in potentially abusive situations longer than they should.

Recommendation

We recommend the Commissioner and Deputy Commissioner of Child Safety develop a plan to address the root cause of staff's noncompliance with investigation timelines. As management addresses the staffing crisis, they should ensure that all investigations are consistently and thoroughly conducted, documented, reviewed, and closed, and that staff meet key investigative time benchmarks. As a part of this effort, DCS should continue to perform quality reviews of investigations.

Management's Comment

We concur with the finding.

As of August 2022, the date of submission and the date of supervisory approval for the SIU assessments are captured in Redcap.[28] It is being monitored for compliance in Redcap until it is

[27] The "Protocol for Completion of the Family Advocacy and Support Tool (FAST)" requires case managers to submit the safety assessment component of the FAST to the supervisor within five business days from the intake date and requires the supervisor to approve it within three business days of submission by the case manager.

[28] DCS works with Vanderbilt's Center of Excellence Research Electronic Data Capture (REDCap) data collection system, which is geared to support online and offline data capture for research studies and operations.

accessible in TFACTS and Safe Measures.[29] Funding for this project has been approved for the FY24 budget which will help with more timely review going forward. Historically, SIU investigators emailed their supervisors when they submitted the FAST in Redcap to alert the supervisor that a review and approval was needed. The SIU assessment has never been housed in TFACTS. For October 2022, the SIU assessments were in compliance 71% of the time for timely submission and 76% of the time for timely approvals by the supervisors.

DCS will also implement time studies to ensure policies and procedures are within acceptable limits for this process.

Staffing shortages have impacted the agency's ability to meet key timelines and meet best practices when seeing children and completing documentation. Budget requests to substantially increase salaries for case managers in fiscal year 2023/2024 should enable the Department to attract personnel. Additional training and field support strategies to be implemented in mid-year 2023 will impact retention. These up-staffing goals will enable DCS to meet key goals and outcomes set forth in audit findings and DCS policies.

Residential Facility Sexual Abuse/Harassment Investigations and the Prison Rape Elimination Act

Residential Facility Sexual Abuse/Harassment Background

DCS has a responsibility for ensuring the health, safety, and well-being of all children by investigating all allegations of sexual abuse, assault, misconduct, harassment, and lack of supervision within all residential facilities

When a child enters custody, DCS becomes responsible for ensuring the health, safety, and well-being of that child. As mentioned in the **Child Placement** section of this report, DCS finds places for these children to live based on each child's needs. Some children reside in foster home settings while others live in residential facilities, residential treatment centers, or youth development centers.

According to DCS Policy 18.8, "Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)," DCS is committed to a zero-tolerance standard for all forms of sexual abuse, assault, misconduct, harassment, or rape within all residential facilities. The policy further states that DCS must ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse, assault, misconduct, and harassment. Additionally, a lack of supervision by facility staff is covered under the department's definition of neglect. As such, consensual sexual activity between children who live together in residential facilities may be investigated by the department as a lack of supervision by facility staff.

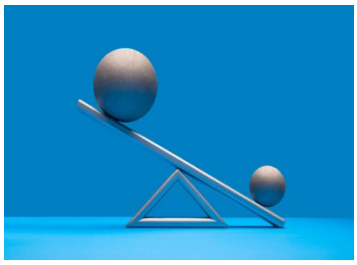
[29] SafeMeasures is an application that serves as a live dashboard and creates reports using TFACTS data.

Our review included a look at DCS's response to allegations of sexual abuse, sexual harassment, and sexual misconduct involving children in DCS custody living in residential facilities, as well as reports of consensual sexual activity between those children, because we saw the potential for some of these allegations to fall through the cracks.

Finding 7

DCS did not ensure that reported allegations of sexual abuse, sexual harassment, or lack of supervision of custodial children living in residential facilities were investigated

DCS did not investigate 34 allegations of sexual abuse and sexual harassment within residential facilities



DCS has a zero-tolerance policy on all forms of sexual abuse, assault, misconduct, harassment, or rape within residential facilities and must act to protect all children in their care. Our review of management's response to sexual abuse and sexual harassment allegations, however, disclosed that DCS did not investigate all reported incidents[30] of suspected sexual abuse, sexual harassment, sexual misconduct, or consensual sexual activity between children living in residential facilities.

Based on a review of 211 unique sexual abuse and sexual harassment incidents reported within residential facilities during calendar year 2021, we found 34 instances where the department did not investigate allegations in residential facilities for the reasons listed in **Table 8** below.[31]

[30] Residential facility staff, case workers, or provider staff report suspected incidents of sexual abuse or sexual harassment within the Incident Reporting module of TFACTS. Any incidents that contain suspected abuse or neglect are required by Section 37-1-403, *Tennessee Code Annotated,* to be reported to the Child Abuse Hotline, which starts DCS's process of evaluating the allegation and determining how to respond to the allegation.

[31] According to PREA Standard 115.322(a), "The agency shall ensure that an administrative or criminal investigation is complete for all allegations of sexual abuse and sexual harassment." Additionally, DCS Policy 18.8, "Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault, or Rape Incidents and Prison Rape Elimination Act (PREA)," states, "DCS ensures that an administrative or criminal investigation is complete for all allegations of sexual abuse/assault/misconduct/harassment."

Table 8
DCS's Reasons for Not Investigating Allegations of Sexual Abuse and Harassment

Number of Instances	DCS's Reasons for Not Investigating	Why This Is Still an Issue
28	The allegation occurred at a facility that did not primarily house juvenile delinquents and therefore was not picked up for a PREA investigation. OR The allegation involved sexual abuse or harassment between two children ages 13 to 17, and DCS chose to refer the allegation to law enforcement rather than investigate.	DCS did not give the same care and consideration to allegations that involve children in **non-juvenile justice focused facilities,** also classified by the department as a **non-PREA facility**.
2	The Statewide PREA Coordinator marked these as needing a PREA investigation but did not assign them for an investigation.	These investigations were missed due to staff oversight.
2	The Statewide PREA Coordinator marked these as not a PREA facility when she had previously agreed to investigate PREA allegations at these facilities.	The Statewide PREA Coordinator indicated these facilities requested to be included in DCS's PREA investigation process and had agreed to include them but did not.
2	The Statewide PREA Coordinator marked these allegations as non-PREA allegations.	Due to the nature of these allegations, we believe that they would meet the requirements for a PREA investigation.

Source: Auditor created this table based on our testwork results and discussions with DCS management.

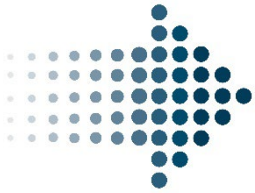
While DCS did refer these allegations to law enforcement to investigate, the department did not track the referrals or follow up with law enforcement on the results of the investigations, therefore, the results of the allegations and subsequent investigation are unknown.

DCS did not investigate staff for lack of supervision in connection to 37 reports of potential consensual sexual activity between children in residential facilities

During our review of sexual abuse and sexual harassment incidents, we also noted 37 reports of possible consensual sexual activity between children in residential facilities, which DCS deemed to

not be sexual abuse or harassment and thus did not investigate. Although these acts were not considered sexual abuse or sexual harassment, they may indicate a lack of supervision at the facilities, which the department has a duty to investigate. The department's policies did not clearly indicate when consensual activity among youth indicates a lack of supervision by a facility.[32]

If DCS does not address all potential sexual abuse, sexual harassment, and lack of supervision allegations within **all facilities**, then they cannot be sure they are providing a safe, humane, and secure environment for all children under DCS's care, especially those that live in non-juvenile justice focused facility settings.



Recommendation

The Commissioner and top management should ensure that DCS has a robust response system that promotes zero-tolerance of sexual abuse, sexual harassment, and lack of supervision within **all** residential facilities. Specifically, management must ensure all allegations of sexual abuse, harassment, sexual misconduct, and lack of supervision (resulting in consensual sex between children) for children in custody are investigated regardless of their placement, but especially involving all children placed in residential facilities. In addition, management should create a robust policy and procedures that define who is responsible for investigating any allegation of sexual abuse, sexual harassment, and lack of supervision.

See our **Matter for Legislative Consideration** for more information on how the General Assembly could clarify DCS's responsibility for investigating these types of allegations.

Management's Comment

We partially concur with the finding.

All allegations of sexual abuse or harassment were investigated appropriately. DCS did not follow up with local law enforcement to ensure law enforcement was investigating all cases to resolution. DCS will update the PREA policy to reflect the new standard that any PREA investigation that was referred to law enforcement will be followed up with the PREA team and documented as

[32] According to DCS's Work Aid 1, a lack of supervision falls under the definition of neglect and includes when "the child has been placed in a situation that requires actions beyond that child's level of maturity, physical ability, and/or mental ability."

appropriate. DCS will ensure that all allegations that involve potential lack of supervision are fully investigated regardless of the outcome of the allegation of sexual abuse or sexual harassment.

Matter for Legislative Consideration

The Department of Children's Services (DCS) receives allegations of sexual abuse through its Child Abuse Hotline. Hotline staff review all allegations to determine if the allegations meet the definition of sexual abuse as defined in statute. Sections 37-1-602(a)(3)(D) and 37-5-103(5)(D), *Tennessee Code Annotated,* state,

> For the purposes of the reporting, investigation, and treatment provisions of §§ 37-1-603 – 37-1-615 "child sexual abuse" also means the commission of any act . . . against a child thirteen (13) years of age through seventeen (17) years of age if such act is committed against the child by a parent, guardian, relative, person residing in the child's home, or other person responsible for the care and custody of the child.

DCS investigates allegations of child-on-child sexual abuse between children ages 13 and 17 that occurred in traditional (family or foster) home settings but does not investigate the same type of allegations if the children reside in residential (group or facility) settings. Rather, the sexual abuse allegations between children ages 13 and 17 that occur within residential settings are referred to law enforcement, and DCS does not follow up on the referred allegations to determine the outcome or whether law enforcement even pursued the allegation. As such, children in these cases have not been afforded the same level of care and protection by the department.

DCS has taken the position as to the intent of statute that a "person residing in the home" would not include situations of child-on-child sexual abuse between children ages 13 and 17, meaning that children living in residential settings may be exposed to child sexual abuse (by another child) and will not be protected because the department does not investigate. For the children placed in residential settings, the department should consider the facility as a child's home while they are in DCS custody and, therefore, should investigate sexual abuse allegations the same as those allegations involving children placed in a traditional home.

The General Assembly may wish to consider amending statutory language to define "person residing in the child's home" to clarify their intent for DCS's responsibility to investigate allegations of child-on-child sexual abuse between children ages 13 and 17 that occurred in a residential setting.

Management's Comment

Management had no comments.

Prison Rape Elimination Act Background

Since Prison Rape Elimination Act (PREA) standards only apply to facilities that primarily house juvenile delinquents, DCS must routinely evaluate which facilities have to follow PREA due to changes in the population of juvenile delinquents residing at the facilities

DCS places juvenile delinquents in the Wilder Youth Development Center, contract[33] juvenile detention centers, privately run secure facilities like Mountain View and Standing Tall Music City, and an array of other smaller, privately run congregate care facilities. DCS can also place juvenile delinquents in foster homes. However, federal PREA standards only apply to facilities that primarily house juvenile delinquents.

PREA

The Prison Rape Elimination Act (PREA) is a federal law that was passed in 2003 to prevent, detect, and respond to sexual abuse in confinement facilities. Juvenile PREA standards apply to any facility that primarily houses juvenile delinquents, such as youth development centers, juvenile detention centers, and other secured residential facilities.

Since federal PREA standards only apply to facilities that primarily house juvenile delinquents and DCS places juvenile delinquents in facilities that have mixed populations of delinquent and non-delinquent children, DCS must routinely determine which facilities house at least **50% juvenile delinquents for any given month during the year.** To make this determination, each month the Statewide PREA Coordinator (Coordinator) uses TFACTS data and calculates the percentage of juvenile delinquents in each residential facility across the state. At the end of the calendar year, the Coordinator evaluates each facility's monthly percentages. If the facility met the **50% threshold for the majority of months** in the year,[34] DCS identifies the facility as a PREA facility, and the PREA Coordinator then monitors that facility for PREA compliance and conducts PREA investigations the following year.

The hotline staff make the initial determinations as to sexual abuse/harassment allegations, but the Statewide PREA Coordinator and PREA Investigator are responsible for investigating allegations of sexual abuse and sexual harassment within juvenile justice facilities and to ensure compliance with the federal act

Hotline staff make the first determination as to most allegations and screen out to the PREA group allegations that do not meet the statutory definition of child abuse and neglect but have sexual connotations and occurred at a residential facility. When the Statewide PREA Coordinator gets the allegation from the hotline staff, the Coordinator must manually review each allegation to determine whether the allegation occurred in a facility that **primarily** houses juvenile delinquents (as described above) and whether the allegation meets the PREA definitions for sexual abuse and sexual harassment. If the Coordinator determines the allegation meets these criteria, the Coordinator assigns the allegation

[33] DCS contracts with 8 juvenile detention centers to temporarily house juvenile delinquents.

[34] The PREA Resource Center recommends that states make the 50% determination over a period of one year. DCS chose to make determinations monthly and then again at the end of one year.

From January 1, 2021, to December 31, 2021, the PREA Coordinator received 1,964 screened-out referrals of alleged sexual abuse and sexual harassment from the hotline.

to the PREA Investigator for investigation. If the Coordinator determines that the allegation did not occur in a "PREA" facility, or the allegation does not meet the PREA definition, then there is no PREA investigation. See **Figure 26** in **Appendix 10** for a flowchart explaining the hotline referral process to either the SIU, the PREA Coordinator, or law enforcement.

The PREA investigation process is guided by a strict timeline to ensure a quick response to child sexual abuse and harassment allegations in PREA residential facilities

Once the Coordinator determines an allegation needs an investigation, the Coordinator assigns the investigation to the PREA Investigator, who must follow the PREA Investigator Protocol to investigate the allegation. According to the PREA Investigator Protocol, the investigator has 2 business days to inform the facility of investigation initiation and to request any available video evidence. The investigator has 7 to 10 business days to visit the facility to interview the alleged victim(s), alleged perpetrator(s), and anyone else who may have knowledge of or information about the allegation. As part of the investigation process, the investigator will watch any video evidence and analyze the information obtained in interviews to decide whether there is enough evidence to conclude that the incident occurred. The investigator has 30 to 45 days to decide the results of the case. The investigator documents the investigation case summary and submits it to the Coordinator for review. The Coordinator must notify the facility of the outcome of the case.

We focused our review on DCS's response to and the investigation of sexual abuse and harassment allegations that occurred at "PREA" facilities.

Finding 8

DCS has not developed an effective and efficient process to respond to sexual abuse and harassment allegations to keep children in residential facilities safe

Despite the seriousness and prevalence[35] of sexual abuse and sexual harassment among juvenile delinquents in confinement facilities, management has not designed an effective and efficient process that lends itself to successfully identify, investigate, and take corrective action related to sexual abuse and sexual harassment allegations.

[35] The U.S. Department of Justice Bureau of Justice Statistics reported that children in juvenile facilities experience higher rates of sexual victimization than adults in prisons.

First, DCS's response to sexual abuse/harassment allegations against children in residential facilities depended upon whether DCS identified the facility as a "PREA facility" or a "non-PREA facility"; see **Finding 7**. Second, DCS's process to determine which facilities are required to follow PREA standards is flawed. Third, DCS's Child Abuse Hotline does not have a way to determine which reports are possible PREA allegations, so the Statewide PREA Coordinator must also manually review hundreds of hotline referrals each month to make that determination. Fourth, management only dedicated 2 employees to monitor PREA compliance and conduct investigations for the 31 facilities across the state that **primarily** house juvenile delinquents (referred to as PREA facilities). Finally, management has not developed policies and procedures that are up-to-date, clear, and in alignment with federal PREA standards. These issues are discussed in detail below.

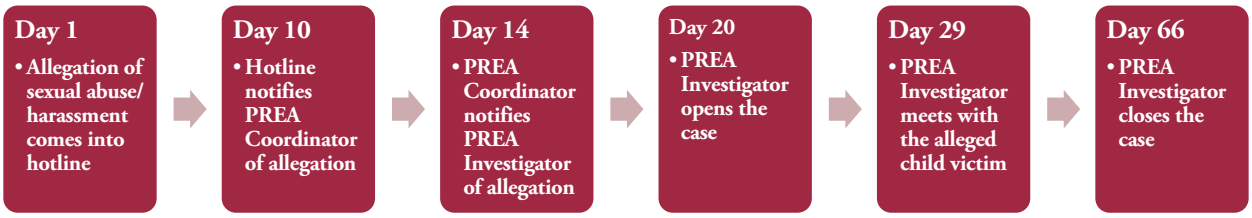
Given these challenges and management's process deficiencies, we identified the following:

- DCS did not ensure reports of sexual abuse and sexual harassment were investigated—see **Finding 7**;
- delays and deficiencies in PREA investigations;
- facilities that were not monitored for PREA compliance; and
- policies that were outdated, unclear, or did not align with federal PREA standards.

The slow initiation and completion of PREA investigations left children in potentially abusive situations for weeks

Federal PREA standards require sexual abuse and sexual harassment allegations to be investigated promptly. However, based on our review of 25 sampled PREA investigations that DCS conducted in 2021, we found that for 92% of the investigations the PREA Investigator did not move the investigation through the investigative process in a timely manner. We found that, on average, it took the PREA Investigator **66 days** to complete each investigation; however, DCS's PREA Protocol requires investigations to be completed within 30 to 45 days. See **Figure 9** for a timeline of the average length of time to complete PREA investigations.

Figure 9
Average Timeline of PREA Investigations



Source: Auditors created this figure based on the results of our testwork.

We also found that 3 case files contained unorganized, contradictory information[36] and that DCS had no formal, documented process for notifying facilities and victims of the results of their investigations.[37] See **Table 15** in **Appendix 10** for a summary of our results.

Delays in allegation referrals from the hotline to the Statewide PREA Coordinator and delays from the Coordinator to the PREA Investigator delayed the start of these investigations, resulting in children remaining in potentially abusive situations for weeks before the investigator spoke to them. According to management, a staffing crisis at the hotline led to the delays in getting allegations to the Coordinator. Additionally, the volume of allegations coupled with the fact there is only one PREA Investigator to conduct investigations for the entire state further contributed to investigation delays and inaccurate case files.

We discussed our conclusions with the Statewide PREA Coordinator, who stated that she issues case completion extensions, reviews case summaries for completeness and accuracy, and verbally notifies the facilities of the results of PREA investigations. The Coordinator, however, did not document her actions; thus, neither DCS management nor we could verify these actions were performed or consistently performed in this critical child safety process.

DCS's process for identifying which facilities are required to follow PREA standards was flawed

Based on a review of DCS's calculations for calendar years 2018 through 2021, we found that DCS's process for identifying which facilities primarily house juvenile delinquents, and thus are required to follow PREA standards, was flawed because the calculations

- included youths who exited DCS custody since the beginning of the previous month,

[36] Green Book Principle 10.01 states, "management should design control activities to achieve objectives and respond to risks."

[37] According to federal PREA Standard 115.373, "following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded."

- excluded other non-DCS private placement children who resided at the facility, and
- only considered the makeup of the population of a facility on one day of the month.[38]

We found that DCS's calculations identified 18 facilities that met the threshold in 2021, whereas our recalculation using the Coordinator's process identified 21 facilities which should have been monitored for PREA compliance. We also learned that an additional 10 facilities (facilities that did not meet the 50% threshold) had requested to be included in PREA monitoring and investigations. As a result, DCS should have monitored a total of 28 facilities based on their own calculation and a total of 31 based on our recalculation of facilities. According to management, this is the way they have always done the calculations, and they had not considered these limitations mentioned above. Management stated that they would reevaluate how they calculate these percentages to address the concerns.

Based on our review of a random sample of 25 PREA investigation cases from a population of 62 unique investigations for calendar year 2021, we noted the following:

- 48% of the time – Child Abuse Hotline staff referred allegations between 4 and 40 days after the call.
- 54% of the time – The PREA Investigator initiated an investigation between 3 and 18 days beyond the 2-day requirement.
- 35% of the time – The PREA Investigator interviewed and obtained statements from the alleged victim(s), witnesses, and perpetrators between 2 and 35 days beyond the 10 business days requirement.
- 50% of the time – The PREA Investigator completed investigations between 6 and 44 days beyond the 45-day requirement.

If the calculations include youths who are no longer living in the facility or exclude other non-DCS children who live at the facility, then there is a chance that DCS could fail to identify the facilities which should be monitored for PREA compliance, thus failing to investigate potential child sexual abuse. Also, due to the constant fluctuation of the number of children in facilities throughout the month, a one-day snapshot does not provide an accurate picture of the true makeup of the population over time. Since these calculations drive DCS's PREA compliance monitoring and investigation efforts, it is important that these calculations are accurate.

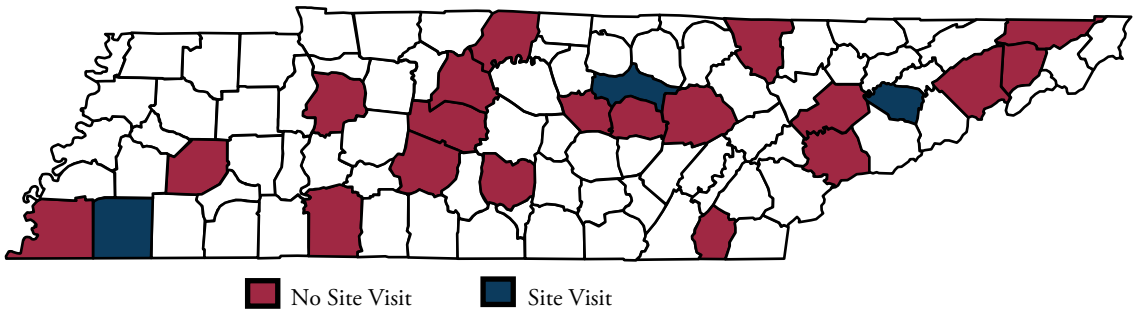
DCS management did not ensure that the Statewide PREA Coordinator monitored juvenile facilities for PREA compliance in 2021

According to DCS Policy 18.8, the Statewide PREA Coordinator is responsible for monitoring DCS's efforts to comply with PREA standards in all its facilities and contract provider facilities. In calendar year 2021, however, the Statewide PREA Coordinator only conducted PREA compliance

[38] According to guidance from the PREA Resource Center, agencies that have facilities with mixed populations need to calculate whether, over the period of one year, the facility holds more juvenile delinquents than non-delinquents.

reviews at 3 of 31 juvenile facilities and did not document what evidence she reviewed to support her conclusions that those facilities were PREA compliant.[39] See **Table 17** in **Appendix 10** for other results noted from our review. The Coordinator also did not obtain all PREA staffing plan assessments[40] for contract juvenile facilities. See **Figure 10** for a map of the counties where the juvenile facilities are located and where annual compliance visits occurred.

Figure 10
Map of Site Visits for PREA Facilities



Source: Auditor created this figure based on the results of our testwork.

The Statewide PREA Coordinator reported that she did not formally monitor all facilities in 2021 due to COVID-19 and because she was preparing for the triennial federal PREA audit of the only DCS-managed juvenile facility, the Wilder Youth Development Center. At the time of the federal audit, the Statewide PREA Coordinator was also the facility's primary PREA compliance manager due to turnover within the facility. The Coordinator stated that she did maintain phone contact with most facilities she was unable to visit; however, she did not maintain documentation of her verbal contacts or the substance of the discussion as it related to PREA compliance at these facilities.

If DCS does not monitor all juvenile justice facilities for PREA compliance, then management cannot ensure that they are placing children in facilities that are committed to reducing the risk of sexual abuse/harassment, assault, and misconduct.

Management has not developed policies and protocols that align with federal PREA standards

Based on our review of DCS Policy 18.8 and the Protocol for Statewide DCS PREA Coordinator, we found that these documents contained contradicting guidance, referenced outdated

[39] The Protocol for Statewide DCS PREA Coordinator states the Coordinator "conducts a comprehensive review of the residential contract agencies, state operated facilities and Youth Development Centers annually to ensure they are complying with PREA standards."

[40] PREA staffing plans are created by facility management to ensure adequate levels of staffing and video monitoring to protect residents from sexual abuse. PREA Standard 115.313 requires these plans to be developed and updated annually or anytime there is significant change.

processes and documents, and did not always align with federal PREA standards. For a breakdown of these inconsistencies in policy, see **Table 18** in **Appendix 10**.[41]

Recommendation

The Commissioner and Deputy Commissioner of Juvenile Justice should ensure that DCS has a robust response system that supports zero-tolerance of sexual abuse and sexual harassment within all residential facilities.

We recommend the Commissioner and Deputy Commissioner of Juvenile Justice reevaluate and formalize DCS's system for identifying which facilities are required to follow PREA standards; devote more staff to oversee PREA compliance and investigations; and revise DCS policies and protocols to ensure they are up-to-date, clear, and align with federal PREA standards. We also recommend that DCS consider adding a PREA screening section to the Child Abuse Hotline's decision-making tool to automate the PREA allegation identification process.

Management's Comment

We concur with the finding.

DCS is developing policies and a standard operating procedure (SOP) for PREA to define the role DCS will play in ensuring PREA compliance. DCS will develop a new statewide PREA team that will be operational by the first quarter of 2023. This team will be led by a director and six field investigators. The six investigators will be geographically located across the state, two for each of the grand regions (East, Middle, and West) for timely response to allegations.

