TENNESSEE COMPTROLLER OF THE TREASURY

PERFORMANCE AUDIT REPORT

Department of Children's Services

Including the Interstate Compact for Juveniles

December 2025

Jason E. Mumpower
Comptroller of the Treasury

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TENNESSEE COMPTROLLER OF THE TREASURY

TENNESSEE COMPTROLLER OF THE TREASURY

JASON E. MUMPOWER
Comptroller

December 16, 2025

The Honorable Randy McNally
Speaker of the Senate
The Honorable Cameron Sexton
Speaker of the House of Representatives
The Honorable Ed Jackson, Chair
Senate Committee on Government Operations
The Honorable Justin Lafferty, Chair
House Committee on Government Operations
and
Members of the General Assembly
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and
The Honorable Margie Quin, Commissioner
Department of Children's Services
315 Deaderick Street
Nashville, TN 37243
and
Corrie Copeland, Compact Administrator
Interstate Compact for Juveniles
315 Deaderick Street
Nashville, TN 37243

Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Department of Children's Services and the Interstate Compact for Juveniles for the period September 1, 2022, through September 30, 2025.[1] This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, *Tennessee Code Annotated.*

This report presents the conclusions of our audit, including findings, a mission challenge, observations, matters for legislative consideration, and a matter for consideration. The Department of Children's Services management and Interstate Compact for Juveniles management were given the opportunity to respond, and we have included their responses in the respective sections of the report. We will follow up on the audit results to examine managements' corrective actions.

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

Sincerely,

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

KJS/ls
25/010

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

DEPARTMENT OF CHILDREN'S SERVICES

INCLUDING THE INTERSTATE COMPACT FOR JUVENILES

AUDIT HIGHLIGHTS

Department of Children's Services Mission

Act in the best interest of Tennessee's children and youth.

Interstate Compact for Juveniles' Mission

The mission of the Tennessee Interstate Compact for Juveniles is to preserve child welfare and promote public safety interests by providing a uniform standard for the welfare and protection of juveniles, victims, and the public.

Audit Period

September 1, 2022, through September 30, 2025

Scheduled Termination Date

June 30, 2026

Key Audit Conclusions

Finding 1: A lack of management oversight in the Special Investigations Unit allowed for insufficient and untimely investigations of child abuse and neglect by adults in authority roles, increasing the risk that children are not protected from abuse or neglect (page 19).

Finding 2: Management must strengthen its investigative oversight of Child Protective Services to ensure staff meet key timelines for investigating child abuse and neglect (page 30).

Finding 3: Prolonged investigative tasks, delayed supervisory reviews, and the lack of a physician reviewer impacted the department's ability to update information on its website regarding child fatalities and near fatalities (page 39).

Finding 4: Despite recent improvements, the department has not fully met its oversight responsibilities for hard-to-place children and youth remaining in transitional housing (page 67).

Finding 5: Management cannot continue to rely on TFACTS as it currently exists, and as such, management must provide constant and consistent oversight of the new system development to avoid repeating TFACTS' history of unmet user needs that impacted critical child welfare operations (page 76).

Finding 6: The department continues to experience delays in obtaining medical and dental screenings for children in their care, which increases the risk that children may not receive prompt care for their health needs (page 85).

Finding 7: The department's lack of oversight of provider eligibility determinations resulted in stipend payments that did not comply with program requirements (page 110).

Finding 8: The department must strengthen its oversight of residential facilities and juvenile detention centers that house custodial youth to ensure safety, compliance, and accountability (page 124).

Observation 1: The Child Abuse Hotline has improved call abandonment rates and wait times since they peaked in September 2024; however, further work is needed to strengthen screening tools and online report monitoring (page 44).

Observation 2: Beyond the issues noted for TFACTS, department management and Strategic Technology Solutions did not provide adequate internal controls in one specific area (page 80).

Observation 3: Management has reduced vacancy and turnover rates since 2023; however, establishing clear benchmarks for turnover, vacancy, and overtime among case managers and investigative staff would enhance management's ability to identify and respond early to staffing challenges and increasing caseloads (page 96).

Observation 4: Management should develop standardized waitlist procedures and strengthen provider data collection for waitlists (page 114).

Observation 5: Management should strengthen its internal controls to ensure compliance with required probation and aftercare services to achieve full corrective action (page 141).

Observation 6: Management's risk assessment process has significantly improved in recent years, but some risks and controls remain unaddressed (page 153).

Mission Challenge: The department is challenged to meet the needs of children and youth in its custody with complex behavioral and mental health needs who must remain in temporary housing settings for extended periods of time (page 57).

Matter for Consideration: Department management should continue to work with federal and state partners to change or seek an exception on the tax classification of stipend payments to relative caregivers (page 116).

Matter for Legislative Consideration 1: The General Assembly may wish to consider whether the department's statutory regulatory authority should be expanded or clarified to provide more direct enforcement mechanisms over the publicly administered juvenile detention centers (page 134).

Matter for Legislative Consideration 2: The General Assembly may wish to evaluate the legislative options to enhance the state's oversight of the Interstate Compact for Juveniles to establish a privacy requirement that does not impede the state's oversight responsibilities to ensure transparency and accountability of the Interstate Compact (page 149).

CONTENTS

INTRODUCTION

Audit Authority

These performance audits of the Department of Children's Services (the department) and the Interstate Compact for Juveniles were conducted pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated.* Under Section 4-29-247, the department and the Interstate Compact for Juveniles are scheduled to terminate June 30, 2026. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. These audits are intended to aid the committee in determining whether the department and the Interstate Compact for Juveniles should be continued, restructured, or terminated.

Background

Department of Children's Services

The Department of Children's Services (the department) was created by the General Assembly in July 1996. Section 37-5-102(a), *Tennessee Code Annotated,* establishes that the department was created to provide services to children who are unruly, delinquent, dependent, and neglected, as well as their respective families. The department also serves children who are at imminent risk and in need of services to prevent entry into state custody, those in custody pending family reunification or other permanent placement, or as otherwise required by state law. These statutory mandates continue to guide the department's work in safeguarding Tennessee's most vulnerable children and youth.

The department's current mission is to *"Act in the best interest of Tennessee's children and youth,"* with the vision of *"Children First!"* In pursuit of these goals, the department emphasizes **child safety**, **permanency**, and **well-being** through a variety of services.

Child safety is promoted through the Child Abuse Hotline, Special Investigations Unit, and Child Protective Services teams that respond to allegations of abuse and neglect.

Permanency is achieved through foster care, adoption, guardianship, and family support services, with a strong emphasis on family-like placements and sibling connections.

Child **well-being** is supported through access to health care, education, and behavioral health services.

In addition to direct services for children and families, the department provides oversight, training, and support for case managers, foster parents, and community partner agencies. The department collaborates with juvenile courts, law enforcement, schools, and other state agencies to deliver coordinated responses to child welfare needs. These efforts aim to ensure that children served by the department experience stability, continuity of care, and improved long-term outcomes. See **Appendix 2** for the department's organizational chart and structure. See **Appendix 3** for the department's financial information.

Real Estate Strategic Plan

Since August 2023, department management has been developing and implementing a strategic plan to assess the department's real estate portfolio. The real estate strategic plan recommends a strategy for using current spaces or building new ones to better address the complex placement needs of custodial children and youth. Throughout this process, management has worked to identify the population of children and youth in its custody that face placement challenges and to look for options to increase placement capacity to meet the needs. Department management has been evaluating uses of juvenile justice facilities and exploring new concepts such as assessment centers and intake facilities to clinically assess the needs of children and youth so that management has better information