Quality Control: Alleged Perpetrator SIU Reviews

Within the Office of Continuous Quality Improvement, management has established the Provider Quality Team (PQT) to perform reviews of closed Special Investigations Unit (SIU) cases for the purpose of identifying potential child safety risks perpetrated by providers' employees as well as employees of the Wilder Youth Development Center. The Special Investigations Unit is responsible for investigations of child abuse that involve caregivers, foster parents, residential provider employees,

[41] According to Green Book 12.05, "management periodically reviews policies, procedures, and related control activities for continued relevance and effectiveness in achieving the entity's objectives or addressing related risks..."

and the state's own Wilder Youth Development Center employees. According to "DCS Work Aid 3: Child Protective Services Investigative Tasks and Activities,"

> Each allegation is classified at the discretion of DCS according to one of the seven following categories . . . :
>
> - Allegation Substantiated, Perpetrator Substantiated;
> - Allegation Substantiated, Perpetrator Unsubstantiated;
> - Allegation Substantiated, Perpetrator Unknown;
> - Allegation Unsubstantiated, Perpetrator Unsubstantiated;
> - Allegation Unsubstantiated, Children with Sexual Behavior Problems;
> - Unable to Complete; or
> - Administrative Closure.
>
> An allegation and/or AP may be substantiated based on a preponderance of evidence[42] and on proof of one or more of the following factors (also known as validation criteria), linking the abusive or neglectful act(s) to the A[lleged] P[erpetrator].

PQT meets weekly to discuss any ongoing safety concerns for custodial youth

PQT is responsible to hold providers accountable for corrective action. To do this, PQT meets weekly to discuss cases with key stakeholders and develop corrective action items. Specifically, when PQT identifies potential concerns through their reviews, the team facilitates discussions with central office leadership and regional staff regarding these ongoing safety concerns for custodial youth. If PQT identifies concerns or trends, they develop corrective actions, such as additional staff training, monitoring, and performance improvement plans, to mitigate risks to children and to ensure employees avoid questionable interactions with children in their care. The PQT then follows up with providers to ensure they complete each corrective action item. Incomplete action steps from previous meetings are discussed during the next PQT meeting.

The PQT reviews focus on alleged perpetrators who have been subject to more than 10 investigations over a 3-year period

To start the process of determining who needs a PQT review, the PQT reviews the Special Investigations Unit (SIU) monthly report (a manual report prepared by SIU), which contains a count of the history of all SIU investigations in which each alleged perpetrator has been named. This report is manually compiled by SIU staff because, according to management, TFACTS does not have the

[42] The preponderance of the evidence standard means that the burden of proof is met when there is a greater than 50% chance, based upon all of the evidence shown, that the plaintiff's claims are true and that the defendant did, in fact, engage in the conduct which caused injury or damage to the plaintiff.

capability to produce a report that is based on the number of times a specific provider or employee has been named in an investigation. As a next step, PQT staff locates the alleged perpetrator in TFACTS to manually check whether they were named as a bystander or as the actual alleged perpetrator and count the number of investigations that occurred in the last three years.

Once individuals are identified as having 10 investigations over a 3-year period, the team conducts their PQT review by reading incident reports and reviewing SIU investigations and case recordings. Ultimately, PQT summarizes their conclusions in a written report which is shared with applicable central office leadership.

Prior Audit Results

In DCS's 2020 performance audit, we reported in a finding that DCS did not perform follow-up to ensure that Wilder Youth Development Center or private provider management completed corrective action items related to employee misconduct involving children in their care.

Current Audit

To follow up on the prior finding, we focused our audit testwork on PQT's follow-up of their PQT reviews to ensure providers and Wilder Youth Development Center management had taken action to address employees' questionable interactions with children housed in their facilities. We also focused on management's process to identify potential employee misconduct to offer suggestions for improvement.

New Conditions and Repeat Condition

Finding 9

Deficiencies in management's PQT review process contributed to the PQT not identifying a questionable provider employee, to prevent his contact with children in state custody, and to avoid child endangerment

PQT failed to follow up on an identified safety concern

From October 2020 to September 2022 (end of our fieldwork), PQT only identified 1 person who met their requirements[43] for a PQT review, which was conducted in October 2020. The PQT

[43] DCS's Protocol for the Provider Quality Team states that PQT will conduct a PQT review on alleged perpetrators who meet the following criteria: "any contract provider(s) or Youth Development Center employee who has been identified as an alleged perpetrator in ten (10) or more investigations that occurred within the last three years; or any contract provider(s) or Youth Development Center employee who has been identified as an alleged perpetrator in more than five (5) investigations that occurred within the last three years and PQT received a PQT referral outlining concerns regarding this employee."

review identified that this employee was involved in 16[44] SIU investigations alleging physical abuse, but for which SIU **could not substantiate the allegations** of physical abuse. Based on our review and discussion with the PQT management, we found that in 14 of the 16[45] investigations, SIU had noted safety concerns about this individual including excessive use of force, physical injury to children requiring medical treatment, administering/conducting restraints outside of camera range, and prior criminal history (drunk and disorderly, dismissed battery) in another state, but without hard evidence, management could not take further legal or administrative action.

We discussed the nature of this PQT review with current management and staff and found that this PQT review occurred under the former[46] PQT Director, and the provider employee in question had indicated to DCS in January 2020 that he had submitted his 30-day notice to leave the provider facility and would not be working with children in facilities any longer. According to DCS management, this individual was not employed by any DCS providers from February 2020 to November 2020, and thus did not have any new SIU investigations during this time. In November 2020, the individual began employment with a different DCS provider and resumed working with children. Beginning in May of 2021, SIU investigative staff identified this individual in 6 additional SIU investigations but again could not substantiate the allegations with evidence. Furthermore, SIU did not note any new safety concerns on this individual.[47] We also verified that PQT had not performed any further PQT reviews focused on this individual.

In May 2022, this individual was indicted and charged with aggravated assault and reckless endangerment with a deadly weapon for chasing after children (in his car) who escaped by car from a Nashville-based residential facility in March 2022. The individual was also alleged to have fired his weapon at them while they were driving, causing the children to crash.

We discussed these circumstances with PQT management to obtain their thoughts on how this individual was able to continue working with children in custody. Current management indicated that SIU did not feel that this individual posed any new safety concerns up until the March 2022 incident, despite management's access to prior SIU investigative results where SIU had noted safety concerns.

[44] These 16 investigations were conducted by SIU between September 2016 and March 2020.

[45] SIU classified all 14 investigations as allegation unsubstantiated, perpetrator unsubstantiated.

[46] The former director wrote the report in October 2020 and left her position in November 2020. The current PQT Director and staff member were hired in April 2021.

[47] When we last looked in TFACTS on October 12, 2022, this individual was involved in 9 additional SIU investigations since the October 2020 PQT review.

DCS's process for creating the monthly SIU report is manual and susceptible to human error, which could delay PQT from initiating their review processes

Based on our review of monthly SIU reports from April 2021 to January 2022,[48] we found that DCS relies on a manual process that involves staff looking in TFACTS and entering information into the monthly SIU report spreadsheet to count employee investigations. We found 11 unique employees where this process resulted in inaccurate investigation counts.[49] See **Table 20** in **Appendix 10** for a summary of our results. Had these counts been accurate, 2 individuals would have qualified for a full PQT review. According to management, TFACTS currently does not have the ability to run a report that captures the number of investigations concerning specific providers or employees, so SIU staff must manually create those reports. Management also stated that even though they had not conducted a review of these 2 employees, they were closely watching them and 1 of them had already resigned or was terminated. PQT completed a review on the other individual at the beginning of October 2022.

Additionally, this manual process lends itself to the opportunity for human error during the counts, especially when provider or Wilder Youth Development Center employees have duplicate profiles in the TFACTS information system. Since PQT relies on the data in the SIU report to trigger their initial review process, it is important that these numbers are easily accessed and reliable.

Staff did not follow up with providers 17% of the time to make sure they completed action items to address safety concerns identified in SIU investigations (repeated from prior audit)

In DCS's 2020 performance audit, we reported in a finding that DCS did not perform follow-up to ensure that Wilder Youth Development Center or private provider management completed corrective action items related to employee misconduct involving children in their care.[50]

In our current audit, we found that PQT reviewed 140 closed SIU investigations from April 1, 2021, to January 31, 2022. We randomly selected 30 of these reviews to see whether PQT followed up with providers to ensure they completed all action items to respond to any child safety concerns. While improvements were made to this process, we still found that 20% of the time, PQT did not follow up on corrective action items related to employees' lack of supervision or to sexual abuse, physical abuse, and psychological harm. In some cases, PQT staff stated they could not follow up due to unresponsive providers and ongoing investigation appeals; in other cases, staff followed up verbally

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[48] Our scope for the PQT review process was from April 2021 to January 2022 because new staff were involved in the process and had updated the process.

[49] Green Book Principle 10.06 states, "Control activities can be implemented in either an automated or a manual manner. . . . Automated control activities tend to be more reliable because they are less susceptible to human error and are typically more efficient."

[50] DCS's Protocol for the Provider Quality Team states, "3. PQT contacts the contract provider and discusses action steps within 3 business days from the date the investigation was reviewed in a PQT meeting . . . 4. PQT maintains spreadsheets that includes investigation-specific data and review outcomes."

and did not document in writing that follow-up contact was made and whether corrective actions were taken. See **Table 19** in **Appendix 10** for more details about our testwork results.

Although DCS does include language in provider contracts that states providers must work with DCS to address any issues with provider performance, PQT has not leveraged this contract language to remind providers that they must cooperate with PQT to resolve any safety concerns.

When management does not identify staff with multiple investigations of misconduct, such as those involved in the aggravated assault and reckless endangerment case discussed above, similar tragedies are likely, and management is therefore increasing the risk of harm to children. To reduce or eliminate situations where children are in danger, management must improve its PQT process, review as many questionable employees as possible, and follow up to ensure all corrective actions are taken.

A change in the PQT identification and selection of potential child perpetrator reviews could improve PQT review outcomes

DCS's current PQT protocol calls for a review only when a Wilder Youth Development Center or provider employee has had 10 investigations in a 3-year period or more than 5 investigations in a 3-year period as well as a PQT referral.[51] **This process only resulted in 1 PQT review since our prior audit.** We analyzed the SIU reports from April 2021 to January 2022 to see how many Wilder Youth Development Center and provider employees would qualify for a PQT review if DCS lowered the threshold for reviews to 5 investigations in a 3-year period and found that 6 more individuals would have qualified for the review.[52]

According to management, they have not lowered the threshold for PQT reviews because current PQT staffing levels cannot accommodate an increased workload generated from additional PQT reviews. In addition, management shared concerns that changes to the thresholds for triggering a PQT review could negatively impact providers' employee recruiting efforts because an employee may feel penalized for doing their job.

Recommendation

Management should assess the effectiveness of the PQT reviews and make changes to achieve the intended goal of protecting children in their care from potentially unsafe Wilder and provider employees.

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[51] PQT referrals are forms filled out by regional or central office staff when they have concerns about a particular provider or provider employee and would like PQT to take a closer look.

[52] Green Book Principle 12.05 states, "management periodically reviews policies, procedures, and related control activities for continued relevance and effectiveness in achieving the entity's objectives or addressing related risks" and Principle 16.01 states, "management should establish and operate monitoring activities to monitor the internal control system and evaluate the results."

Management should evaluate all tools and resources, including TFACTS, to ensure PQT staff have all resources to facilitate the identification of those employees who should be subject to a PQT review.

Management should ensure that the Provider Quality Team follows up on each PQT review to determine that the provider and/or DCS's Wilder Youth Development Center management has completed corrective action to resolve all safety concerns involving children placed in these facilities. PQT should also maintain documentation of each follow-up so that top DCS leadership can verify the integrity of the PQT process.

We also recommend management consider lowering the threshold to identify potential employee threats to child safety so that more PQT reviews can be performed to help meet management's goal to protect children in DCS care.

Management's Comment

We concur with the finding.

DCS management has begun revising policies and procedures around the PQT process. The OCQI [Office of Continuous Quality Improvement] Performance Quality Director has a plan to conduct process mapping to review and assess where any gaps in the PQT process may currently lie. PQT has utilized a manual report from SIU in the past. Funding for the automation of this report has been approved in the budget for FY24 which will also reduce the risk of manual error going forward.

Employee, Provider Employee, and Volunteer Background Checks

State statute and DCS policy require DCS and provider agencies to conduct background checks on DCS employees, volunteers, and provider employees

To maintain safe conditions, DCS is legally required to obtain a criminal background check on any employees and volunteers whose function would include direct contact with children in DCS custody or who may have access to children's information. DCS requires all employees, volunteers, and provider employees to be free from a criminal or abuse history that could pose a safety risk to children. For all potential employees, as well as volunteers and provider employees applying to work with children, state statute requires DCS and provider agencies to conduct fingerprint checks through the Tennessee Bureau of Investigation and the Federal Bureau of Investigation, and to check the

Department of Health's vulnerable persons registry (abuse registry). DCS policy also requires additional pre-hire checks of local criminal records, driving records, the national sex offender registry, and the department's own Tennessee Family and Child Tracking System (TFACTS).

Prior Audit Results

In the prior audit, we noted that department staff did not perform employee and volunteer background checks before hire/start dates, department staff did not maintain complete and accurate volunteer records, and department staff did not comply with department policy for ensuring background check results were on the required checklist.

In subsequent follow-up, management indicated they completed a review of all current employees' personnel files and corrected deficiencies by June 15, 2021; retrained Human Resources staff on applicable policy; created a procedure to require Central Office Human Resources staff to review pre-employment documentation before approving new hires in the state's system; and implemented a quarterly review of new employees' files. For volunteers, management indicated they completed a file review of all current and new volunteer files and made corrections by April 30, 2021; retrained volunteer coordinators; created a procedure for regional volunteer coordinators to submit volunteer files to Central Office Human Resources staff to review; and required regional staff to maintain volunteer files in a department-wide shared drive to be reviewed annually.

Observation 1

Management needs to continue to improve the background check process to protect children from unsafe employees and volunteers

Staff did not perform driver record checks prior to hiring employees

In response to the prior audit finding, management improved their background checks on employees and volunteers; however, more improvement is needed to keep children safe. DCS Policy 4.1, "Employee Background Checks," requires Human Resources staff to check driver records for all employees as part of the background check process. We tested 60 department employees to determine whether staff performed background checks. We found the following 15 errors:

- The DCS Human Resources staff were unable to complete driving record checks for 4 employees with non-Tennessee driver licenses who were hired between January 1, 2021, and February 28, 2022, because staff did not have access to other states' driving record databases.
- For another 4 employees, we found that all 4 employees were hired with non-Tennessee driver licenses and Human Resources staff performed the driving record check once the employee obtained a Tennessee driver license.

- For 7 employees hired with Tennessee driver licenses, Human Resources staff performed the driving records check late for 1 employee and did not record the date the driving records check was performed for the other 6 employees. Management could not provide sufficient evidence that the checks were performed prior to hire.

Staff marked checklist items completed before actually completing the background checks

In addition, management needs to continue to train staff to use the background check checklist, which is intended as a tool for staff to use to ensure all pieces of the background check process are completed.[53] Our review of a nonstatistical, random sample of **60 employee and 60 volunteer records** disclosed that staff noted checklist items as completed before actually completing the background checks for 27% of employees and 15% of volunteers. We also noted that 4% of **volunteers were once again allowed to serve children before staff completed the background check process**.[54] We determined that the department did not identify any background check results (once completed) that should have prevented DCS from hiring the employee or allowing the volunteer's service based on our sample.

See **Table 21** in **Appendix 10** for a summary of our results.

Performing background checks and **completing their process before an employee or volunteer starts working** allows DCS to ensure only appropriate individuals are allowed to work with children. **When DCS does not conduct the required background checks,** there is an increased risk that someone who poses a threat to children could come in contact with children or have access to children's information.

We recommend management ensure staff are following DCS's policy regarding employee and volunteer background checks to keep children safe.

The Commissioner and the Executive Director of Human Resources should continue to fine-tune the background check process because it is vital that DCS protect children from unsafe employees and volunteers. Management should ensure that staff complete all required background checks before employees begin working, as required by DCS policy. The Executive Director of Human Resources should also ensure that staff comply with policy and accurately and completely document their reviews on the internal checklist.

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[53] DCS Policy 4.1, "Employee Background Checks," and the *Volunteer Service Procedures Manual* require that results from completed background checks must be documented on form CS-0687, Background Check History and IV-E Eligibility Checklist, and maintained in the applicable employee or volunteer file.

[54] According to the *Volunteer Service Procedures Manual*, "Once the designated Central Office Child Programs staff has determined the file is complete and all background checks have been conducted within the required timeframe, the volunteer's file will be submitted to the DCS Central Office HR contact who will then request certification from the Division of Claims." The Volunteer Certification Letter indicates the "letter will serve to verify that the Department of Children's Services has approved the applicant" for volunteer service.

Management's Comment

We concur with this observation.

Previous policy required all DCS employees to have a TN driver's license at hire. This is not possible for staff who live in bordering states or staff who are spouses of military members stationed at Ft. Campbell who may not establish permanent residency in TN. Additionally, state law allows new residents 30 days after establishing residency to obtain a TN driver's license. These are the majority of the staff listed above. Policy has been amended to allow an exception for these circumstances.

We are working to develop a process to reduce the number of staff responsible for completing background checks by developing an onboarding team. By doing this, these staff will have sole responsibility for completing checks prior to an employee's start date without other tasks (such as offboarding, disciplinary action, etc.).

DCS HR staff will be retrained on proper completion of the background checklist and the necessity to document the date(s) checks are completed if the date does not print on the actual check.

Child Safety Responsibilities: Probation and Aftercare Supervision

The Office of Juvenile Justice provides probation and aftercare services to delinquent children

As of the end of July 2022, DCS had 1,575 children on probation or on aftercare.

The Office of Juvenile Justice provides probation[55] and aftercare supervision services to children who are found delinquent by a juvenile court. DCS provides probation services as a preventive and safety measure to divert children who have broken the law from entering DCS custody. DCS also provides aftercare supervision services to children who are exiting its custody from juvenile justice facilities to ensure that children continue to successfully transition into the community after the end of a trial home visit.[56]

The core concept of probation and aftercare supervision **is the contact DCS has with the children to** ensure they are adhering to the rules of probation and aftercare. These contacts could help children remain in the home and community and prevent them from continuing down the path of juvenile delinquency and entering or re-entering DCS custody. Monthly case manager visits help juvenile justice children stay on track and free from further involvement with crime. DCS Policy 13.12, "Probation Requirements for Delinquent Youth," requires case managers to have face-to-face contact at least once a month with children on probation and aftercare.

[55] Some counties, like Shelby and Knox, have their own probation programs.

[56] A trial home visit is the first 30 days a child spends at home with their family after exiting a juvenile justice facility.

Prior Audit Results

In the department's 2020 performance audit report, we found that the Office of Juvenile Justice staff did not consistently document their supervisory review of family service workers' probation and aftercare supervision and did not perform the required number of contacts for probation and aftercare. In response to this finding, management revised their probation and aftercare policies and protocols, and developed internal control case tracking spreadsheets as part of new supervisory review processes to ensure case managers make the appropriate number of contacts.

Current Audit

During the current audit, we focused our review on following up on the prior audit finding related to Office of Juvenile Justice staff performing the required number of contacts with children on probation, the child's school, and the service providers.

Repeat Finding

Finding 10

Rising turnover and caseloads have impacted juvenile justice case managers' ability to make the essential monthly supervision contacts with children, their families, schools, and service providers for children on probation and aftercare

We found that despite improvements since the prior audit for case managers to make key contacts with children, their families, schools, and service providers, DCS's efforts have been hampered by insufficient staffing and the caseload crisis that DCS is experiencing.

Specifically, we found that case managers did not contact the child's school to evaluate school progress in 55% of probation cases and 28% of aftercare cases. Additionally, case managers did not contact the child's service providers to evaluate whether the child was getting appropriate and satisfactory services in 42% of probation cases and 28% of aftercare cases. See **Table 22** in **Appendix 10** for more details of our testwork results.

According to DCS Policy 13.11, "Trial Home Visit and Aftercare Requirements for Delinquent Youth," and Policy 13.12, "Probation Requirements for Delinquent Youth," contacts should be made as follows.

- Probation/Aftercare
    - 3 face-to-face visits in the first 30 days with 1 being in the home

- 1 face-to-face visit per month in the home
- 1 contact with the parent/legal custodian per month
- 1 contact with school officials per month
- 1 contact with service providers per month

- Intensive Probation/Aftercare
  - 3 face-to-face visits in the first 30 days with 1 being in the home
  - 3 face-to-face visits per month with 1 being in the home
  - 2 contacts with the parent/legal custodians per month
  - 1 contact with school officials per month
  - 1 contact with service providers per month

As echoed in **Finding 2**, high turnover and caseloads place an increased strain on case managers, who already have a tough job, and contribute to longer work hours, burnout, decreased morale, and increased mistakes. According to management, the case managers' efforts to make contacts are directly impacted by unresponsive school personnel and service providers who have their own staffing and workload issues, resulting in missed contacts between case workers and school personnel and service providers. We also noted that region supervisors did not consistently use the internal control case tracking spreadsheets to ensure case workers make all required contacts by the end of each month as the spreadsheets were intended.[57] See **Appendix 10, Figure 27.** All these things negatively impact the children and families DCS is tasked with serving.

Recommendation

The Commissioner and Deputy Commissioner of Juvenile Justice should take steps to ensure all juvenile justice case managers make required monthly contacts with children, their families, schools, and service providers for children on probation and aftercare. Management should also ensure that regional juvenile justice supervisors appropriately utilize internal control case tracking spreadsheets as designed to help ensure case managers make required contacts by the end of the current month.

[57] Green Book 10.1 states "management should design control activities to achieve objectives and respond to risks."

Management's Comment

We concur with this finding.

Management is taking a multi-tiered approach to address this problem. Budget requests to substantially increase salaries for case managers in fiscal year 2023/2024 should enable the Department to attract personnel. Additional training and field support strategies to be implemented in mid-year 2023 will impact retention. Budget requests were submitted for $15.8 million to increase the case manager salaries within the Department for FY 2023/2024. DCS is revising the policy that requires visits based on supervision level. The supervision level is derived from the CANS assessment.

DCS Response to External Reports

Since 2012, DCS has been scrutinized for the management of juvenile detention facilities and the treatment of children within these facilities

Over the past 10 years, DCS's management of youth development centers has been called into question due to repeated serious incidents such as riots and mass breakouts, including one that made national headlines in 2014. In 2018, DCS privatized operations of two youth development centers, Woodland Hills[58] and Mountain View, while maintaining operation of Wilder Youth Development Center. Over the past three years, there have been multiple riots and escape attempts at Wilder and the facility has been decimated by turnover.

Due to staffing issues at Wilder, DCS reduced the number of children from its maximum capacity of 120 down to 32 in May 2022.

In April 2022, Disability Rights Tennessee and the Youth Law Center published a report on the dismal conditions within Wilder, citing violence and the abuse, mistreatment, and neglect of children within the facility. According to the report, *Designed to Fail: A Report on Wilder Youth Development Center, a Department of Children's Services Facility,* "youth at Wilder report similar experiences at other DCS-contracted juvenile justice facilities."

We asked management about planned corrective action to address the above-mentioned report; however, DCS declined to discuss the issues of the report, citing potential litigation.

To address some of the concerns surrounding Wilder and other challenges facing the state's juvenile justice system, the General Assembly created a Joint Ad Hoc Committee on Juvenile Justice, which began meeting with DCS leadership, juvenile judges, advocacy groups, and other community partners in June 2022.

[58] Woodland Hills, formerly known as Gateway, closed operations in 2014.

Child Health

Ensuring that children and youth in the Department of Children's Services' (DCS) custody have the medical and dental services they need is critical to children's health. DCS determines what health services a child needs through medical and dental screenings.

Management should automate the process for medical and dental screenings and supervisory reviews to ensure children and youth in custody receive timely health care services.

General Background

Regular medical and dental care, including prevention, diagnosis, and treatment, is important and necessary to restore and maintain children's health. DCS's Office of Child Health, which includes a regional health team at each of DCS's 12 regions, is responsible for ensuring children and youth in DCS care receive proper health care. Each region has a regional health team, which includes a regional nurse consultant, a health advocacy representative, and a service appeals tracking coordinator, who work with children's insurance providers, including TennCare, and enter medical information into the Tennessee Family and Child Tracking System (TFACTS).

Children and youth must undergo initial and annual comprehensive medical and dental screenings

To determine the medical and dental needs of children in DCS custody, DCS requires all children in its custody to undergo an Early Periodic Screening, Diagnosis, and Treatment (medical) screening. DCS policy requires that all children in DCS custody must receive an initial medical screening within 30 days of entering DCS custody[59] and annually thereafter from the child's primary care provider or other qualified medical professional. Medical screenings are completed according to the schedule established by the American Academy of Pediatrics. A medical screening consists of 7 components:

[59] According to the supplement to DCS Policy 20.7, children and youth in DCS custody must receive an initial medical screening within 72 hours of entering custody. However, if a medical screening cannot be obtained within 72 hours, the child may be seen by a "qualified medical practitioner" for an initial health screening to identify health conditions that require immediate or prompt medical attention. An initial health screening is not as thorough as a medical screening. If an initial health screening is performed within 72 hours of a child entering custody, then the initial medical screening may be completed within 30 days of the child entering custody.

1. comprehensive health and developmental history,
2. comprehensive unclothed physical exam,
3. age-appropriate immunization,
4. age-appropriate lab tests,
5. health education,
6. vision screen, and
7. hearing screen.

DCS policy also requires that all children in DCS custody who are 12 months of age or older must receive a dental examination from a dentist within 30 days of entering custody[60] and every 6 months thereafter. A dental screening consists of 4 components for children and youth:[61]

1. medical/health history,
2. oral hygiene and periodontal health exam,
3. diagnosis of oral health needs, and
4. plan of treatment.

Finding 11

DCS cannot ensure timely dental and medical screenings given the reliance on paper forms and manual processes to complete, review, and follow up on children's medical and dental screenings; timely screenings are critical to identify potential health conditions and/or need for follow-up health services

Manual steps to complete, review, and follow up on children's health screenings create opportunities for errors and delays in follow-up services

We found that there are multiple manual steps in the process to complete and review medical and dental screening results, primarily due to DCS's reliance on paper forms. DCS must use paper forms due to limitations of the TFACTS system. See **Figure 28** in **Appendix 11** for a summary of

[60] If a child has had a dental exam within 6 months of entering custody, the child does not have to have a dental screening within 30 days of entering custody.

[61] There are 5 components of a dental screening for infants: medical/health history, oral examination, parental counseling, preventive health education, and determination of appropriate periodic re-evaluation.

DCS's process to complete and review medical and dental screening results. The manual steps in the process could cause delays in children receiving healthcare services and create a risk that the screening results will be

- lost;
- delayed in reaching the regional nurse consultant, whose review is important to determine follow-up services needed; or
- incorrectly keyed into the child's case file in TFACTS.

For example, since DCS uses paper forms to document the results of screenings, the adult accompanying a child to a screening must remember to take the correct paper form to the appointment, have the practitioner complete it, and find time to give the paper form to the child's case manager. Additionally, later in the process, the regional health team must manually enter the results of the screening into the child's TFACTS case file. This not only causes delays in updates to a child's case file, but also creates the potential for keying errors.[62]

Health screenings were late or were not reviewed to determine whether follow-up services were needed

DCS reported that there were 8,965 children in its custody in December 2021. Although children in DCS care do receive medical and dental screenings, we found that many screenings were 30 or more days late, or the regional nurse consultant was not able to review the screening results in the child's case file within the required timeframes. For calendar year 2021, 2,046 children's medical screenings and 4,416 children's dental screenings were more than 30 days late. We also found issues with the quality of the screening date in TFACTS; therefore, neither we nor management can be certain as to the accuracy of the results. For example, a child's screening results were not recorded correctly in TFACTS and as such TFACTS flagged this child's screening as not completed. We also found situations where a child's screening was completed; however, the evidence (the screening form) was not uploaded to TFACTS or reviewed by the regional nurse consultant.

Delays resulting from this manual process can impact how soon a regional nurse consultant can review the child's screening results and make informed decisions about a child's need for additional medical or dental follow-up services.

The medical and dental screening process is also directly impacted by case manager turnover and/or case managers with high caseloads, as either situation creates inconsistency among the case managers who are assigned to

[62] DCS Policy 20.7 sets the timeframes for when medical screenings must occur, and DCS Policy 20.12 sets the timeframes for when dental screenings must occur.

a particular child's case. Therefore, it is even more critical that the regional health nurse review and maintain screening results in TFACTS.

We selected a random, nonstatistical sample of 25 initial and annual medical screenings and 29 initial and biannual dental screenings from the population of screenings that were more than 30 days late that was discussed above; each of these screenings represent 1 child. We reviewed the child's case file in TFACTS to determine why the screening was reported late. We found 4 reasons that staff reported late screenings, and we included the percentage each reason occurred:

- the screening was actually performed late (56% for medical and 45% for dental);
- the screening was performed on time, but there was a delay in the screening results being entered into TFACTS (32% for medical and 21% for dental);
- the screening was performed on time and the scanned paper document was uploaded to TFACTS, but the regional health team had not keyed the screening results into the child's case file in TFACTS, which resulted in the system flagging the screening as late (8% for medical and 31% for dental); or
- there was no evidence in the child's case file that an actual screening had occurred (4% for medical and 3% for dental).

The Deputy Commissioner of Child Health stated that there are multiple reasons screenings may occur late or be keyed to the child's case file and reviewed late:

- the shortage of case managers, as well as the caseloads of the case managers, makes it difficult for case managers to ensure the screenings occur when they should, and there is not always a consistent case manager responsible for ensuring the screening is completed;
- medical and dental providers may not fill out the required form or may not fill it out correctly;
- DCS must use paper forms because TFACTS lacks the functionality to automatically upload the results from the screenings, thus requiring management to use a manual multi-step process to upload screening results to TFACTS; and
- during 2020, many dentist offices were closed due to COVID-19, causing screenings to be late, and even when dental offices reopened, caregivers had to wait several weeks before there was an available appointment for the child.

The Deputy Commissioner stated that her team was in the early stages of working with a vendor to automate parts of the process to enter screening results directly into TFACTS, reducing DCS's reliance on paper documents and increasing the use of electronic documents. She also stated that Office of Child Health staff are working with the Department of Finance and Administration's

Strategic Technology Solutions staff who support DCS to create new reporting that will be more accurate and provide more details about children with late screenings.

Recommendation

The Commissioner and Deputy Commissioner of Child Health should ensure all children receive timely medical and dental screenings and have immediate access to follow-up care by minimizing risks of delay within the manual process.

The Commissioner and Deputy Commissioner of Child Health should continue to pursue opportunities to reduce the reliance on paper medical and dental forms as well as work to automate steps in the process to complete screenings and expedite nurse reviews to prioritize children who need follow-up medical and dental services.

Management's Comment

We concur with the finding.

Management has already selected a vendor to implement the automated solution. The vendor was selected as a result of similar work performed at another state agency and a successful 3-day planning session where the current beta version was created. Funding for this project was approved last month and DCS management has since reengaged the vendor to further develop this project with a goal of implementation during the fiscal year 2024.

Tennessee Family and Child Tracking System (TFACTS)

The Department of Children's Services' (DCS) information system, TFACTS, is vital to DCS's ability to maintain case management information so that DCS management and case managers can make informed decisions about the children and families in DCS's care. TFACTS is the central point for all information regarding children and families DCS serves.

Since TFACTS was implemented in 2010, DCS has been challenged with system functionality issues including delayed foster parents' payments, slow system processing, and unexpected user logouts.

While DCS was able to implement the financial component in November 2021, and the enhancement improved DCS's ability to complete financial transactions to foster care families and providers, the new enhancement negatively impacted the system's non-financial functionality. These setbacks involved management and staff's inability to run needed program reports and to maintain data efficiency and accuracy.

Given the long-standing issues with TFACTS, DCS management must decide the best course to ensure the case management system has the capability and functionality to help management effectively and efficiently care for the children in custody or at risk of custody and to provide the best automated resources and tools to DCS employees to achieve all of DCS's goals.

General Background

TFACTS was implemented as DCS's statewide automated child welfare information system to help management collect information about children and families who are assisted by DCS and to track children through all phases of their care, known as case management

DCS began using the Tennessee Family and Child and Tracking System (TFACTS) as its statewide case management system in 2010. TFACTS supports case management for Child Protective Services, Foster Care, Juvenile Justice, Foster Homes, Adoptive Homes, and Adoptive case files. The TFACTS application houses electronic data related to the tracking and care of children in state custody, as well as children in jeopardy of entering state custody. DCS works with the Department of

Finance and Administration's Division of Strategic Technology Solutions (STS) to maintain TFACTS.

DCS has a history, stretching back more than a decade, of being slow to implement change to correct issues and ensure the functionality of TFACTS

Soon after TFACTS was implemented, DCS staff and foster parents began expressing concerns about the system's functionality. In 2012, our office issued a special review report of TFACTS, which highlighted issues that management disregarded pre-implementation. The special report also stated that after implementation, management did not track problems with TFACTS and, as a result, did not proactively address issues in the system. See **Table 23** in **Appendix 12** for the specific issues noted in the 2012 report.

In 2014, 2016, and 2020, we reported additional long-standing functionality issues with TFACTS including slow speeds, unexpected logouts, and cumbersome functionalities, and we made recommendations for management's corrective action. Since 2010, DCS has initiated some enhancements to TFACTS's capabilities and has spent approximately **$125 million** in state and federal funds for the added enhancements and to maintain the system. Despite these investments, however, management has not achieved permanent resolution to the ongoing system functionality issues.

We had specifically recommended 10 years ago that DCS implement financial enhancements to allow TFACTS to manage payments to third parties such as foster parents and maintain accurate accounting for state and federal financial reporting purposes. Management did not implement the financial enhancement until recently, and staff for years have had to use manual workarounds to ensure third parties were paid. These manual workarounds also required considerably more staff resources than would have been required had TFACTS been upgraded to manage the payments.

According to management, and as reported in prior performance audits, DCS encountered delays with the implementation of the financial enhancement because TFACTS users requested additional features when system testing (prior to implementation) revealed extensive system errors that required DCS and STS to rewrite code to fix the errors. Management also had to train users how to use the financial enhancement features. Finally, in November 2021, management and STS implemented the TFACTS financial enhancement.

Current Audit

We reviewed the financial enhancement, management's response to issues that arose as a result of the implementation of the financial enhancement, and management's response to other issues we have previously reported with the system.

Repeat Finding

Finding 12

DCS cannot continue to rely on TFACTS as it currently exists, and management must carefully examine the costs and benefits between continuing to update TFACTS and implement necessary improvements or replacing TFACTS with a new system

TFACTS's functionality issues impact multiple areas and responsibilities within DCS and date back to the system's implementation. In the current audit, we identified four critical areas of responsibility where the TFACTS functionality problems have persisted and thus continue to frustrate both internal and external parties. These areas include

- non-payments or delayed payments to foster parents and private providers;
- insufficient ad-hoc reporting for both users and management to facilitate day-to-day decision making (in fact, the new financial enhancement negatively impacted other non-financial functionality, such as reporting capabilities);
- inefficient manual workarounds that had to be used because the system is not capable of providing all critical information or timely information so that the case manager can make informed case management decisions for the children in their care; and
- system latency concerns as well as an outdated functionality that is inefficient for case managers, who already have limited time given their direct responsibilities with children and their families.

Based on our review of the TFACTS system implementation and management's continuing efforts to improve TFACTS functionality, we found that management must decide the best course of action to secure the right child welfare system. This decision must include consideration of TFACTS's sustainability.

DCS has struggled to implement changes to TFACTS and fix functionality issues partially because the vendor does not support the software, and has not supported it since TFACTS was implemented

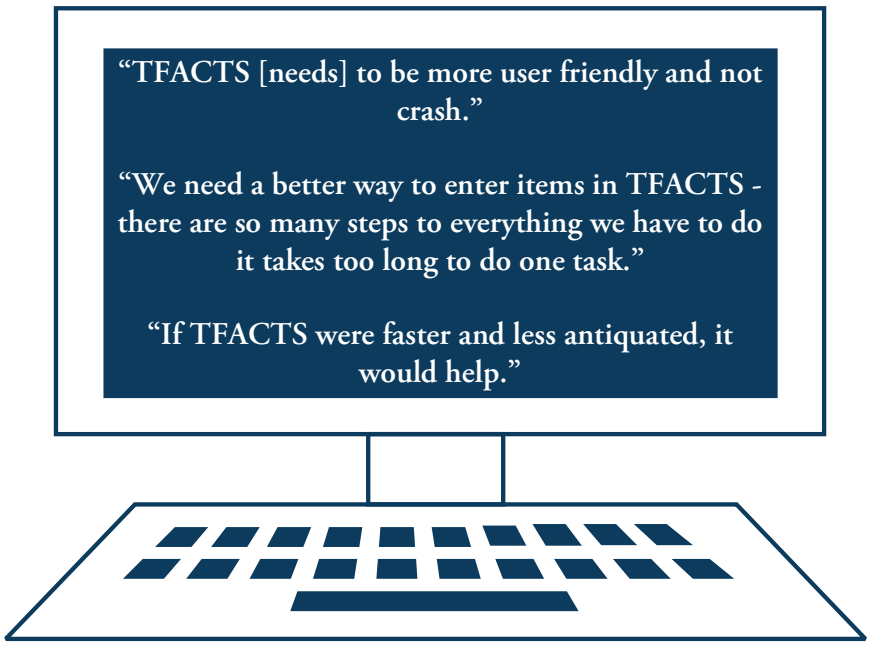
In 2008, prior to DCS's implementation of TFACTS, Vendor A, which created the software used to build TFACTS, decided to stop supporting the software. When a vendor chooses to stop supporting a software, it means that the vendor will no longer provide updates to the software—including new features and functionality enhancements. Knowing this, DCS decided to continue building TFACTS with the unsupported software because they believed that the software was one of the best available at the time, and it would take longer and cost more for a different vendor, Vendor B (who was responsible for building TFACTS) to re-code the system with a different software. Based on the information available to us, we also learned that Vendor B had also preferred to use Vendor A's software and signed the contract with DCS in April 2008. The software updates stopped in May 2008.

Working with outdated and unsupported software makes it difficult not only to make updates and changes to TFACTS, but also to find and hire staff who are able to work with the legacy software.

Case managers told us that functionality issues with TFACTS make their jobs more difficult

We surveyed all case managers in May 2022 (see **Case Manager Turnover and Caseloads** section and **Findings 2** and **3**), and we asked questions specific to what tools and resources would make their job easier. About 8% of survey respondents shared frustrations related to TFACTS functionality, which included the following:

Figure 11
Case Manager Responses Regarding TFACTS



Source: Auditor created based on case manager survey responses.

Due to financial enhancement implementation issues, DCS either delayed payment or failed to pay at least $859,025 to at least 78 foster families, 137 adoptive parents, and 40 private providers

Based on our review of internal issue logs and emails management provided, we noted that at least $400,000 of payments to third parties were either delayed or not made at all between November 2021 and April 2022, impacting at least 78 foster families, 137 adoptive parents, and 40 private providers. We also discovered that, as of September 2022, DCS had not paid 1 private provider $459,025 due to issues caused by the financial enhancement implementation, even after the private provider contacted DCS and made multiple complaints to fiscal staff over 6 months.

Management was aware of the delayed payments but was not able to confirm the exact amount of delayed payments because of limited availability of TFACTS data. Management reported that the delays were attributed to implementation, system defects, and the learning curve for the financial enhancement.

Management did not require training for all users

After the financial enhancement was implemented, management had to train staff to use the new financial module. Management, however, only required DCS staff to complete training for the financial enhancement features. Management made the training optional for foster parents, adoptive parents, or private provider employees. As of November 1, 2021, DCS had 4,869 foster parents, and only 642 foster parents had completed the training for the financial enhancement features. We found that the lack of training potentially contributed to users' confusion with how features worked and might have exacerbated payment delays. Furthermore, after the implementation of the financial enhancement, management required foster parents to submit more information to DCS to request payment of funds, which may have also contributed to confusion and payment delays.

TFACTS functionality issues and insufficiency of system reporting capabilities caused staff to create manual workarounds to fulfill their responsibilities in case management and child care

Because the system could not meet the needs of management and case managers, especially child tracking and placement needs, management and staff were forced to create manual processes to ensure children and families received the care they needed. Based on our review, we found that staff have created workaround procedures because of the following issues:

TFACTS is not designed to capture the locations of children placed in temporary/transitional housing

As a result, for top management and regional management to know the immediate location of any child at any time, the 12 regional offices have created their own unique methods to track children placed in temporary settings. These workarounds include manually updated spreadsheets, emails, and phone calls to track children instead utilizing TFACTS. We provide more details about children

staying in temporary settings, including the manual workarounds to track these children, in **Finding 5**.

Staff cannot rely on TFACTS to help them find long-term placements for children

Because TFACTS does not provide real-time information for placement capacity and availability, staff must manually seek availability of space in a potential long-term location. Because case managers must follow this manual process, the case managers are further delayed in finding placement options for children. See **Finding 4** for more information.

TFACTS cannot automate results of the Special Investigations Unit's (SIU) monthly report, which is used to identify systemic child abuse trends in foster homes, facilities, program areas, or school systems

The SIU monthly report is intended to capture the number of investigations in which the same individual (who has direct access to children) has been identified as an alleged perpetrator. When an individual has had 10 or more investigations, the person is then subject to an alleged perpetrator history review. During our audit, we found that TFACTS could not accurately aggregate and generate the data for the SIU report; as such, staff were manually counting the number of investigations per individual in TFACTS and inputting this number on a spreadsheet. We also found that the manual process to count information in TFACTS was subject to human errors. Specifically, staff had miscounted the investigations because TFACTS contained duplicate alleged perpetrator profiles. As a result of both the deficiencies of TFACTS and human errors in the manual process, management may not have performed all required alleged perpetrator history reviews. See **Finding 9** for more information.

Having a system that provides accurate, real-time, and easily accessed data on available child placements (such as a report of available placement options) could help case managers find appropriate placements for children much sooner than is currently possible. Furthermore, a truly automated system to eliminate manual processes would save time for DCS staff and allow them to quickly identify potential issues and address them to protect the children they serve.

Recommendation

DCS and STS should carefully examine the costs and benefits between continuing to update TFACTS and implement necessary improvements or replacing TFACTS with a new system. Neither option will be simple, and either option DCS and STS choose will likely take significant resources—both staffing and financial resources—to implement. However, due to the issues we have outlined in this finding, DCS cannot continue to rely on TFACTS as it currently exists. Whichever course

DCS decides, the system must have the capability and functionality to help management effectively and efficiently care for the children in DCS's custody or at risk of custody and to provide the best automated resources and tools to DCS employees to achieve all of DCS's goals.

Management's Comment – Department of Children's Services

We concur with both the finding and the response from F&A.

Budget requests for Fiscal Year 2023/2024 to purchase a new TFACTS system for DCS would ultimately solve the issue, but the timing is not immediate. Work arounds and intermediate solutions will necessitate STS involvement and contractors working on updates and will require vigilance on the part of DCS and STS IT staff.

Management's Comment – Department of Finance and Administration, Division of Strategic Technology Solutions

We concur.

Many of the enhancements and defect fixes that have been developed, tested, and promoted to the TFACTS production environment over the past twelve years have not always adequately met the needs of DCS or the citizens they serve. This experience, in addition to the advanced technology and functionality that is available today and being implemented in other states, has led us (STS and DCS working together) to the conclusion that the replacement of TFACTS with a modern child welfare system is in the best interest of the State. However, since multiple years will be required to replace a system of this complexity, TFACTS must be updated to address payment delays and other high impact concerns affecting the department's ability to serve children and their providers. In addition, it is anticipated that system updates to TFACTS will occasionally be required to respond to federal and state mandates until the new system is implemented.

Repeat Finding

Finding 13

As noted in the prior audit, DCS management and Strategic Technology Solutions management did not provide adequate internal controls in one area, increasing the risk of unauthorized access to sensitive data

The Department of Children's Services' (DCS) management and the Department of Finance and Administration's Strategic Technology Solutions' (STS) management did not effectively design

and monitor internal controls in one area, increasing the risk of unauthorized access to sensitive data. We found internal control deficiencies related to one of DCS's systems; both DCS and STS did not adhere to state policies. Ineffective implementation and operation of internal controls increase the likelihood of errors, data loss, and unauthorized access to DCS information.

Pursuant to Standard 9.61 of the U.S. Government Accountability Office's *Government Auditing Standards*, we omitted details from this finding because they are confidential under the provisions of Section 10-7-504(i), *Tennessee Code Annotated*. We provided DCS and STS management with detailed information regarding the specific conditions we identified, as well as the related criteria, causes, and our specific recommendations for improvement.

Recommendation

Management should implement internal controls in this area.

DCS and STS management should correct the conditions in this area by promptly developing and consistently implementing internal controls in these areas. Management should implement effective controls to ensure compliance with applicable requirements, assign staff to be responsible for ongoing monitoring of the risks and mitigating controls, and take action if deficiencies occur.

Management's Comment – Department of Children's Services

We concur with both the finding and the response from F&A.

Management's Comment – Department of Finance and Administration, Division of Strategic Technology Solutions

We concur.

STS has revised certain processes and implemented additional internal controls to further mitigate the risk associated with this finding.

APPENDICES

Appendix 1
Objectives, Conclusions, and Methodologies

Strategic Planning and Risk Assessment

1. **Audit Objective:** In DCS's 2020–2024 Strategic Plan and annual Customer Focused Government plans, did management set goals and objectives that focus on mission-critical challenges DCS faces?

   Conclusion: Management prepared a strategic plan and annual Customer Focused Government plans; however, the plans did not include goals and objectives designed to swiftly address the current staffing and placement challenges DCS faces. The plans also do not address the root cause of other long-standing issues, such as the functionality of DCS's information system, TFACTS. See **Finding 1.**

2. **Audit Objective:** In management's formal risk assessment, did they identify fiscal, operational, reporting, and compliance risks and list control activities to prevent or minimize the identified risks?

   Conclusion: Management prepared a risk assessment; however, they did not evaluate all DCS operations, did not identify risks in all program areas including risks identified in prior audit findings, and did not design internal controls for the identified risks. See **Finding 1**.

Methodology to Address the Audit Objectives

To address audit objective 1, which includes gaining an understanding of DCS's strategic planning process, we interviewed DCS's Assistant Commissioner of Continuous Quality Improvement and Internal Audit Director. We reviewed state statute to gain an understanding of the requirements of the Tennessee Government Accountability Act of 2013. We reviewed the Office of Customer Focused Government's (under the Department of Finance and Administration) guidance for state agency strategic plans and annual Customer Focused Government plans. We obtained and reviewed DCS's initial and revised 2020–2024 Strategic Plan and annual Customer Focused Government plans for fiscal years 2019 through 2023.

To address audit objective 2, which includes gaining an understanding of management's risk assessment process, we interviewed the Director of Continuous Quality Improvement and the Internal

Audit Director. We reviewed state statute to gain an understanding of the requirements of the Financial Integrity Act. We reviewed the Department of Finance and Administration's "Management's Guide for Enterprise Risk Management and Internal Control" and the Green Book's requirements for risk assessments. To determine if management identified risks for prior audit findings and the current audit objectives, we obtained and reviewed DCS's 2021 risk assessment documents. We also obtained and reviewed DCS's written policies and standard operating procedures that were relevant to the risk assessment.

Case Manager Turnover and Caseloads

Audit Objective: Did management have enough case managers to support the day-to-day operations of ensuring the safety, permanency, and well-being of the children in DCS's care, and did management ensure adequate staffing levels of case managers for each region so that caseloads did not exceed the state's statutory caseload average of 20 cases?

Conclusion: Because of high caseloads among case managers, caused by a severe staffing shortage, management was not always able to ensure that the needs of children in DCS's care were met, and management was not in compliance with the state's statutory caseload average. See **Finding 2**, **Finding 3**, and the related **Matter for Legislative Consideration**.

Methodology to Address the Audit Objective

To address our audit objective, we interviewed the Office of Continuous Quality Improvement's Program Director; the Deputy Commissioner of Child Programs; the Deputy Commissioner of Child Safety; the Deputy Commissioner of Juvenile Justice; the Assistant Commissioner of Administration; the Director of System Integration and Innovation; the Director of Human Resources; the Human Resources Manager; regional staff and case managers at the Davidson, Knox, Shelby, and Upper Cumberland regional offices; staff and case managers at the Clarksville county office; and other case managers. We also reviewed Section 37-5-132, *Tennessee Code Annotated*; the case manager job description; the caseload compliance and averages reports from August 2020 through May 2022; procedures for compiling the caseload compliance and averages reports; and case manager training documents. We obtained Edison data for case managers' salary, overtime, and employment data, as well as for management's employee turnover reports, and we observed the process to create the caseload compliance and averages reports to gain an understanding of case manager caseloads and turnover.

We surveyed all 2,111 case managers that were employed as of April 26, 2022; see **Appendix 8** for information about the survey. To determine turnover and vacancy rates, we analyzed Edison employment data for the Case Manager 1 through Case Manager 4 positions from July 1, 2017, through July 31, 2022. We analyzed Edison employment data from March 2022 and the DCS

caseload compliance and average report from March 15, 2022, to compare what the actual average caseloads were for each region to what the average caseloads would have been for each region if all case manager positions that worked in DCS's 12 regional offices had been filled. We calculated the average if all positions were filled by dividing the number of cases reported as open for each region on the caseload compliance and average report by the total number of positions for each region, according to employee data we retrieved from Edison. The average if all positions were filled number assumes that all case managers positions are filled, and all case managers can work a full caseload (i.e., case managers are not in initial training or using leave). Our analysis did not consider variances in caseloads by case type. We analyzed Edison employment data for the Case Manager 1 through Case Manager 4 positions from fiscal years 2018 through 2022 to determine DCS's turnover among case managers. We analyzed Edison overtime data to determine how much overtime case managers worked in fiscal year 2022. We analyzed Edison salary data for full-time Case Manager 1 through Case Manager 4 positions as of May 20, 2022, to determine how many case managers were paid the maximum for their pay range. We performed data reliability procedures on the underlying data and code used to generate the caseload compliance and averages reports to determine their completeness and accuracy.

Child Placement

1. **Audit Objective:** Did DCS take action to recruit and retain placements for children for whom they assumed custody?

   Conclusion: Management did not increase their available long-term and temporary foster care placements on pace with the increase in custodial children. See **Finding 4**.

2. **Audit Objective:** Did DCS establish a formal process to track children and written guidance to dictate standards for consistent quality of facilities housing children overnight in temporary settings until a long-term placement could be found?

   Conclusion: Management did not establish a formalized process to track children who stayed overnight in a temporary setting until April 2022, and they did not provide written guidance to dictate standards for consistent quality of facilities housing children in temporary settings until July 2022. Established written guidance still did not address amenities in temporary placements. See **Finding 5.**

3. **Audit Objective:** Did DCS staff place the children who entered department custody in accordance with the child's assessed needs?

   Conclusion: Based on our testwork, management placed children in accordance with assessed needs. We noted three minor instances where staff did not complete children's needs assessments within timeframes as required by DCS policies and procedures.

Methodology to Address the Audit Objectives

To address our audit objectives, we interviewed DCS staff including the Deputy Commissioner of Child Programs, the Director of Network Development, the Deputy General Counsel, the Regional Administrator of the Knox region, the Regional Administrator and the Assistant Regional Administrator of the Davidson region, the Placement Coordinator of the Davidson region, the Regional Administrator of the Mid-Cumberland region, and the Placement Coordinator of the Shelby region.

To address audit objectives 1 and 2 and to assess the design of internal control for audit objective 2, we reviewed the Chapin Hall Tennessee Accountability Center's needs assessment, DCS's "Client's Rights Handbook," and legislative hearings and obtained the number of DCS and provider foster homes that DCS approved and the number of DCS foster homes that DCS closed in 2016 through 2021. We also reviewed DCS Policy 16.46, "Child/Youth Referral and Placement"; the supplement to Policy 16.46, "Guide to Placement Exception Categories"; each region's tracking sheet for temporary placements; informal procedures for updating the tracking sheet for temporary placements; DCS's fiscal year 2021 risk matrix; regional staff's spreadsheets for tracking temporary placements; the Youth in Office or Transitional (Safe) House Overnight spreadsheet as of July 4, 2022; the Memorandum of Understanding (MOU) template for use with transitional houses; and two signed MOUs with transitional houses. We analyzed the Youth in Office or Transitional (Safe) House Overnight spreadsheet as of July 4, 2022, to determine the count of children and the minimum, average, and maximum number of nights children were temporarily placed in office buildings or transitional houses in each region. We surveyed all 2,111 case managers that were employed as of April 26, 2022. The survey was open from May 3, 2022, through May 23, 2022, and we received 610 responses, which we analyzed to understand why case managers thought that caseloads and turnover were high.

To address and assess the design, implementation, and operating effectiveness of internal control for audit objective 3, we also interviewed the Program Director for Federal Programs Division; a Vanderbilt University Consultant; the Executive Director of Child Programs; the Director of the Foster Care Division; and regional staff, including placement staff, to gain an understanding of the processes for assessing and placing children. We also performed a walkthrough of how staff document each Child and Family Team Meeting in the Tennessee Family and Child Tracking System (TFACTS). We obtained and reviewed from the Director of Network Development a population of 9,623 children in DCS custody, which included both social services and juvenile justice cases between August 1, 2020, and March 31, 2022. From the population of children in custody, we randomly selected 25 children's custodial episodes and selected the first 2 instances of 1 region not in the initial sample of 25 children's custodial episode, to determine if DCS placed the child in accordance with their assessed needs. Based on our initial testwork results, we decided to expand our random sample to test a total of 60 children's custodial episodes. We reviewed electronic case files in TFACTS, including Child and Adolescent Needs and Strengths (CANS) and Family Advocacy and Support

Tool (FAST) assessments, most recent placement location, and Child and Family Team Meeting decisions, for a total of 60 children's custodial episodes between August 1, 2020, and March 31, 2022.

Child Safety

Child Protective Services' Child Abuse and Neglect Investigations

Audit Objective: In response to the prior audit finding, did DCS move allegations through key points of the investigation process for child abuse allegation investigations, as required by DCS policies and procedures?

Conclusion: Based on our review and discussion with management, management and staff still did not meet key timelines of the investigative process. See **Finding 6.**

Methodology to Address the Audit Objective

To address our audit objective, we reviewed

- Sections 37-1-403(a) and 37-1-406, *Tennessee Code Annotated*;
- Rule 0250-4-11-.01(4)(g); and
- DCS Policies 14.1, 14.3, 14.6, 14.7, and 14.26.

We interviewed the Deputy Commissioner of Child Safety, the Director of the Child Abuse Hotline, and an Executive Director to gain an understanding of the Tennessee Child Abuse Hotline and the investigation and assessment processes, along with the internal controls that are significant to our audit objective.

To assess the design, implementation, and operating effectiveness of the related internal controls, we obtained a population of allegations including investigations, assessments, and special investigations with an intake date from January 1, 2021, to February 28, 2022. From populations of 26,912 investigations, 54,614 assessments, and 2,394 special investigations, we selected a sample of 25 cases from each for a total of 75 cases tested. We reviewed the investigation files in TFACTS to determine if staff timely responded to allegations and performed investigations as required.

Residential Facility Sexual Abuse/Harassment Investigations and the Prison Rape Elimination Act

1. **Audit Objective:** Did DCS have a process to investigate and document all Prison Rape Elimination Act (PREA) allegations in accordance with federal PREA standards and DCS policy?

Conclusion: Based on our testwork, DCS did not investigate and document PREA allegations in accordance with federal PREA standards and DCS policy. In addition, DCS did not ensure that all PREA allegations were investigated. See **Finding 7**, **Finding 8**, and the related **Matter for Legislative Consideration**.

2. **Audit Objective:** Did DCS have a process to monitor all facilities that primarily house juvenile delinquents to ensure they are PREA compliant?

Conclusion: Based on our testwork, DCS's staff did not monitor all PREA facilities during calendar year 2021 to ensure the facilities complied with PREA standards. See **Finding 8.**

3. **Audit Objective:** In response to the prior audit finding, did DCS evaluate and respond to Wilder Youth Development Center's PREA assessment's recommendations?

Conclusion: Based on our review, management implemented procedures to ensure that Wilder's PREA staffing plan assessment was complete and evaluated each year. In response to the staffing shortage issues noted in the staffing plan assessment, DCS management moved children out of Wilder to other facilities with more resources and staff to reduce the population. Based on the population changes, management resolved the prior finding**.**

4. **Audit Objective:** In response to the prior audit finding, did licensing staff determine if the juvenile detention centers met staffing ratios?

Conclusion: Based on our testwork, DCS management designed and implemented a new process for licensing staff to document the review of staffing ratios at juvenile detention centers, which resolved the prior audit finding.

Methodology to Address the Audit Objectives

To address audit objective 1, which includes gaining an understanding of DCS's process to investigate and document all PREA allegations, we interviewed the Executive Director of Juvenile Justice, the Deputy Commissioner of Child Safety, the Director of the Child Abuse Hotline, the Statewide PREA Coordinator, and the PREA Investigator. We conducted walkthroughs of DCS's allegation referral process and the PREA investigation process. To gain an understanding of allegation reporting and investigation requirements, along with the internal controls that are significant to our audit, we reviewed state statute, federal PREA requirements, and DCS policies and procedures.

To assess the design, implementation, and operating effectiveness of the related internal controls, we obtained a population of 64 PREA investigations that DCS conducted in calendar year

2021. From that population, we selected a nonstatistical random sample of 25 cases to test. We also obtained a population of 381 sexual abuse and sexual harassment allegations reported in DCS's Incident Reporting System in calendar year 2021. We removed duplicate incident reports and reviewed the entire population of 213 unique sexual abuse or sexual harassment incidents.

To address audit objective 2, we interviewed DCS's Executive Director of Juvenile Justice and the Statewide PREA Coordinator, obtained and reviewed feedback from the federal PREA Management Office, obtained and reviewed the most recent federal PREA audit for the facilities that obtained one, reviewed DCS policies and procedures, reviewed federal PREA standards, observed operational processes, and visited facilities to obtain an understanding of internal control significant to our audit objective.

To assess the design, implementation, and operating effectiveness of the related internal controls, we obtained and reviewed DCS's monthly calculations to identify applicable PREA facilities from January 1, 2018, through December 31, 2021. DCS could not provide the calculations for May 2018 due to a technical error. We reperformed the calculations and obtained additional reports from the Statewide PREA Coordinator to identify which facilities that DCS should have monitored for PREA compliance in 2021. We obtained and reviewed the monitoring visit reports for the three facilities DCS monitored for compliance in 2021. We also obtained and reviewed each facility's federal PREA audit.

To address audit objective 3, we obtained the three staffing plan assessments DCS completed for the Wilder Youth Development Center during the audit scope (August 1, 2020, through July 30, 2022); interviewed the Statewide PREA Coordinator and the Executive Director of Juvenile Justice; reviewed DCS's policies and procedures; and reviewed federal PREA standards to gain an understanding of the process of completing, evaluating, and responding to the staffing plan assessments completed for Wilder. We assessed DCS's actions to reduce the population at Wilder as a response to the staffing issues noted within those staffing plan assessments.

To address audit objective 4, we interviewed DCS's Director of Licensing, reviewed DCS's policies and procedures, and observed operational processes to gain an understanding of the juvenile detention center licensing process and how staffing ratios were verified at juvenile detention centers, as well as to obtain an understanding of internal controls significant to our audit objective and to our audit.

To assess the design, implementation, and operating effectiveness of the related internal controls, we obtained and reviewed licensing staff's documentation from their most recent licensing visits for all 17 juvenile detention centers. To assess the implementation and operating effectiveness of the internal control and compliance, we performed testwork on the full population of juvenile detention centers.

Quality Control: Alleged Perpetrator SIU Reviews

Audit Objective: In response to the prior audit finding, did Provider Quality Team (PQT) staff follow up and conduct reviews on provider or Wilder Youth Development Center employees who were investigated for violating DCS standards, contract provisions, or state regulations?

Conclusion: Based on our review, we found that PQT did not follow up on an employee with identified safety concerns who then went on to cause harm to children in his care. We also found that DCS's process for creating the monthly Special Investigations Unit (SIU) report is manual and susceptible to human error, which could delay PQT from initiating their review process. We noted that PQT could identify and review concerning employee behaviors sooner if they lowered their thresholds for their reviews. Finally, we found PQT did not follow up with providers to make sure they addressed safety concerns identified in SIU investigations. See **Finding 9.**

Methodology to Address the Audit Objective

To address the objective, we interviewed the Director of Provider and Foster Home Quality Teams, the Executive Director of the Office of Continuous Quality Improvement, and the Provider and Foster Home Quality Program and Incident Report Coordinator to gain an understanding of PQT and how they follow the Protocol for Provider Quality Team regarding provider and Wilder Youth Development Center employees who have multiple investigations. We also performed a walkthrough of the PQT review process of alleged perpetrators who have been named in multiple SIU investigations.

To assess the operating effectiveness of internal control and compliance with written policies and procedures, we obtained and reviewed the Office of Continuous Quality Improvement's policies, the department's rules, and statute. In addition, we reviewed PQT's meeting minutes from April 2021 through January 2022, the tracking spreadsheet for PQT regarding action steps discussed in the PQT meetings from April 2021 through January 2022, Provider Performance Improvement Plans for providers from August 2020 to March 2022, and PQT referrals from April 2021 to January 2022. We also obtained and reviewed the one completed PQT review report from October 2020. Finally, we obtained the SIU monthly report from April 2021 through January 2022 and completed an analysis of the SIU investigations according to the Protocol for Provider Quality Team.

Employee, Provider Employee, and Volunteer Background Checks

1. **Audit Objective:** In response to the prior audit finding, did DCS staff perform all required background and registry checks on employees and volunteers?

Conclusion: Based on our review and interviews with management, DCS staff did not perform background checks on employees and volunteers in accordance with state statute and DCS policy. See **Observation 1.**

2. Audit Objective: In response to the prior audit finding, did DCS improve their monitoring process over provider agencies' performance of all required background and registry checks for provider employees?

Conclusion: We found that DCS improved their monitoring process over provider agencies' performance of all required background and registry checks for provider employees.

Methodology to Address the Audit Objectives

To address audit objective 1, including gaining an understanding of management's process and assessing management's design and implementation of internal controls significant to our audit objective, we interviewed DCS staff to gain an understanding of background check requirements and DCS's background check process and control procedures. We interviewed the Executive Director of Human Resources, Human Resources Directors, a Program Coordinator, a Program Supervisor, and Human Resource Analysts. We also reviewed

- Section 37-5-511, *Tennessee Code Annotated*;
- DCS Policy 4.1, "Employee Background Checks";
- DCS Policy 4.30, "Department of Children's Services Volunteer Services Program"; and
- the *Volunteer Service Procedures Manual.*

To assess the operating effectiveness of internal controls, we obtained populations of the 649 employees and 448 volunteers who started with DCS from January 1, 2021, through February 28, 2022. We tested nonstatistical, random samples of 60 employees and 60 volunteers to determine if staff completed required background checks, background check checklists, and volunteer certification letters.

To address objective 2, we examined Section 37-5-511, *Tennessee Code Annotated;* DCS's *Contract Provider Manual,* Section 1, "Core Standards"; and DCS Policy 4.1 to determine the statutory responsibilities of DCS regarding background checks for contract provider employees. Additionally, we interviewed the Director of Provider Monitoring and Evaluation and a Program Quality Improvement Coordinator and observed walkthroughs for key components of the monitoring process to gain an understanding of the processes in place to monitor background checks for contract

provider employees, to obtain an understanding of internal control significant to our audit objective, and to assess management's design and implementation of internal control.

To determine whether DCS improved their monitoring process over provider agencies' performance of all required background and registry checks for provider employees, we obtained a population of 93 provider employees monitored for pre-hire background checks between July 1, 2021, and February 28, 2022. We selected a nonstatistical, random sample of 23 provider employees and performed testwork. From the DCS and provider agencies, we obtained the provider employee background check documentation to compare to the monitoring results from DCS's Provider Monitoring and Evaluation staff. To assess the implementation and operating effectiveness of internal control, we obtained a copy of the Provider Monitoring and Evaluation (PME) Performance Based Contract schedule and tracker, and a copy of all the PME monitoring reports from July 1, 2021, to February 28, 2022, to ensure that the Director of PME reviewed the results of the site visits prior to the submission of the monitoring report. We also obtained the monthly quality assurance (QA) reports for background checks to compare with our testwork items, and we obtained and reviewed the QA team's review of the 15 employees in our sample that QA reviewed.

Child Safety Responsibilities: Probation and Aftercare Supervision

Audit Objective: In response to the prior audit finding, did the Office of Juvenile Justice staff conduct the required number of face-to-face visits and respond to electronic monitoring alerts for juveniles in probation and aftercare supervision?

Conclusion: While the Office of Juvenile Justice staff have made improvements since the prior audit, staff still are not meeting the required number of contacts with youths, with school personnel, with service providers, or with the youth's parent/legal custodian for youths on probation and aftercare. See **Finding 10**. DCS implemented a new Electronic Monitoring Unit in October 2020 to respond to electronic monitoring alerts for juveniles in probation and aftercare supervision. We found that this unit responded to alerts and documented their responses in TFACTS.

Methodology to Address the Audit Objective

To address our audit objective, we interviewed the Office of Juvenile Justice Executive Director, Program Coordinators, Team Coordinators, Team Leaders, and case managers to gain an understanding of probation and aftercare supervision. We also performed a walkthrough of how staff document their review of cases. To gain an understanding of the new Electronic Monitoring Unit, we interviewed the unit's Team Leader. We performed a walkthrough of how staff respond to and document alerts and a walkthrough to understand the unit's review process.

To assess design, implementation, and operating effectiveness of internal control for the audit objective and to determine compliance with DCS's written policies and procedures, we obtained from the Executive Director a population of 1,246 children on probation and aftercare between October 1, 2020, and March 31, 2022, and pulled reports from Safe Measures to verify the population was complete. We selected a nonstatistical, random sample of 60 children on probation or aftercare and reviewed electronic case files in TFACTS, analyzing face-to-face visits, home visits, provider contacts, and school contacts. We also obtained and reviewed the internal control case tracking spreadsheets and fidelity review spreadsheets. We received all 53,816 unique electronic monitoring alerts that came through the Electronic Monitoring Unit (EMU) from October 1, 2020, to March 31, 2022. We tested a nonstatistical, random sample of 60 EMU alerts and reviewed electronic case files in TFACTS showing how EMU workers responded to the alerts. We also obtained and reviewed the spreadsheets the unit uses for their fidelity review.

Child Health

Audit Objective: Did management's process ensure that all children in DCS custody received screenings to identify medical, mental health, and/or dental needs within the timeframes established by DCS Policies 20.7, "Early Periodic Screening Diagnosis and Treatment Standards (EPSDT)," and 20.12, "Dental Services"?

Conclusion: Management did not ensure timely dental and medical screenings for children in DCS custody due to DCS's reliance on paper forms and manual processes to complete, review, and follow up on children's medical and dental screenings. See **Finding 11**.

Methodology to Address the Audit Objective

To address our audit objective, we interviewed the Deputy Commissioner of Child Health, the Director of Nursing, the Child Health Data Analyst, and the South Central and Smoky Mountain regions' Public Health Nursing Consultants. We also reviewed relevant state statute and rules, DCS Policy 20.7 and its supplement, DCS Policy 20.12, DCS organizational charts, DCS's 2020–2021 annual report, and the Medical and Dental Overdue and Upcoming EPSDT reports from August 2020 through March 2022 to gain an understanding of the medical and dental screening process, to obtain an understanding of internal control significant to our audit objective, and to assess management's design of internal control. To assess the cause of late medical and dental screenings, we selected a random, nonstatistical sample of 25 initial and annual medical screenings and 29 initial and biannual dental screenings, from a population of 2,046 medical screenings and 4,416 dental screenings that were reported as more than 30 days late in a month, from January 2021 through December 2021. We also reviewed each child's case file in TFACTS to determine why the screening was reported late.

Tennessee Family and Child Tracking System (TFACTS)

1. **Audit Objective:** In response to the prior audit finding, did DCS management and Strategic Technology Solutions (STS) implement our recommendations relating to system and network performance and financial function improvements in the Tennessee Family and Child Tracking System (TFACTS)?

   Conclusion: Although management implemented enhancements to address our recommendations relating to TFACTS's financial function improvements, we found DCS has faced ongoing problems with the system's functionality since its implementation. See **Finding 12**.

2. **Audit Objective:** In response to the prior audit finding, did DCS management follow state information systems security policies regarding information systems controls?

   Conclusion: As noted in the prior audit, DCS management and STS management did not follow state information systems security policies regarding information systems controls. See **Finding 13**.

3. **Audit Objective:** Did DCS management establish general and application security controls for TFACTS?

   Conclusion: We found that DCS had designed and implemented relevant general and application controls over the TFACTS application.

Methodology to Address the Audit Objectives

To address our audit objectives, we interviewed the former Chief Information Officer, executive leadership, fiscal personnel, and staff; we reviewed screenshots, manuals, and other available electronic documentation; and we observed controls in place to gain an understanding of TFACTS. We performed testwork to determine management's implementation of information technology controls around TFACTS.

Public Records Management

Audit Objective: In response to the prior audit finding, did management update DCS's records retention policies and procedures to cover all public records and maintain files until the end of the Records Disposition Authorizations-specified retention period?

Conclusion: Based on our discussions with DCS's Public Records Officer and our review of relevant documentation, we found that management implemented policies and procedures for the proper maintenance and disposition of records.

Methodology to Address the Audit Objective

To address the audit objective, which includes gaining an understanding of the department's public records management process, we interviewed DCS's Public Records Officer, the Executive Director of Human Resources, and the Internal Audit Director. We reviewed pertinent *Tennessee Code Annotated*, the Secretary of State's *Records Management Best Practices and Procedures*, and the *Rules of the Public Records Commission*. We also reviewed DCS's records disposition policies and procedures, as well as agency-specific and statewide Records Disposition Authorizations (RDAs) listed on the Secretary of State's website. We also reviewed DCS Policy 1.3, "Continuous Quality Improvement: Communication, Meetings, Information Sharing, Policy Development and Review," and the Background Check History and IV-E Eligibility Checklist to ensure management referenced active RDAs.

Appendix 2
Internal Control Significant to the Audit Objectives

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) sets internal control standards for federal entities and serves as best practice for nonfederal government entities, including state and local government agencies. As stated in the Green Book overview,[63]

> Internal control is a process used by management to help an entity achieve its objectives . . . Internal control helps an entity run its operations effectively and efficiently; report reliable information about its operations; and comply with applicable laws and regulations.

The Green Book's standards are organized into five components of internal control: control environment, risk assessment, control activities, information and communication, and monitoring. In an effective system of internal control, these five components work together to help an entity achieve its objectives. Each of the five components of internal control contains principles, which are the requirements an entity should follow to establish an effective system of internal control. We illustrate the five components and their underlying principles below:

Control Environment	
Principle 1	Demonstrate Commitment to Integrity and Ethical Values
Principle 2	Exercise Oversight Responsibility
Principle 3	Establish Structure, Responsibility, and Authority
Principle 4	Demonstrate Commitment to Competence
Principle 5	Enforce Accountability
Risk Assessment	
Principle 6	Define Objectives and Risk Tolerances
Principle 7	Identify, Analyze, and Respond to Risks
Principle 8	Assess Fraud Risk
Principle 9	Identify, Analyze, and Respond to Change

Control Activities	
Principle 10	Design Control Activities
Principle 11	Design Activities for the Information System
Principle 12	Implement Control Activities
Information and Communication	
Principle 13	Use Quality Information
Principle 14	Communicate Internally
Principle 15	Communicate Externally
Monitoring	
Principle 16	Perform Monitoring Activities
Principle 17	Evaluate Issues and Remediate Deficiencies

In compliance with generally accepted government auditing standards, we must determine whether internal control is significant to our audit objectives. We base our determination of significance on whether an entity's internal control impacts our audit conclusion. In the following matrix, we list our audit objectives, indicate whether internal control was significant to our audit objectives, and identify which internal control components and underlying principles were significant to those objectives.

[63] For further information on the Green Book, please refer to https://www.gao.gov/greenbook/overview.

Appendix 2
(Continued)

			Internal Control Components and Underlying Principles Significant to the Audit Objectives																
			Control Environment					Risk Assessment				Control Activities			Information & Communication			Monitoring	
	Audit Objectives	Significance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1	In DCS's 2020-2024 Strategic Plan and annual Customer Focused Government plans, did management set goals and objectives that focus on mission critical challenges DCS faces?	Yes	Yes	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
2	In management's formal risk assessment, did they identify fiscal, operational, reporting, and compliance risks and list control activities to prevent or minimize the identified risks?	Yes	Yes	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
3	Did management have enough case managers to support the day-to-day operations of ensuring the safety, permanency, and well-being of the children in DCS's care, and did management ensure adequate staffing levels of case managers for each region so that caseloads did not exceed the state's statutory caseload average of 20 cases?	No	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
4	Did DCS take action to recruit and retain placements for children for whom they assumed custody?	No	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
5	Did DCS establish a formal process to track children and written guidance to dictate standards for consistent quality of facilities housing children overnight in temporary settings until a long-term placement could be found?	Yes	–	–	–	–	–	–	–	–	–	Yes	–	–	–	Yes	–	–	–
6	Did DCS staff place the children who entered department custody in accordance with the child's assessed needs?	Yes	–	–	–	–	Yes	–	–	–	–	–	–	–	Yes	–	–	–	–
7	In response to the prior audit finding, did DCS move allegations through key points of the investigation process for child abuse allegation investigations, as required by DCS's policies and procedures?	Yes	–	–	–	–	–	–	Yes	–	–	–	–	Yes	–	Yes	–	–	–
8	Did DCS have a process to investigate and document all Prison Rape Elimination Act (PREA) allegations in accordance with federal PREA standards and DCS policy?	Yes	–	–	Yes	–	–	–	–	–	–	Yes	–	Yes	–	–	–	Yes	–
9	Did DCS have a process to monitor all facilities that primarily house juvenile delinquents to ensure they are PREA compliant?	Yes	–	–	Yes	–	–	–	–	–	–	Yes	–	Yes	–	–	–	Yes	–
10	In response to the prior audit finding, did DCS evaluate and respond to Wilder Youth Development Center's PREA assessment's recommendations?	Yes	–	–	Yes	–	–	–	–	–	–	Yes	–	Yes	–	–	–	Yes	–
11	In response to the prior audit finding, did licensing staff determine if the juvenile detention centers met staffing ratios?	Yes	–	–	–	–	–	–	Yes	–	–	–	–	–	Yes	–	–	Yes	–

Appendix 2
(Continued)

			Internal Control Components and Underlying Principles Significant to the Audit Objectives																
			Control Environment					Risk Assessment				Control Activities			Information & Communication			Monitoring	
	Audit Objectives	Significance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
12	In response to the prior audit finding, did Provider Quality Team (PQT) staff follow-up and conduct reviews on provider or Wilder Youth Development Center employees who were investigated for violating department standards, contract provisions, or state regulations?	Yes	–	–	–	–	–	–	–	–	–	Yes	–	Yes	–	–	–	Yes	–
13	In response to the prior audit finding, did DCS staff perform all required background and registry checks on employees and volunteers?	Yes	–	–	–	–	–	–	Yes	–	–	–	–	–	–	–	–	Yes	–
14	In response to the prior audit finding, did DCS improve their monitoring process over provider agencies' performance of all required background and registry checks for provider employees?	Yes	–	–	–	–	–	–	Yes	–	–	–	–	–	–	–	–	Yes	–
15	In response to the prior audit finding, did the Office of Juvenile Justice staff conduct the required number of face-to-face visits and respond to electronic monitoring alerts for juveniles in probation and aftercare supervision?	Yes	–	–	–	–	–	–	Yes	–	–	–	–	–	–	–	–	Yes	–
16	Did management's process ensure that all children in DCS custody received screenings to identify medical, mental health, and/or dental needs within the timeframes established by DCS Policies 20.7, "Early Periodic Screening, Diagnosis, and Treatment Standards (EPSDT)" and 20.12, "Dental Services"?	Yes	–	–	–	–	–	–	–	–	–	Yes	–	–	–	–	–	–	–
17	In response to the prior audit finding, did DCS management and Strategic Technology Solutions (STS) implement our recommendations relating to system and network performance and financial function improvements in the Tennessee Family and Child Tracking System (TFACTS)?	No	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
18	In response to the prior audit finding, did DCS management follow state information systems security policies regarding information systems controls?	Yes	–	–	–	–	–	–	–	–	–	–	Yes	–	–	–	–	–	–
19	Did DCS management establish general and application security controls for TFACTS?	Yes	–	–	–	–	–	–	–	–	–	–	Yes	–	–	–	–	–	–
20	In response to the prior audit finding, did management update DCS's records retention policies and procedures to cover all their public records and maintain files until the end of the Records Disposition Authorizations-specified retention period?	No	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

Appendix 3
Department of Children's Services Operations

The Department of Children's Services (DCS) consists of a central office, located in Nashville; 12 regional offices; and a youth development center. DCS is divided into the following operational divisions:

The Office of Child Programs supports child permanency through foster care, adoption, in-home family support services, and child independent living. This office also manages DCS's network of private providers of in-home and out-of-home support services.

The Office of Child Health is responsible for the physical health, emotional and behavioral well-being, and educational success of children served by DCS (covers nursing, food services, and health advocacy).

The Office of Child Safety operates the Child Abuse Hotline and conducts investigations of serious or severe child abuse and neglect. The Special Investigations Unit responds to allegations of abuse and neglect in settings such as schools, day cares, or foster homes involving an employee or volunteer acting as a caregiver.

The Office of Juvenile Justice serves youth adjudicated delinquent.[64] The department places and treats youth in custody at provider and department facilities, and monitors youth then placed on aftercare and probation. The office also administers the Interstate Compact for Juveniles to transfer supervision of these youth between states.

The Office of Training and Professional Development develops and administers training and professional development to DCS staff, foster parents, and provider staff.

The Office of Continuous Quality Improvement includes divisions responsible for reviewing and monitoring DCS's and partner agencies' operations. These divisions assess compliance with federal standards and accreditation requirements, monitor risk management, conduct internal audits, oversee agencies licensed by DCS, monitor data, manage records releases, monitor contracted providers, and review child deaths.

DCS also has administrative divisions including the following:

The Office of Human Resources manages human resource functions for DCS employees across the state, including recruitment, hiring, and employee engagement. This office also includes the

[64] A youth who a judge determined to have committed an act designated as a crime under the law if committed by an adult.

Office of Internal Affairs, which is responsible for investigating matters related to the department's management and operation.

The Office of Finance and Budget provides fiscal services including accounts payable, financial planning, and budgeting.

The Office of Information Technology (OIT) was a division of the department until January 2018. Due to a statewide initiative to consolidate IT services, all OIT staff were reassigned to the Department of Finance and Administration as IT support for DCS. All DCS IT support provides IT support specifically for DCS. See Assistance From Other State Agencies below.

The Office of General Counsel provides legal advice and representation to DCS.

The Administrative Procedures Division includes attorneys as administrative judges that preside over DCS's contested cases.

The Office of Customer Focused Services communicates with customers to answer questions and responds to comments and concerns.

The Communications Office coordinates DCS's internal and external communications.

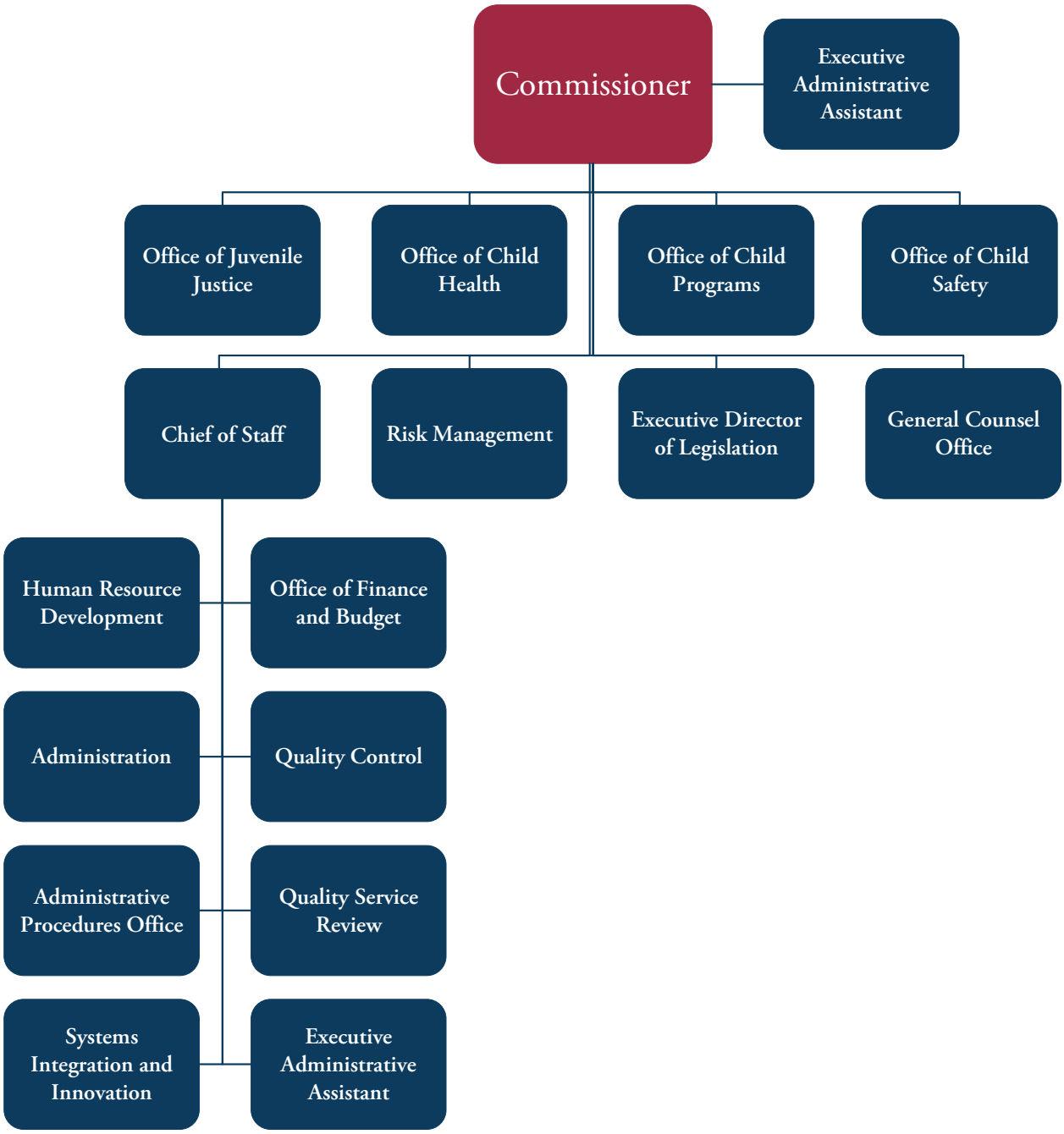
The Legislative Office manages DCS's legislative actions and monitors legislation that may impact DCS.

The Office of Facilities Management coordinates DCS facility use, change, and compliance with safety regulations.

Assistance From Other State Agencies

DCS contracts with the Department of Finance and Administration (F&A) for general accounting functions, such as recording accounting transactions, reviewing and approving DCS's state payment card purchases, maintaining accounts receivables, monitoring collection efforts, and determining monthly agency cost allocations and labor distributions. F&A's Strategic Technology Solutions provides DCS with computer workstation support.

Appendix 4
Organizational Chart



Source: Department of Children's Services management.

Appendix 5
Financial Information

Table 9
Department of Children's Services
Fiscal Year 2021
Budget and Actual Expenditures and Revenues

Department of Children's Services		FY 2021 Recommended Budget	FY 2021 Actual Expenditures and Revenues
Expenditures	Payroll	$283,337,500	$254,607,900
	Operational	684,005,800	656,725,800
	Total	$967,343,300	$911,333,700
Revenues	State	$383,154,200	$330,778,600
	Federal	175,717,400	161,618,500
	Other	408,471,700	418,936,600
	Total	$967,313,300	$911,333,700

Source: For the recommended budget, our source was the *Tennessee State Budget, Fiscal Year 2020–2021*. For actual expenditures and revenues, our source was the *Tennessee State Budget, Fiscal Year 2022–2023.*

Table 10
Department of Children's Services
Fiscal Year 2022 Budget

Department of Children's Services		FY 2022 Recommended Budget
Expenditures	Payroll	$281,719,200
	Operational	711,340,400
	Total	$993,059,600
Revenues	State	$382,748,900
	Federal	177,185,000
	Other	433,125,700
	Total	$993,059,600

Source: *Tennessee State Budget, Fiscal Year 2021–2022.*

Appendix 6
Strategic Planning and Risk Assessment

Figure 12
Summary of DCS's 2020–2024 Strategic Goals and Objectives

Goal 1: Implement Family First Prevention Services Act (FFPSA)
Objective 1: By July 1, 2022, the Division of Federal Programs will host informational sessions with provider agencies on well-supported evidence-based treatment models included in Tennessee's Five-Year Prevention Services Plan to better enable those providers to make informed decisions about choosing new treatment models. • Define new FFPSA structure and merge existing workgroups into one workgroup. The workgroup will meet frequently to ensure DCS is on track with implementation benchmarks. • Work with providers to collect and distribute information regarding the eight new prevention programs. • Partner with Fiscal to develop service rates for each of the new treatment models covered by the prevention services plan.
Objective 2: By July 2025, recruit and train provider agencies to deliver Parent-Child Interactive Therapy, Parents as Teachers, Home Builders, Brief Strategic Family Therapy, and Nurse Family Partnership across the state. • Publish Request for Proposals to solicit provider agencies interested in delivering the new prevention services by October 2023. • Use FFPSA implementation funding to pay for the delivery of the new prevention programs by September 2025. • Assess current Multi-Systemic Therapy contract to determine need for expansion by July 2023.
Objective 3: By August 2023, the Division of Federal Programs will assess the Qualified Residential Treatment Programs (QRTP) to identify trends in children and youth who remain in a QRTP long enough to require a designated Commissioner Review and provide performance information on regions meeting required QRTP benchmarks. • Review Commissioner Review forms submitted between July 2022 and June 2023 to identify trends in children/youth's reason for requiring longer stays, as well as providers that have longer lengths of stay. • Review regional QRTP spreadsheets created between July 2022 and June 2023 to identify regional trends, training needs, and potential court or other systemic barriers impacting performance.

Goal 2: Address Workforce Recruitment, Training, and Retention
Objective 1: The Human Resources Division, working in tandem with regional leadership, will develop a recruitment strategy to attract and retain qualified staff. • Continue recruitment efforts at colleges and universities to include at least two visits annually and expand participation at other career fairs and venues at least quarterly to identify qualified candidates. • Continue partnership with Communications to improve social media messaging of frontline positions and attract career professionals. • Increase recruitment of multilingual employees and implement a pay differential for those with fluency in needed languages by January 2023. • Analyze case manager job specifications to ensure alignment of expectations for qualified staff by July 2022.
Objective 2: Employ an external consultant to review current standards of practice and provide recommendations to create a more efficient and streamlined system that continues to place an emphasis on quality services. • Hire an external consultant to provide guidance, direction, and recommendations to streamline system by June 2022. • Identify representatives from all program areas and divisions to engage in this work with the consultant by June 2022. • Representatives will review existing standards of practice with consultant by December 2022. • Consultant will provide recommendations to DCS by June 2023. • DCS will vet recommendations and identify action steps to implement by December 2023. All action steps will be fully implemented by June 2024.
Goal 3: Develop and Implement Strategies to Strengthen Network Development and to Address Child/Youth Placement Stability
Objective 1: DCS will initiate strategies and action steps that progressively assess and reevaluate the efficiencies embedded under the umbrella of DCS Network Development as part of ongoing quality improvement efforts. • Reassess how regional vs. central office placement responsibilities are aligned and make changes as indicated for improved efficiency. • Revisit provider agreements to address referral process and responsiveness to agreements. • Institute protocols and methodologies to ensure that placement requests are guided by appropriate assessments. • Work with regions to develop utilization review practices that result in appropriate and timely movement and a higher percentage of step-downs from high-level placements.

- Integrate Chapin Hall needs assessment recommendations into placement planning where indicated.
- Expand the network through exploration of unused beds or expanded capacity.
- Reassess the unique care agreement process, how it currently functions, and implement practice changes to improve efficiency and reduce cost.

Objective 2: DCS will implement a foster home placement assessment model designed to test the validity of improving placement stability rates by assuring that when children enter custody a full-scale clinical assessment may guide the efficacy and sustainability of future placements.

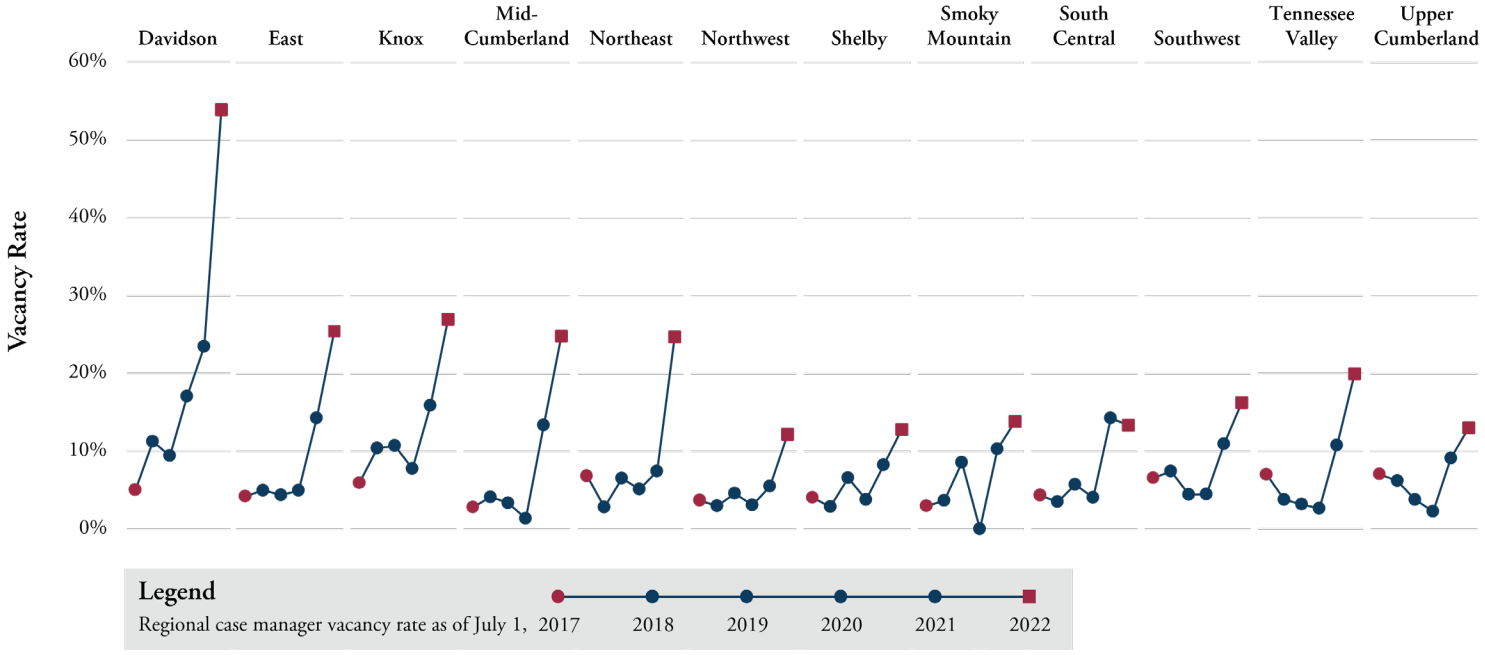
- Develop a profile and protocol for assessment foster homes.
- Recruit homes that are willing to serve as assessment homes.
- Create an orientation and an enhanced training module for homes selected.
- Research and adapt a structured methodology to meet the educational needs of children/youth placed in homes outside their school districts.
- Select a provider skilled in clinical assessments and consultation to evaluate the child/youth in the foster home setting for a period of 14 to 30 days and provide an informed recommendation regarding needed level of care.
- Develop an evaluation process that determines whether outcomes for children placed in assessment homes reflect measurable improvements in placement stability.

Appendix 7
Case Manager Turnover and Caseloads

Case Manager Vacancy and Turnover Details

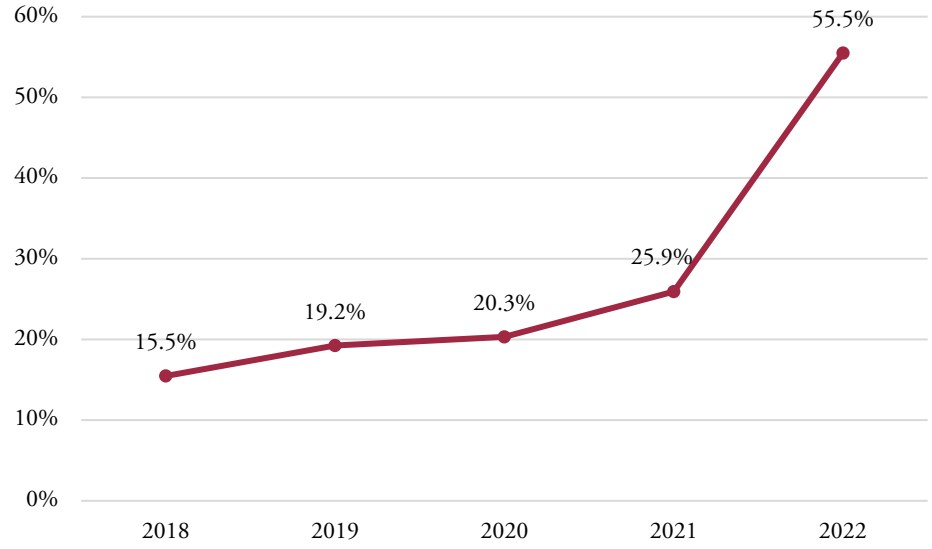
Chart 7 has the vacancy rate for each DCS region's Case Manager 1 through Case Manager 4 positions, as of the beginning of each July, from 2018 through 2022. **Chart 8** displays the annual turnover rate for all of DCS's case managers from fiscal year 2018 through fiscal year 2022.

Chart 7
Case Manager Vacancy Rates by Region
Measured at the Beginning of Each Fiscal Year for July 2018 to July 2022



Source: Auditor created based on Edison employee data.

Chart 8
Annual Case Manager Turnover Rate
Fiscal Years 2018 Through 2022



Source: Auditor analysis of Edison employment data.

Case Manager Caseload Details

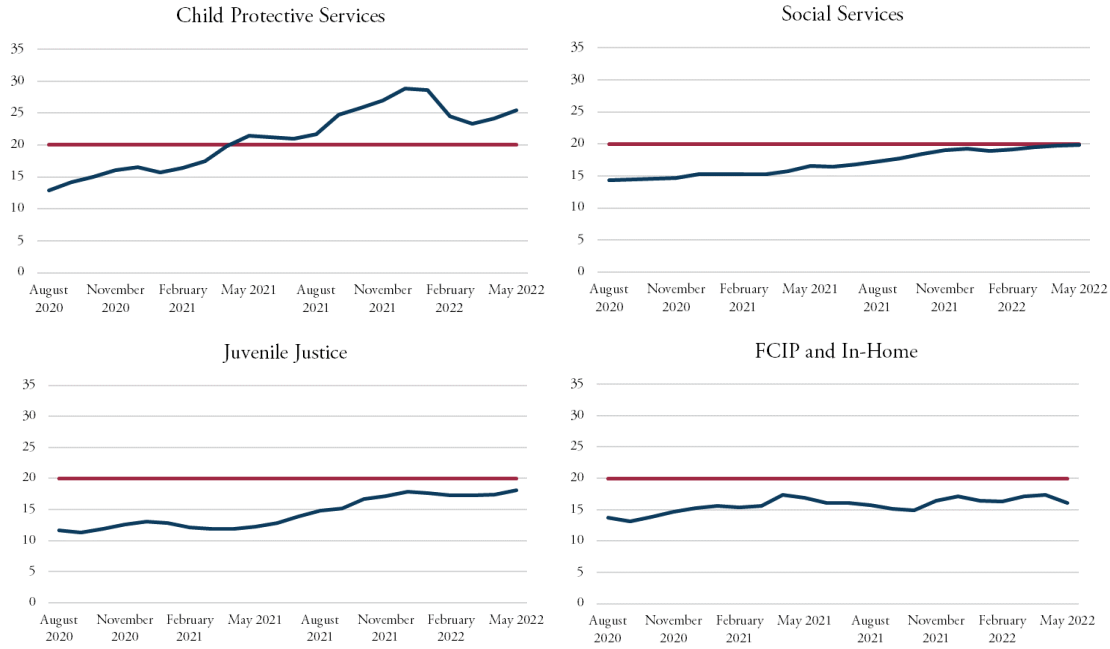
Table 11 shows the number of cases assigned to case managers by region as of May 2022. **Chart 9** is the statewide caseload average for each of DCS's 4 program areas—child protective services, social services, juvenile justice, and family crisis intervention program (FCIP) and in-home—from August 2020 through May 2022. The blue line is the actual caseload average for each month, and the red line represents the statutorily mandated caseload average of 20 cases. **Table 12** compares actual average regional caseloads to what the average regional caseload would be if all case manager positions were filled, as of March 2022.

Table 11
Number of Cases Assigned to Case Managers by Region*
As of May 2022

Region	Minimum	Average	Maximum
Davidson	1	29	108
Shelby	1	17	82
South Central	1	25	79
Mid-Cumberland	1	20	68
Northeast	1	21	49
Smoky Mountain	1	18	46
Northwest	1	16	46
TN Valley	1	17	45
Upper Cumberland	1	18	42
Knox	1	19	41
East Tennessee	1	15	34
Southwest	1	13	32

*These do not include Interstate Compact on the Placement of Children, Resource Linkage, Order of Reference, Permanency Specialist, or Special Investigations Unit cases. The low minimum cases are generally caused by new case managers (who cannot carry a full caseload) or by supervisors carrying cases.
Source: Auditor analysis of DCS's Caseload Compliance and Averages report.

Chart 9
Statewide Average Caseloads for Each Program Area
August 2020 Through May 2022



Source: Auditor analysis of DCS's Caseload Compliance and Averages reports.

Table 12
Comparison of Actual Average Regional Caseloads to the Average if All Positions Were Filled
As of March 2022

Region	Actual Average Caseload	Potential Average Caseload if All Positions Were Filled
Davidson Region	32.3	11.0
Mid-Cumberland Region	25.5	13.0
South Central Region	23.7	14.4
Northeast Region	22.9	14.8
Knox Region	22.4	11.5
Shelby Region	19.2	11.0
TN Valley Region	19.2	10.2
Smoky Mountain Region	19.1	10.8
Upper Cumberland Region	17.5	11.3
East Tennessee Region	16.5	10.9
Northwest Region	16.2	11.4
Southwest Region	15.0	8.7

Source: Auditor analysis of Edison employee data and DCS's caseload compliance and averages report. The table only includes case managers that work at one of DCS's 12 regional offices.

Appendix 8
Case Manager Survey Form and Responses

We administered a survey, using Microsoft Forms, to all 2,111 case managers employed by DCS as of April 26, 2022, to help us understand how high caseloads affected case managers and why case managers were leaving DCS. The form that the case managers received is shown in **Figure 13**. The survey was available for case managers to respond to from May 3, 2022, through May 23, 2022, and we received 610 responses, a 29% response rate. In **Charts 10** through **26**, we have provided details about the responses we received for each question. For the questions that required a written, narrative response, we have presented the 10 most common "word pairs," or two words that occurred consecutively together, among all responses. Word pairs have common words, such as "for," "an," "the," and "of" removed, and are more formally referred to as "bigrams." We also combined some word pairs that we determined were substantially the same (such as "case manager" and "case managers"). Finally, we have not included full narrative responses, due to responses potentially containing private or confidential information about case managers or the children whose cases they manage.

Figure 13
Survey Form Sent to Case Managers

DCS Case Manager Survey

We are currently conducting a performance audit of the Tennessee Department of Children's Services and we would like your input and feedback to help make your department and state government better. You play a very important role in the department's mission to serve the state's children and we would like to hear your thoughts for improvement.

Please complete the brief anonymous survey below. We will only know who you are if you choose to provide personally identifiable information in a response (name, email, phone number, etc.). We will use your responses to help us understand how the department is supporting its case managers. We plan to provide recommendations or suggestions to the Department of Children's Services and the General Assembly based on the overall results of the survey; however, we do not plan to share individualized results.

* Required

1. How long have you worked for DCS? *

- ◯ Less than 1 year
- ◯ 1-5 years
- ◯ 6-10 years
- ◯ 11-15 years
- ◯ 16-20 years
- ◯ 21-25 years
- ◯ 26+ years

2. In what region do you currently work? *

- ◯ Northwest Region
- ◯ Mid-Cumberland Region
- ◯ Davidson Region
- ◯ Upper Cumberland Region
- ◯ East Region
- ◯ Northeast Region
- ◯ Shelby Region
- ◯ Southwest Region
- ◯ South Central Region
- ◯ TN Valley Region
- ◯ Knox Region
- ◯ Smoky Mountain Region
- ◯ [ ] Other

3. What do you enjoy about your job? *

4. What challenges do you face with your job? *

5. While performing your job responsibilities, have you been concerned about your personal safety? *

- ◯ Yes
- ◯ No

6. Please explain your answer to question number 5 regarding your personal safety. *

7. Do you have the support and resources you need to do your job? *

- ◯ Yes
- ◯ No

8. Please explain your answer to question number 7 regarding support and resources needed: *

9. Can you openly and candidly bring your requests, concerns, and/or suggestions to leadership? *

- ◯ Yes
- ◯ No

10. Please explain your answer to question number 9 regarding requests, concerns, and/or suggestions. *

11. How has case manager turnover affected your ability to do your job? *

12. What tools or resources would make your job easier? *

13. What ideas do you have that would help you and your team have a greater impact on the youth and families that you serve? *

14. Did you feel pressured to answer this survey in a particular way? *

- ◯ Yes
- ◯ No

15. Have you searched for another job in the last 30 days? *

- ◯ Yes
- ◯ No

16. Would you recommend someone to work as a case manager for the Department of Children's Services? *

- ◯ Yes
- ◯ No

17. Is there anything else you would like to tell us? *

18. Optional: Name

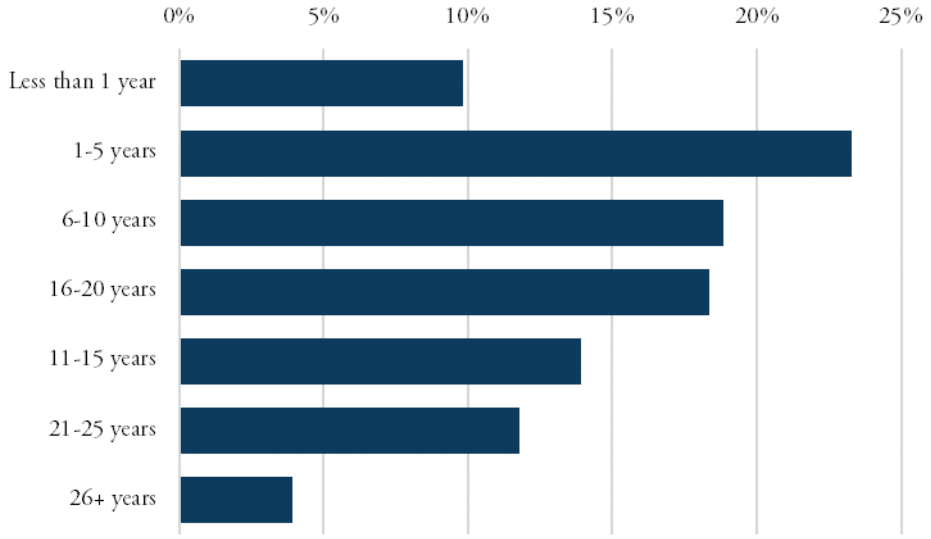
19. Optional: Title

20. Optional: Phone

This content is neither created nor endorsed by Microsoft. The data you submit will be sent to the form owner.

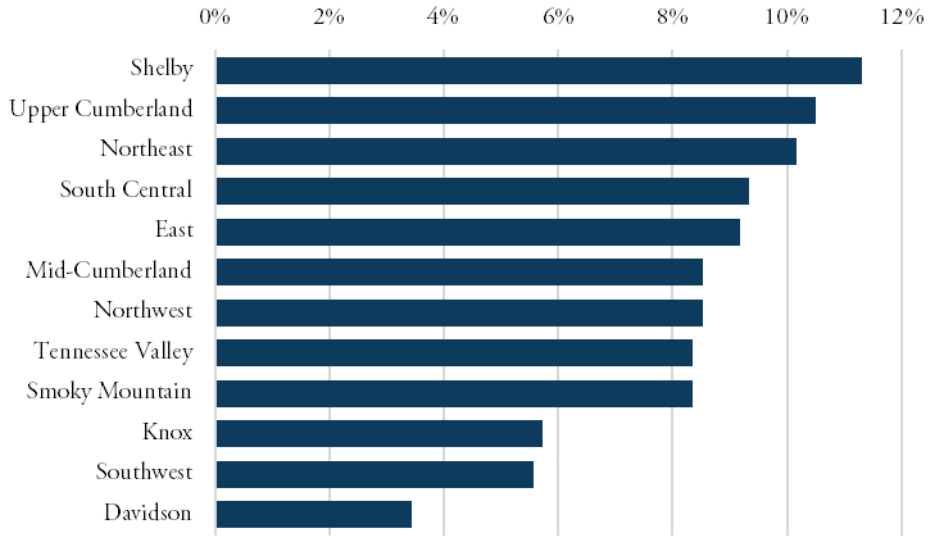
Microsoft Forms

Chart 10
Survey Responses to the Question
How long have you worked for DCS?



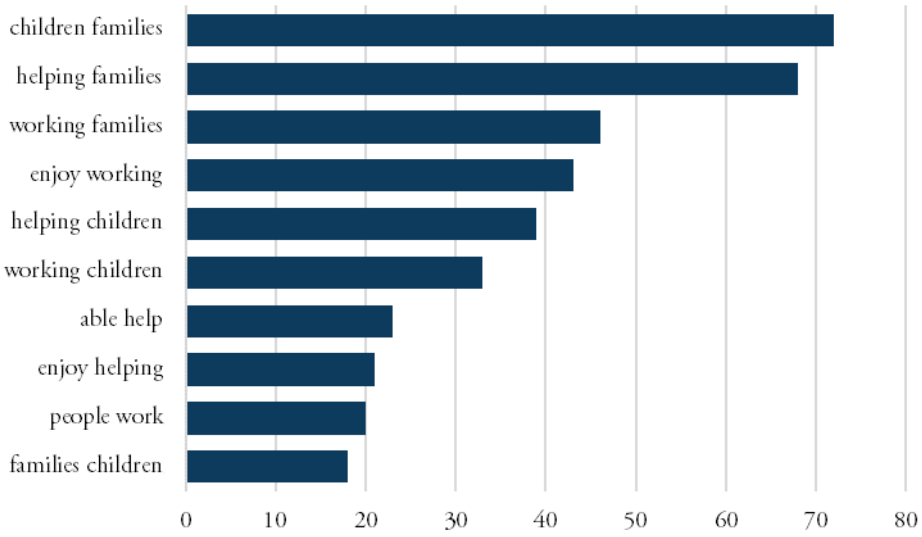
Source: Auditor analysis of case manager survey responses.

Chart 11
Survey Responses to the Question
In what region do you currently work?



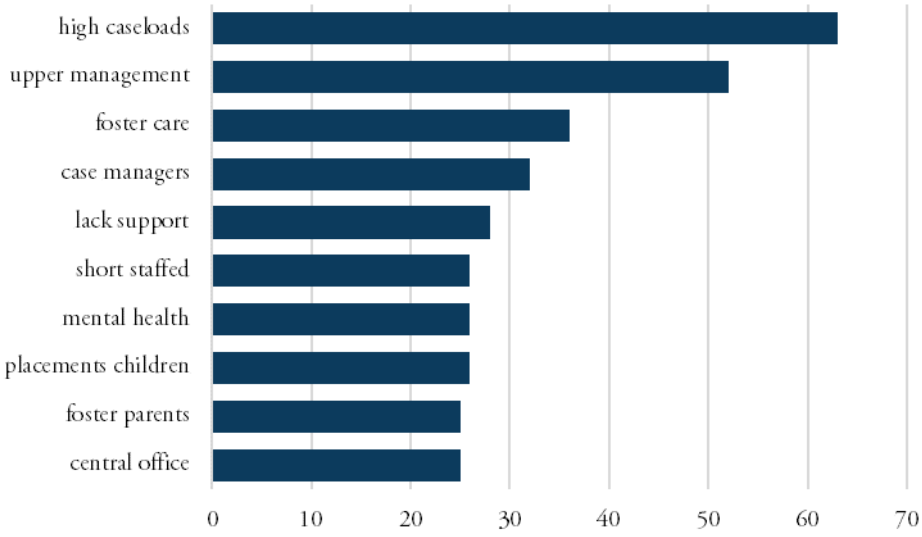
Source: Auditor analysis of case manager survey responses.

Chart 12
Top Ten Word Pairs in Responses to the Question
What do you enjoy about your job?



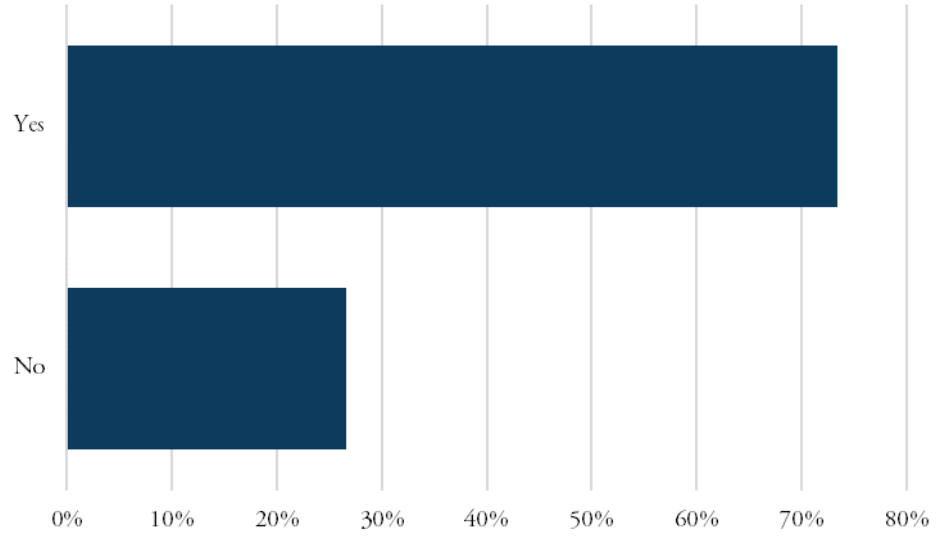
Source: Auditor analysis of case manager survey responses.

Chart 13
Top Ten Word Pairs in Responses to the Question
What challenges do you face with your job?



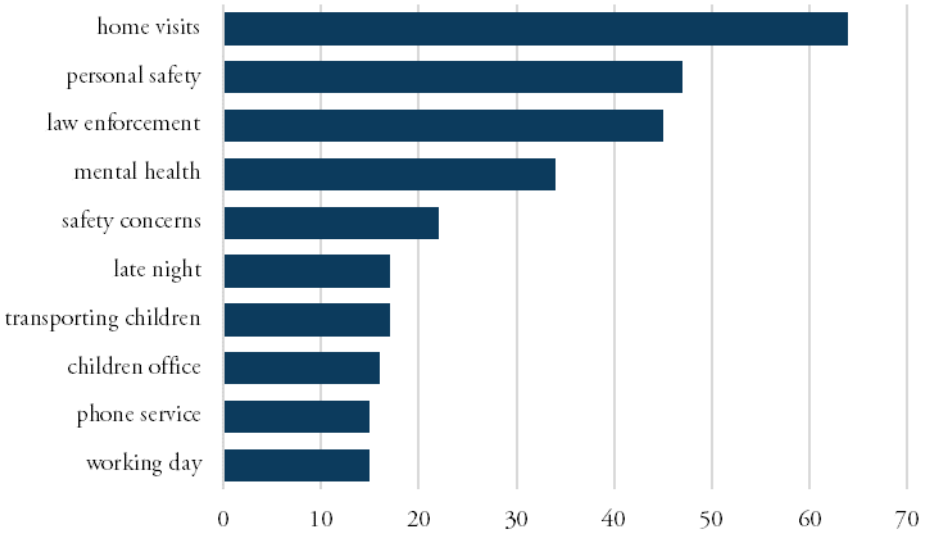
Source: Auditor analysis of case manager survey responses.

Chart 14
Survey Responses to the Question
While performing your job responsibilities, have you been concerned about your personal safety?



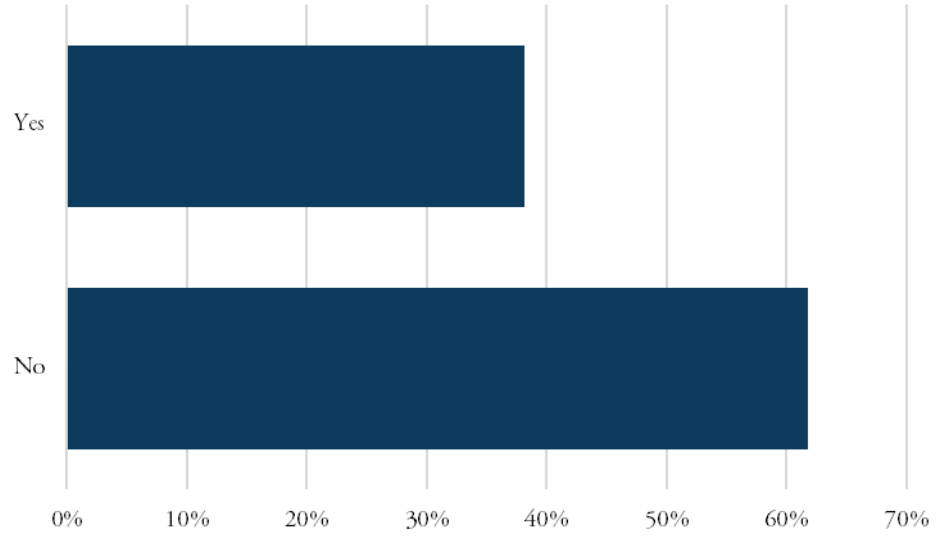
Source: Auditor analysis of case manager survey responses.

Chart 15
Top Ten Word Pairs in Responses to the Question
Please explain your answer to question number 5 regarding your personal safety.



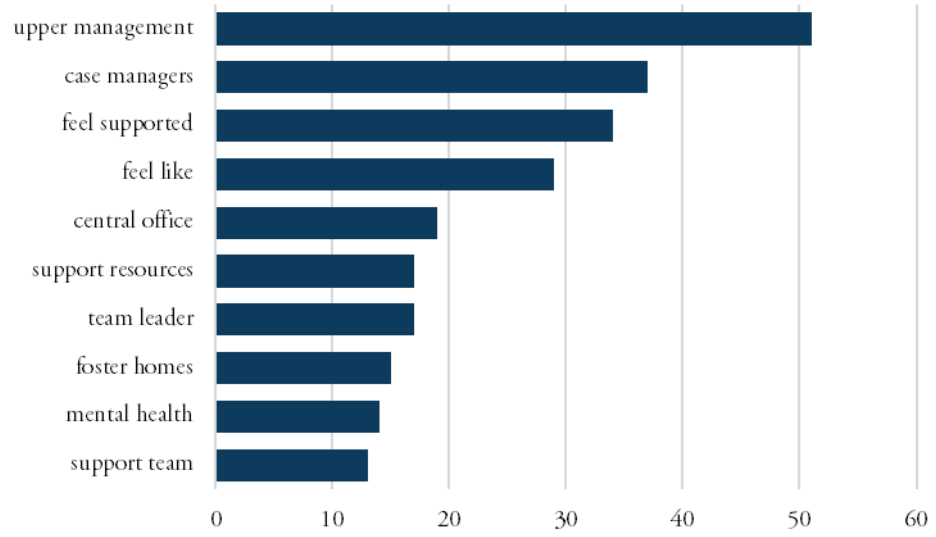
Source: Auditor analysis of case manager survey responses.

Chart 16
Survey Responses to the Question
Do you have the support and resources you need to do your job?



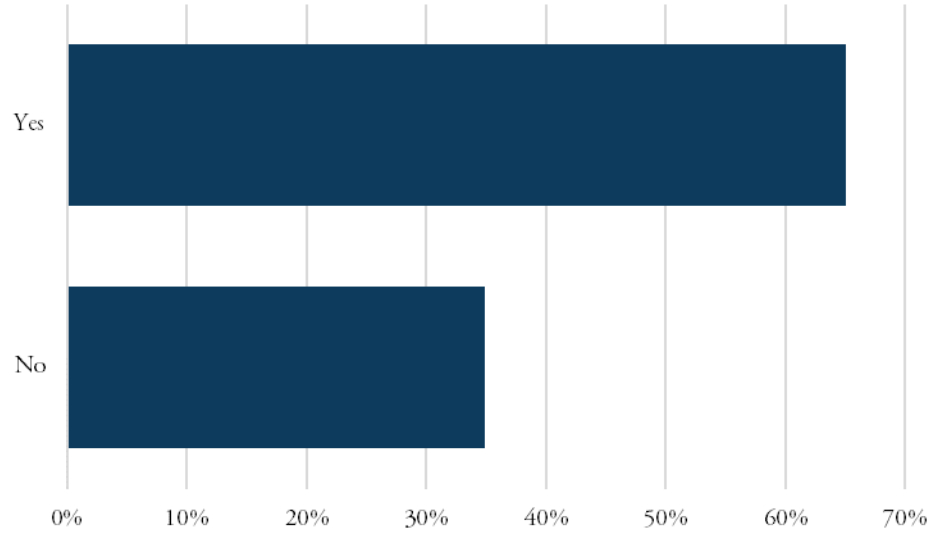
Source: Auditor analysis of case manager survey responses.

Chart 17
Top Ten Word Pairs in Responses to the Question
Please explain your answer to question number 7 regarding support and resources needed.



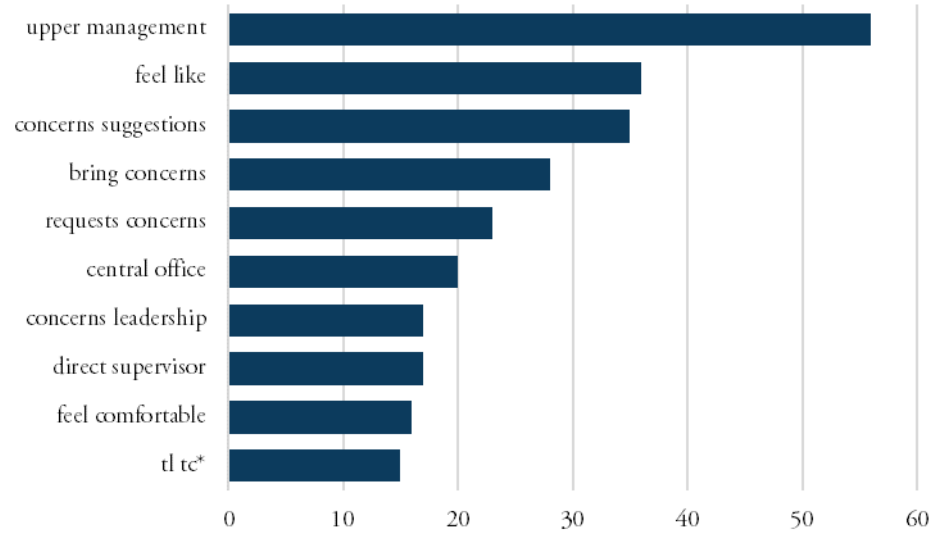
Source: Auditor analysis of case manager survey responses.

Chart 18
Survey Responses to the Question
Can you openly and candidly bring your requests, concerns, and/or suggestions to leadership?



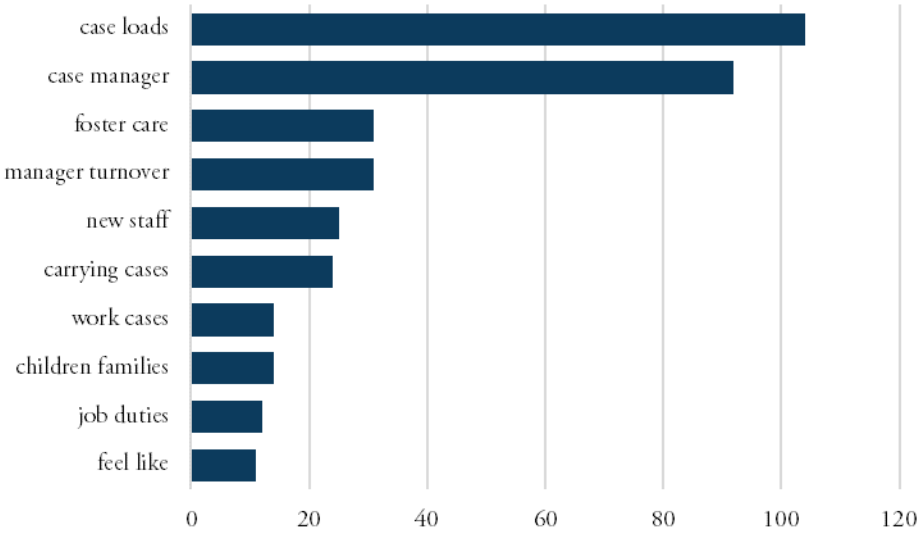
Source: Auditor analysis of case manager survey responses.

Chart 19
Top Ten Word Pairs in Responses to the Question
Please explain your answer to question number 9 regarding requests, concerns, and/or suggestions.



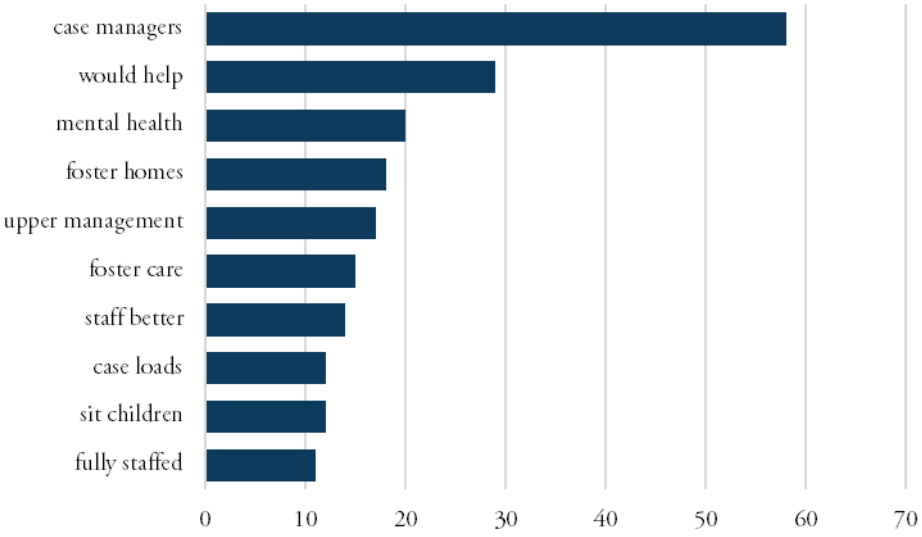
Source: Auditor analysis of case manager survey responses.
*Team leader (TL) and team coordinator (TC)

Chart 20
Top Ten Word Pairs in Responses to the Question
How has case manager turnover affected your ability to do your job?



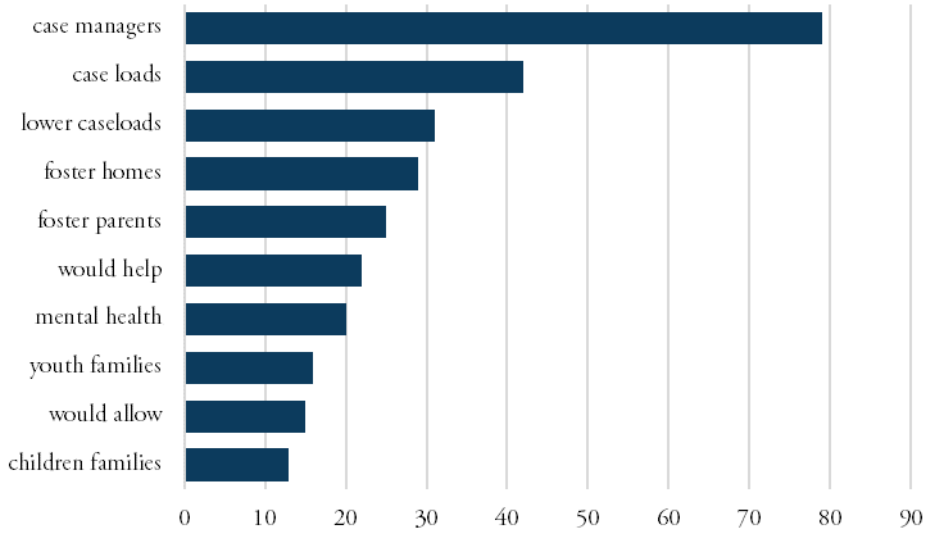
Source: Auditor analysis of case manager survey responses.

Chart 21
Top Ten Word Pairs in Responses to the Question
What tools or resources would make your job easier?



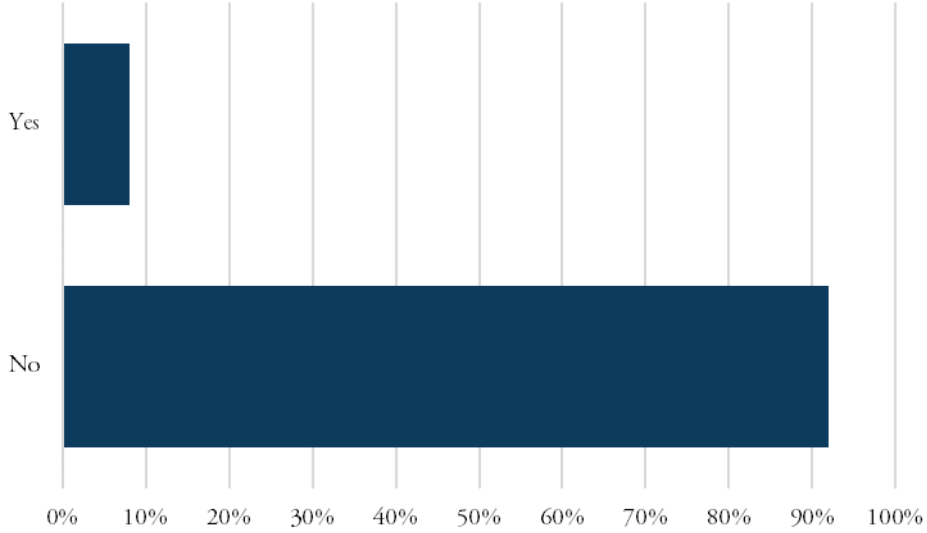
Source: Auditor analysis of case manager survey responses.

Chart 22
Top Ten Word Pairs in Responses to the Question
What ideas do you have that would help you and your team have a greater impact on the youth and families that you serve?



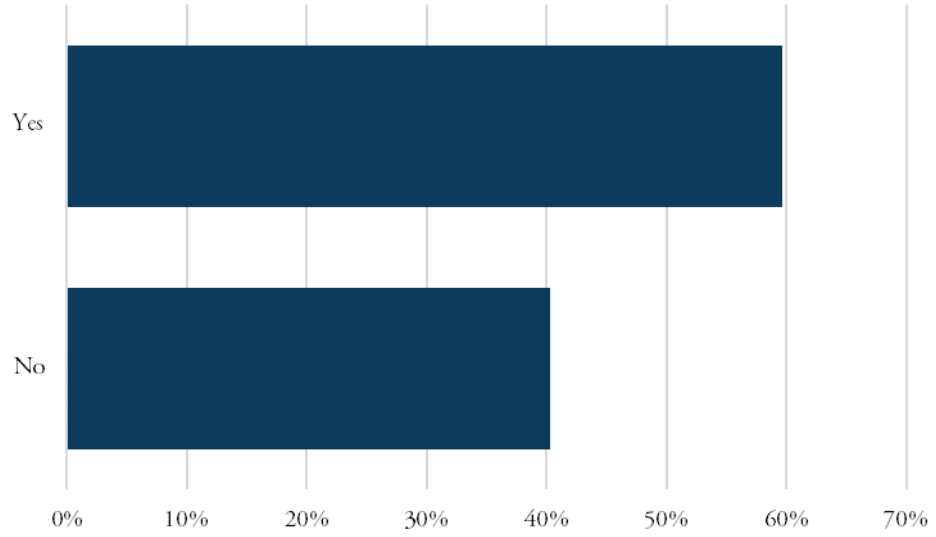
Source: Auditor analysis of case manager survey responses.

Chart 23
Survey Responses to the Question
Did you feel pressured to answer this survey in a particular way?



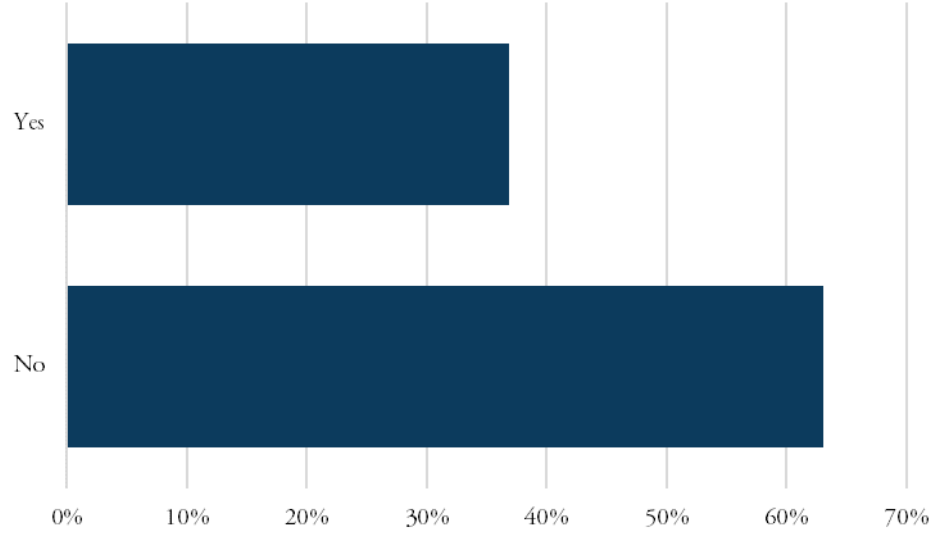
Source: Auditor analysis of case manager survey responses.

Chart 24
Survey Responses to the Question
Have you searched for another job in the last 30 days?



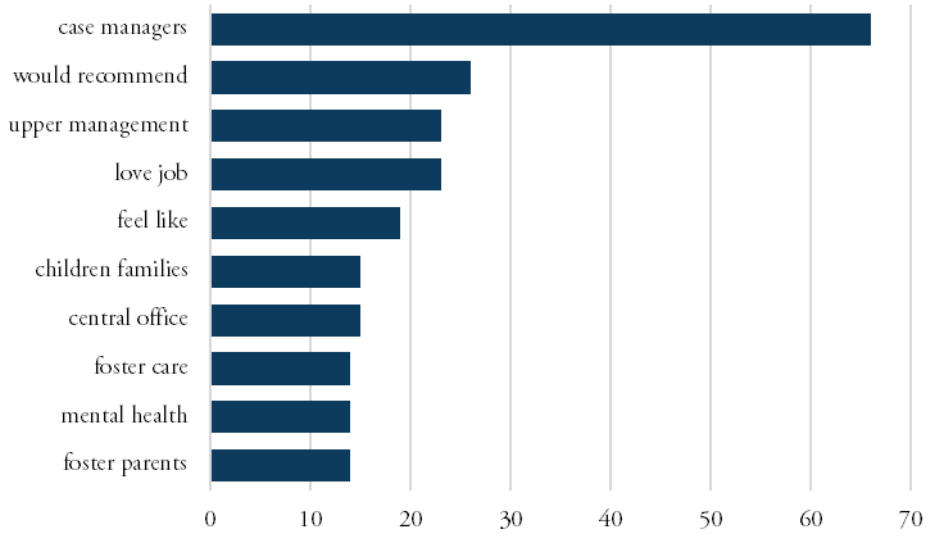
Source: Auditor analysis of case manager survey responses.

Chart 25
Survey Responses to the Question
Would you recommend someone to work as a case manager for the Department of Children's Services?



Source: Auditor analysis of case manager survey responses.

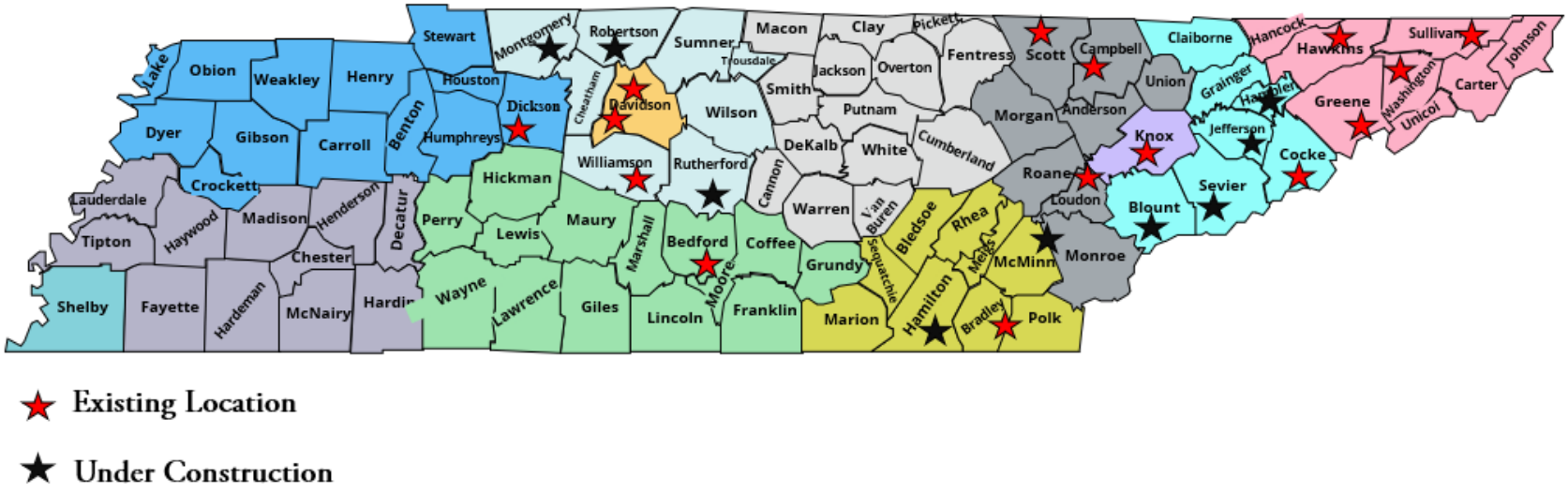
Chart 26
Top Ten Word Pairs in Responses to the Question
Is there anything else you would like to tell us?



Source: Auditor analysis of case manager survey responses.

Appendix 9
Child Placement

Figure 14
Transitional House Locations
As of April 1, 2022



Source: Assistant Commissioner of Child Programs.

Table 13
Approved Foster Homes and Children Placed by Region
As of September 16, 2022

Region	Approved Homes	Children Placed in Region
Davidson	**275**	**495**
DCS	*130*	*173*
Private Provider	*145*	*322*
East Tennessee	**295**	**496**
DCS	*178*	*260*
Private Provider	*117*	*236*
Knox	**353**	**490**
DCS	*194*	*252*
Private Provider	*159*	*238*
Mid-Cumberland	**683**	**1,037**
DCS	*332*	*440*
Private Provider	*351*	*597*
Northeast	**497**	**917**
DCS	*318*	*466*
Private Provider	*179*	*451*
Northwest	**239**	**430**
DCS	*160*	*251*
Private Provider	*79*	*179*
Shelby	**693**	**1,306**
DCS	*340*	*471*
Private Provider	*353*	*835*
Smoky Mountain	**336**	**610**
DCS	*194*	*294*
Private Provider	*142*	*316*
South Central	**482**	**898**
DCS	*259*	*403*
Private Provider	*223*	*495*
Southwest	**290**	**570**
DCS	*108*	*236*
Private Provider	*182*	*334*
TN Valley	**493**	**693**
DCS	*226*	*278*
Private Provider	*267*	*415*
Upper Cumberland	**350**	**606**
DCS	*281*	*473*

Region	Approved Homes	Children Placed in Region
Private Provider	*69*	*133*
Unidentified*	**135**	**619**
DCS	*126*	*435*
Private Provider	*9*	*184*
Total	**5,121**	**9,167**
DCS	*2,275*	*4,432*
Private Provider	*2,846*	*4,735*

* Includes out-of-state placements.
Source: Auditor created using DCS's Mega report and the Resource Home Mega report.

We performed site visits at the Shelby, Davidson, Knox, and Mid-Cumberland regions

We visited the Shelby, Davidson, Knox, and Mid-Cumberland regions to interview regional staff and to view the areas reserved for children who stay overnight in the office buildings and transitional houses. The following information captures more about those visits.

Shelby

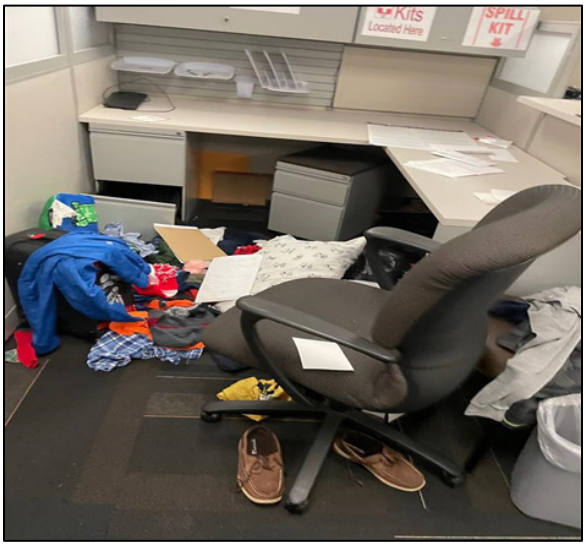
While Shelby region staff told us during our visit in April 2022 that children had not stayed in the office since January 2022, based on the Shelby region's history of using office buildings to temporarily place children, and the conditions and items we saw in the office, as shown in **Figures 15 through 17**, it appeared a child or children had recently stayed at the office building. Additionally, the Shelby region does not have any transitional houses. **Figure 15** shows a room where a child appeared to have recently stayed, and the area was filled with dust, footprints tracked throughout the room, and garbage spread throughout the room.

Figure 15
Photos of an Area Where a Child Could Sleep
Shelby Region Office Building

Source: Auditor photographs.

Figure 16 shows a separate area, at an office cubicle, where it appeared a child had been staying and sleeping. **Figure 17** shows the food options that were available at the office building. We did not see any beds, air mattresses, or cots set up or stored at this office.

Figure 16
Photos of an Office Cubicle With a Child's Belongings
Shelby Region Office Building



Source: Auditor photograph.

Figure 17
Photos of Food Options for Children
Shelby Region Office Building

Source: Auditor photographs.

Davidson

We visited the Davidson region in May 2022, and the Assistant Regional Administrator for the Davidson region told us that no children had needed to stay overnight in the office since February 2022, since the Davidson region has several transitional houses the region can utilize. **Figure 18** shows the general sleeping and playing area for children.

Figure 18
Photos of the Sleeping and Playing Area
Davidson Region Office Building

Source: Auditor photographs.

Knox

We visited the Knox region in April 2022, and staff told us that children frequently had to stay overnight at the office. **Figure 19** exhibits the sleeping and playing area at the Knox region office building. The area included a crib for infants, two futons that pull out, and a couch for sleeping. The area also included a gaming system, television, books, and toys to keep children entertained. The space had a table for children to eat and complete their homework. There were two desks where DCS staff could sit and complete work while supervising the youth.

Figure 19
Photos of Sleeping and Play Area
Knox Region Office Building

Source: Auditor photographs.

In the Knox region, children who stay in the office building can pick clean clothes and shoes in the office's closet, from donated items, and backpacks for school, as shown in **Figure 20**. **Figure 21** shows snacks and food options for children who stay in the office building.

Figure 20
Photos of Clothes and Backpacks for Children
Knox Region Office Building

Source: Auditor photographs.

Figure 21
Photos of Snacks and Food for Children
Knox Region Office Building

Source: Auditor photograph.

Montgomery County Office, Mid-Cumberland

We visited the Montgomery County office, within the Mid-Cumberland region, in April 2022, and staff told us that children regularly had to spend the night in that office building. **Figure 22** exhibits the sleeping and playing areas for children. **Figure 23** shows food options for children who stay at this office.

Figure 22
Photos of Sleeping and Playing Areas
Montgomery County Office Building

Source: Auditor photographs.

Figure 23
Photos of Food Options for Children
Montgomery County Office Building

Source: Auditor photographs.

We visited two transitional houses in the Nashville area

Figure 24 has photos from two different transitional houses in the Nashville area we visited in June 2022. The photos show sleeping and playing areas, donated clothes available for children to take, and food options available for children. We did not provide the exact names and locations of the transitional houses due to potential privacy and security concerns.

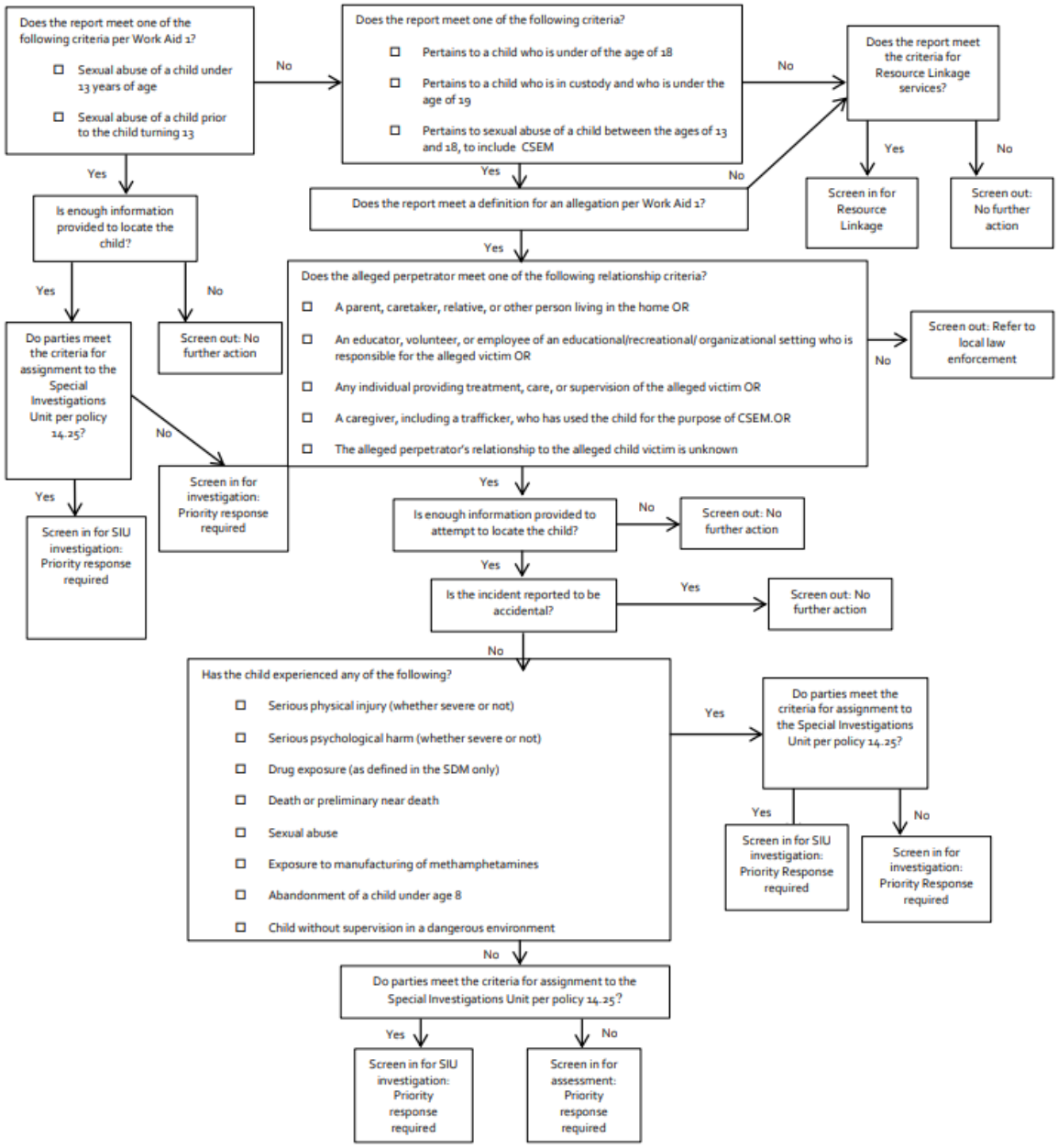
Figure 24
Photos of Living Areas, Clothes, and Food Options for Children
Transitional Houses

Source: Auditor photographs.

Appendix 10
Child Safety

Child Protective Services' Child Abuse and Neglect Investigations

Figure 25
Child Abuse Hotline Decision-Making Tool



Note: Acronyms used in the decision tool: Special Investigations Unit (SIU), Child Sexual Abuse/Exploitation Materials (CSEM), and Structured Decision Making (SDM).
Source: Child Abuse/Neglect Intake Assessment Policy and Procedures Manual.

Testwork Results and Criteria

Management indicated they made improvements to their administrative review policies and procedures; however, these procedures were not sufficient to ensure the timely completion of key points of the investigation process, as detailed in **Table 14**.[65]

Table 14
Error Rates for DCS's Response to Child Abuse Allegations

Error	Error Rate*	Additional Information
Timely Response†	4%	These cases were Priority 2 and 3, though case managers at times arrive at lower priority-level cases and find a more severe situation than initially reported to hotline staff.
Timely Submission and Review of FAST Safety Assessment‡	43%	Case managers submitted FAST safety assessments late or not at all, or we could not determine if they were done timely because DCS used a separate system for the Special Investigations Unit FAST that did not record the submission date.
Timely Classifications§	27%	Case managers classified cases late, including 5 cases noted as "severe."
Convening of Child Protective Investigative Team (CPIT)‖	8%	The case did not indicate staff included any member of the CPIT in the case "immediately upon disclosure of severe abuse."
Documentation of CPIT Review#	19%	For 4 of the 5 cases without this documentation, the case manager noted in the case that the CPIT met, but they did not include the form to document that meeting, as required.
Timely Case Closure, Transfer, or Extension**	25%	These cases were closed late without documentation of required administrative reviews for extension.

* Error rate is for a sample of 75 cases, except the Child Protective Investigative Team (CPIT) errors, which apply to the 26 severe cases in our sample.

† According to DCS Policy 14.3, "Screening, Priority Response and Assignment of Child Protective Services Cases," Priority 1 (P-1) cases "are initiated by face-to-face contact with the [alleged child victim] ACV no later than twenty-four (24) hours"; P-2 cases "are initiated by face-to-face contact with the ACV within two (2) business days"; and P-3 cases "are initiated by face-to-face contact with the ACV within three (3) business days."

‡ The "Protocol for Completion of the Family Advocacy and Support Tool (FAST)" requires case managers to submit the safety assessment component of the FAST to the supervisor within five business days from the intake date and requires the supervisor to approve it within three business days of submission by the case manager.

§ DCS Policy 14.7, "Child Protective Services Investigation Track," and Policy 14.26, "Child Protective Services Assessment Track," require case managers to classify cases within 30 days, with exceptions for investigations marked as "severe," which are to be classified within 60 days.

[65] DCS Policy 4.4, "Performance and Case Supervision Practice Guidelines and Criteria," states, "Supervisors are responsible for monitoring staff performance. . . Supervisors. . . [p]rovide constructive feedback and intervene when performance does not meet agency expectations [and] . . . [m]onitor and utilize data to provide feedback on performance and ensure compliance with agency requirements."

‖ DCS Policy 14.6, "Child Protective Investigation Team," stipulates that the CPIT must be convened upon notification of severe or sexual abuse allegations.

DCS Policy 14.6 requires completion of the CS-0561, Child Protective Investigative Team Review form.

** DCS Policy 14.7 requires case managers to complete their responsibilities and close the case within 60 calendar days. DCS Policy 14.26 states, "to properly close a CPS case, all CPS tasks, tools, decisions, and notifications are completed, documented, and approved within ninety (90) calendar days." For both investigations and assessments, if a case goes beyond the timeframe for closure, the supervisor documents an administrative review in TFACTS as an explanation for the delay, including the next steps to complete the case and the estimated date of closure.

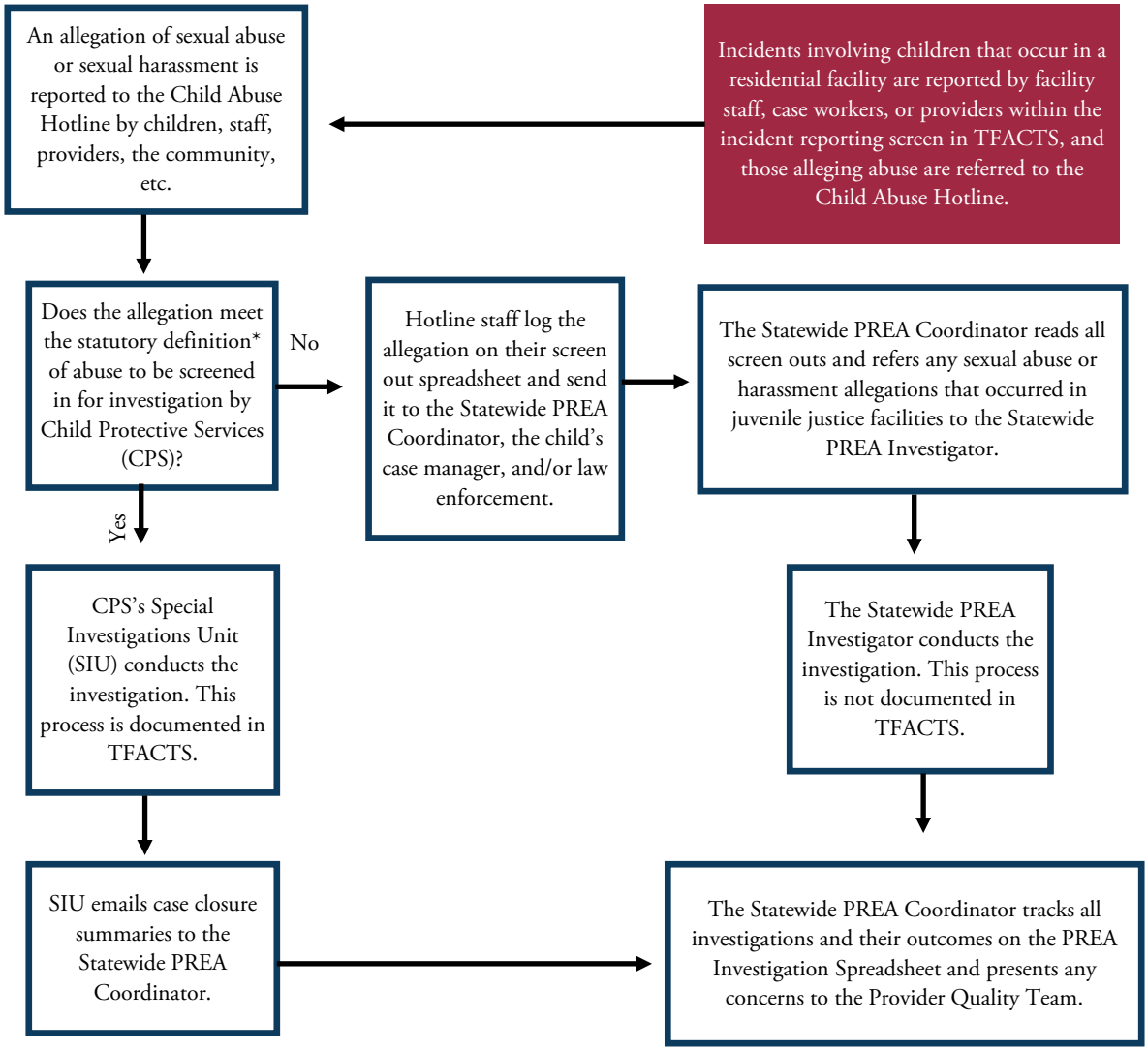
Source: Auditor testwork.

Residential Facility Sexual Abuse/Harassment Investigations and the Prison Rape Elimination Act

Sexual Abuse/Sexual Harassment Allegation Receipt and Investigation Process

We created the figure below based on discussions of DCS's intake, referral, and investigation processes for sexual abuse and sexual harassment investigations with DCS's Director of Child Protective Services, the Director of the Child Abuse Hotline, and the Statewide PREA Coordinator and based on our review of DCS policies and procedures.

Figure 26
PREA Allegation Referral and Investigation Process



* The Child Abuse Hotline staff use a standardized decision tree to help them determine if allegations meet the statutory definition of abuse. If the allegation does meet the definition of abuse, then it is screened in, and CPS investigates. If the allegation does not meet the statutory definition of abuse, then they screen the allegation out.

Source: Auditor created based on walkthroughs with DCS management.

Testwork Results and Criteria

Based on a review of 211 sexual abuse and sexual harassment incidents reported[66] within residential facilities from January 1, 2021, to December 31, 2021, we found that DCS did not investigate 71reports of sexual abuse, sexual harassment, or potential lack of supervision. The details of our results are summarized below.

Table 15
Results of Auditors' Review of 2021 Sexual Abuse and Sexual Harassment Incidents and Resulting Investigations

Error	Count	Additional Information
Allegation Not Assigned to PREA Investigator*	4	The Statewide PREA Coordinator noted three allegations that needed a PREA investigation, but the Coordinator did not refer the allegation to the PREA Investigator. The Coordinator also marked two allegations as occurring not in a PREA facility when she had previously agreed to investigate PREA allegations at these facilities.
Not a PREA Incident†	2	The Statewide PREA Coordinator noted these allegations of unwanted touching, pantsing, flashing, sexual misconduct, and more were not PREA incidents even though we believe that they would meet the requirements for a PREA investigation.
Not a PREA Applicable Facility‡	28	The Statewide PREA Coordinator did not refer these allegations of rape, sexual assault, staff sexual misconduct, pantsing, flashing, other consensual yet inappropriate sexual acts between children, and more to the PREA Investigator because the facility where the allegation occurred did not primarily house juvenile delinquents. The allegations were not investigated by Child Protective Services or the PREA Investigator.
Not Investigated as a Lack of Supervision§	37	These allegations contained potential consensual sexual activity between children in residential facilities, which may indicate a lack of supervision at the facility.

* According to PREA Standard 115.322(a), "The agency shall ensure that an administrative or criminal investigation is complete for all allegations of sexual abuse and sexual harassment." Additionally, DCS Policy 18.8, "Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault, or Rape Incidents and Prison Rape Elimination Act (PREA)," states, "DCS ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse/assault/misconduct/harassment."

† DCS Policy 18.8 states, "DCS ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse/assault/misconduct/harassment."

‡ According to Policy 18.8, DCS is committed to a zero-tolerance standard for all forms of sexual abuse, assault, misconduct, or rape at all facilities that provide congregate care for children.

§ DCS's Work Aid 1 states that a lack of supervision includes "failure to provide adequate supervision, by a parent or other legal custodian/caretaker, who is able to do so."

Source: Auditor testwork.

[66] Residential facility staff, case workers, or provider staff report suspected incidents of sexual abuse or sexual harassment within the Incident Reporting module of TFACTS. Section 37-1-403, *Tennessee Code Annotated,* requires these incidents to be reported to the Child Abuse Hotline, which starts DCS's process of evaluating the allegation and determining how to respond to the allegation.

According to federal PREA Standard 115.322(a), "Policies to Ensure Referrals of Allegations for Investigations," "the agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment." According to DCS Policy 18.8, "Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)," DCS "ensures that an administrative or criminal investigation is complete for all allegations of sexual abuse/assault/misconduct/harassment."

Based on a review of 26 randomly selected PREA investigation case files from calendar year 2021, we found the errors listed in **Table 16** below.

Table 16
Results of Auditors' Review of DCS's Calendar Year 2021 PREA Investigations

Error	Error Rate	Additional Information
Timely Referral of Allegation From Hotline to Statewide PREA Coordinator*	48%†	Child Abuse Hotline staff did not send the screened-out allegation to the Statewide PREA Coordinator within 3 business days of receipt of the allegation.
Timely PREA Investigation Initiation‡	54%	The PREA Investigator did not contact the facility within 2 business days of initiating the investigation to inform them that a PREA case been opened.
Timely Contact With Involved Parties§	35%	The PREA Investigator did not interview and obtain statements from the alleged victim(s), witnesses, and perpetrators within 7 to 10 business days of receipt of the allegation.
Timely PREA Investigation Completion‖	50%	The PREA Investigator did not complete the investigation within 30 to 45 calendar days of receipt of the allegation.
Notification of Investigation Outcome#	100%	The Statewide PREA Coordinator did not document whether they notified the facility and the alleged victim of the outcome of the investigation.

* Federal PREA Standard 115.371(a) states, "When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports." Since DCS policies do not define how quickly the hotline must refer screened-out allegations to the Statewide PREA Coordinator, we used 3 business days, which is the most lenient amount of time the hotline has to refer allegations for investigation per Policy 14.3, "Screening, Priority Response and Assignment of Child Protective Services Cases."

† We ended up testing 25 items instead of 26 for this attribute because the hotline only sent the allegation to the Statewide PREA Coordinator 1 time, but the Coordinator sent the same allegation to the PREA Investigator twice and she investigated the allegation twice.

‡ DCS's Protocol for DCS PREA Investigators to Conduct Prison Rape Elimination Act Investigations (PREA Protocol) states the investigator will "contact the facility within two (2) business days to inform the PREA compliance manager, facility manager/administrator and/or superintendent that a PREA case has been opened and to determine the availability of video evidence."

§ DCS's PREA Protocol states that the investigator must "complete the following tasks within seven (7) business days at Juvenile Detention Centers and within ten (10) business days at all other facilities: interview and obtain statements from the alleged victim(s), witnesses, and perpetrators, and other persons with relevant information."

‖ DCS's PREA Protocol states the DCS PREA Investigator must "complete investigations on all Child Abuse Hotline (CAH) Screen-out cases sent by the Statewide PREA Coordinator (SPC) within 45 days of receipt for all facilities with the exception of the Juvenile Detention Centers. Investigations involving cases at a Juvenile Detention Center must be completed within thirty (30) days."

PREA Standard 115.373(a), "Reporting to Residents," states, "Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded." DCS's PREA Protocol states that "The SPC provides the facility the outcome of the investigation."

Source: Auditor testwork.

Based on a review of the three annual PREA compliance visit summaries the Statewide PREA Coordinator completed in 2021, we found the following errors:

Table 17
Results of Auditors' Review of DCS's Annual PREA Compliance Monitoring Visits

Error	Error Rate	Additional Information
Monitoring Conclusions Not Supported by Evidence	100%	The Statewide PREA Coordinator did not document the evidence she reviewed to support her conclusions that the facilities were in compliance with PREA standards. Additionally, the Coordinator did not use the monitoring visit report to document any efforts to ensure facilities obtain their triennial federal PREA audits. We found 5 facilities that did not obtain a federal PREA Audit in Cycle 3 (August 20, 2019, to August 19, 2022).
No Documentation and Follow-up on Noted Deficiencies	33%	In one instance, the Statewide PREA Coordinator marked a compliance requirement deficient but did not include the details of the deficiency in the summary of the report or whether the Coordinator followed up with the facility to ensure the deficiency was resolved.

Source: Auditor testwork.

DCS Policy 18.8, "Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and Prison Rape Elimination Act (PREA)," states, "The DCS Statewide PREA Coordinator monitors PREA requirements and provides oversight for all applicable state-owned facilities and contract agencies." The supplementary Protocol for DCS Statewide PREA Coordinator requires that the Coordinator

> conducts a comprehensive review of the residential contract agencies, state operated facilities and Youth Development Centers annually to ensure they are complying with the PREA standards. This annual review is an on-site mini audit for the agency/facility and includes the following: reviews paper, electronic files and documents; conducts interviews; and tours all facilities.

Based on a review of DCS's PREA policy and protocols, we identified the deficiencies listed in **Table 18.**

Table 18
Results of Auditors' Review of DCS's PREA Policy and Protocol

Number	Category	Policy/Protocol Reference
1	Contradictory Language	The DCS PREA Investigation Protocol contains contradictory language regarding investigation timeliness. The protocol states that investigations should be completed within 45 days (30 days for juvenile detention centers) on page 1; however, it also states that the Statewide PREA Coordinator must let the facility know the outcome of the investigation within 10 days (7 days for juvenile detention centers) on page 1.
2	Outdated Information	Page 2 of the DCS PREA Investigation Protocol mentions the use of the CS-1239 Checklist that staff stated they no longer used during the investigation process.
3	Outdated Information	The DCS Statewide PREA Coordinator's Job Protocol requires the Coordinator to collect monthly reports for all PREA facilities (page 1); however, the Coordinator stated that this action is not a part of her current process for monitoring PREA facilities. If obtaining these reports is a necessary part of the Coordinator's job protocol, management should consider including more information for what the reports are and how the Coordinator should obtain, review, and maintain the reports.
4	Policy Does Not Align With PREA Standards	PREA Standard 115.331(a)(8) states, "the agency shall train employees who many have contact with residents on how to avoid inappropriate relationships with residents" whereas DCS Policy 18.8 states "applicable [youth development center]/Agency employees are trained on . . . how to avoid relationships with children/youth," which excludes the term "inappropriate."
5	Policy Does Not Align With PREA Standards	PREA Standard 115.367(f) regarding retaliation states, "An agency's obligation to monitor shall terminate if the agency determines that the allegation is **unfounded**" whereas DCS Policy 18.8 states, "The [youth development center]/Agency's responsibility to monitor terminates if the allegation is **unsubstantiated**."
6	Process Not Clearly Defined in Policy	DCS does not have a written guidelines on how to complete the 50% juvenile justice population calculations to identify which facilities must follow PREA standards.

Source: Auditor created based on our review of DCS policies and federal PREA standards.

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government,* Principle 12.05, "Periodic Review of Control Activities," states,

> Management periodically reviews policies, procedures, and related control activities for continued relevance and effectiveness in achieving the entity's objectives or addressing related risks. If there is a significant change in an entity's process, management reviews this process in a timely manner after the change to determine that the control activities are designed and implemented appropriately.

Quality Control: Alleged Perpetrator SIU Reviews

Testwork Results

From a sample of 30 Special Investigations Unit (SIU) investigations, we could not determine if the Provider Quality Team (PQT) reviewed corrective action items for 5 investigations (17%) because there was no evidence of PQT's follow-up on the action items. See **Table 19** for a summary of our results.

Table 19
PQT Follow-up on Corrective Action Items Results

SIU Case Description	Investigation Result	Corrective Action Item	PQT Response
Lack of Supervision/ Drug Exposure	Unsubstantiated	Follow up with the provider regarding termination of staff and re-training on topics such as incident reporting, staffing ratios, and proper communication with staff and parents.	PQT discussed this case with facility management either over the phone or in person and did not document the conversation.
Sexual Abuse	Unsubstantiated	Follow up with the facility to remind staff to bring inappropriate personal letters they receive from residents to management to be appropriately addressed, and to never just throw the letters away.	PQT discussed this case with facility management either over the phone or in person and did not document the conversation.
Physical Abuse	Unsubstantiated	Follow up on discipline, Handle with Care* certifications, and any corrective action the facility has taken.	PQT discussed this case with facility management either over the phone or in person and did not document the conversation.
Physical Abuse	Unsubstantiated	PQT will follow up with Legal on the legalities of having the AP work directly with youth after having a substantiation in a previous investigation.	This case is still pending an appeal, so PQT paused any follow-up until the results are finalized.
Physical Abuse	Unsubstantiated	Follow up on documentation for re-training of AP and have a conversation with facility about de-escalation† vs. restraining, particularly with this. Follow up with facility on whether the alleged child victim was provided medical care.	PQT reached out to the facility for follow-up, but the facility did not respond to PQT.

* Handle with Care is a crisis intervention program designed to teach staff how to respond to incidents with safe intervention techniques.
† De-escalation refers to defusing situations before they reach the point of physical aggression or violence.
Source: Auditor testwork.

We reviewed DCS's monthly SIU Closure Reports from April 2021 to January 2022 and found that **staff's manual count of the all-time number of investigations** each alleged perpetrator (AP) had been named in and staff's creation of duplicate TFACTS profiles for the same alleged perpetrator resulted in the errors listed in **Table 20** below.

Table 20
SIU Closure Report Discrepancies

Employee #	Month of SIU Report	Number of Investigations AP Named in on SIU Report*	Actual Number of Investigations AP Named in in TFACTS† (Human Counting Errors + Duplicate TFACTS Profiles)
1	May 2021	7	12
2	May 2021	26	37
3	May 2021	5	20
4	June 2021	8	12
5	July 2021	7	8
6	July 2021	5	7
7	July 2021	15	19
8	October 2021	7	11
9	September 2021	12	22
10	January 2022	6	10
11	January 2022	16	18

* This number represents SIU **staff's manual all-time count of investigations** each alleged perpetrator had been named in at the time of the SIU monthly report.

† This number represents the all-time count of investigations each alleged perpetrator had been named in based on the information in TFACTS at the time of the SIU monthly report.

Source: Auditor testwork.

Employee, Provider Employee, and Volunteer Background Checks

Testwork Results and Criteria

Table 21
Results of Employee and Volunteer Background Check Review

Error	Error Rate	Additional Information
Employee driver record checks were not performed, were performed late, or were undated*	25%	Staff did not perform driving record checks as required by DCS policy because the prospective employees had an out-of-state driver license during the hiring process, and DCS does not have access to most outside states' driving records.
Volunteers began before DCS staff issued certification letters†	4%‡	The certification letter shows that a volunteer has passed all required background checks. Before we started our work, management made us aware that some volunteers started their service with DCS before the certification letter was issued, and our testwork identified one additional volunteer that started early. According to the Program Director, these volunteers began before the certification letter was issued because staff did not know the procedures; she stated that staff have since received training.
Employee and volunteer background check checklist was not completed correctly or timely§	Employee: 27%	The Executive Director explained that she believed the errors were due to staff starting checklist items, inputting the date the first item was completed, and not updating the date for the remaining items, even if the remaining items were completed at a later date.
	Volunteer: 15%	The Program Director indicated volunteer coordinators did not update the signature date on the background check checklist when updates had to be made to the volunteers' background checks.

* DCS Policy 4.1, "Employee Background Checks," outlines specific required background checks, including a "Driving records check to include current valid driver license and a check of moving violations records."

† According to the *Volunteer Service Procedures Manual*, "Once the designated Central Office Child Programs staff has determined the file is complete and all background checks have been conducted within the required timeframe, the volunteer's file will be submitted to the DCS Central Office HR contact who will then request certification from the Division of Claims." The Volunteer Certification Letter indicates the "letter will serve to verify that the Department of Children's Services has approved the applicant" for volunteer service.

‡ This error rate applies to the full population of 414 volunteers that began service January 1, 2021, through February 28, 2022.

§ DCS Policy 4.1, "Employee Background Checks," and the *Volunteer Service Procedures Manual* require that results from completed background checks must be documented on form CS-0687, Background Check History and IV-E Eligibility Checklist, and maintained in the applicable employee or volunteer file.

Source: Auditor testwork.

Child Safety Responsibilities: Probation and Aftercare Supervision

Testwork Results and Criteria

Based on a review of 31 children's probation cases and 29 children's aftercare cases opened from October 1, 2021, to March 31, 2022, we found the following errors, as shown in **Table 22.**

Table 22
Results of Auditor's Probation and Aftercare Case Reviews

Error	Probation Supervision		Aftercare Supervision	
	Prior Audit Results	Current Audit Results	Prior Audit Results	Current Audit Results
The juvenile justice case worker did not make monthly contact with the child's school.*	91%	55%	85%	28%
The juvenile justice case worker did not make monthly contact with the child's service providers.†	Not in Scope	42%	Not in Scope	28%
The juvenile justice case worker did not make at least 1 face-to-face visit with the child in the home each month.‡	53%	0%	37%	7%
The juvenile justice case worker did not perform 3 face-to-face visits within the first 30 days of probation or the Trial Home Visit.§	44%	10%	23%	10%
The juvenile justice case worker did not perform the monthly face-to-face visits based on the child's level of supervision.‡	29%	0%	32%	7%
The juvenile justice case worker did not make the required number of contacts with the child's parent/legal guardian based on the child's level of supervision.#	53%	10%	37%	7%

* According to DCS Policy 13.12, "Probation Requirements for Delinquent Youth," and Policy 13.11, "Trial Home Visit and Aftercare Requirements for Delinquent Youth," after the initial 30-day period, the juvenile probation officer (JPO) or juvenile service worker (JSW) should maintain contact with the child's school officials "a minimum of one (1) contact a month."

† According to DCS Policies 13.12 and 13.11, after the initial 30-day period, the JPO or JSW should maintain contact with the child's service provider "a minimum of one (1) contact a month."

‡ DCS Policy 13.12 states, "Probation – Youth: A minimum of one (1) face to face visit in a month in the home. . . . Intensive Probation – Youth: A minimum of three (3) face to face visits a month, with at least one (1) of the visits being in the home." Policy 13.11 states, "Aftercare – Youth: A minimum of one (1) face to face visit in a month in the home. . . . Intensive Aftercare – Youth: A minimum of three (3) face to face visits a month, with at least one (1) of the visits being in the home."

§ DCS Policy 13.12 states, "The JPO conducts three (3) face to face visits with the youth, during the first thirty (30) days for both probation types, excluding youth in non-custodial placements. The JPO is required to conduct at least one (1)

of these visits in the home." Policy 13.11 states, "During the first thirty (30) days of the THV [trial home visit] the JSW conducts three (3) face to face visits with the youth. The JSW is required to conduct at least one (1) of these visits in the home with the youth and family."

According to DCS Policy 13.11 and Policy 13.12, for probation and aftercare, the JPO or JSW should maintain contact with the Parents/Legal Custodians "a minimum of one (1) contact a month . . . Intensive Probation. . . A minimum of two (2) contacts a month."

Source: Auditor testwork.

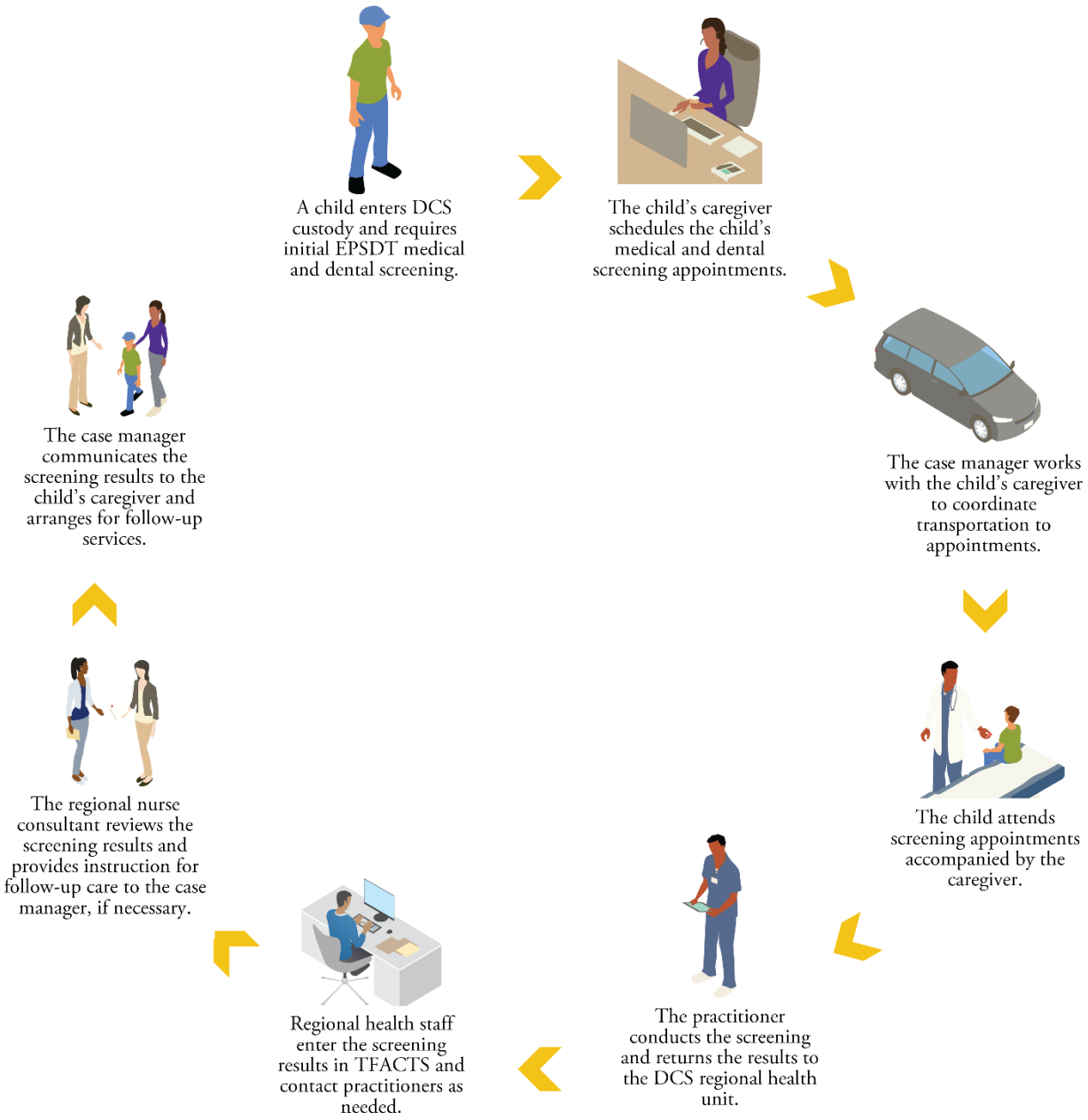
We reviewed 2 internal control case tracking spreadsheets from random team leaders in each region, for a total of 12 spreadsheets, from October 2021 to March 2022. Our results are in **Figure 27** below.

Figure 27
Internal Case Tracking Spreadsheets Conclusion

DCS designed an "Internal Control Case Tracking Spreadsheet" to help regional supervisors track the status of case workers' monthly contacts with children, their families, schools, and service providers. Per management, for the tool to work, supervisors must use the tool proactively on a weekly basis to ensure all contacts have been made by the end of the current month. However, some supervisors only use the tool as a post-review of contacts from the previous month. If the tool is not used weekly as intended, then the internal control will not work.

Appendix 11
Child Health

Figure 28
Process to Complete and Review Medical and Dental Screening Results



Source: The auditor prepared this figure based on discussions with management.

Appendix 12
Tennessee Family and Child Tracking System

Finding Criteria

According to the Strategic Technology Solution's Policy 5.00, "Information Systems Management & System Development Life Cycle," the objectives include the need to "Deliver quality systems on time and within budget in a consistent and maintainable manner that conforms to the State's software and hardware, architectural, and security standards."

Best practices outlined in the National Institute of Standards and Technology's Special Publication 800-53 (Rev. 5), *Security and Privacy Controls for Information Systems and Organizations,* Section SI-2, "Flaw Remediation," explain that organizations should do the following:

- Identify, report, and correct system flaws;
- Test software and firmware updates related to flaw remediation for effectiveness and potential side effects before installation;
- Install security-relevant software and firmware updates within *[Assignment: organization-defined time period]* of the release of the updates; and
- Incorporate flaw remediation into the organizational configuration management process.

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) sets internal control standards and is considered best practice for nonfederal entities. Green Book Principle 13.06, "Data Processed into Quality Information," states, "Management processes relevant data from reliable sources into quality information within the entity's information system. An information system is the people, processes, data, and technology that management organizes to obtain, communicate, or dispose of information."

Table 23
Issues Identified in the 2012 Special Review of TFACTS

Observation 1 – [Management] disregarded obvious and known problems with [TFACTS], as well as the recommendation of an independent reviewer, when they made the decision to implement the system statewide.	Observation 2 – [Management has] compounded the mistakes and errors in judgment related to the decision to implement TFACTS statewide by failing to adequately track the record of problems with the system and proactively address the known issues.
Specific Issues: • The system was not able to make payment adjustments. • Management did not turn on a key feature within TFACTS to prevent payments to foster parents that no longer had custody of a child. • Financial reporting was not available and would not be available until the financial enhancement was complete. • The vendor no longer supported the software used to build and maintain TFACTS. • Payments to third parties were late or duplicated. • Initial staff training during the TFACTS implementation was inadequate. • Before implementation of TFACTS, an independent reviewer determined that TFACTS was materially flawed and advised against implementation until improvements could be made to nearly 200 defects they identified, and yet management implemented the system anyway without fixing the defects.	Specific Issues: • Management made at least $700,000 in duplicate payments to foster families. • Management was not tracking and maintaining records for a hotline, which was the only way foster parents and providers could inform DCS if they did not receive a payment, making it impossible to know if complaints were being resolved and how long it was taking to resolve complaints. • In the first year after the system was implemented, defects increased by 360%, and management was not providing proper oversight and maintenance of defects.

Source: Auditor creation based on the Comptroller of the Treasury's "A Review of the TFACTS Implementation 2012."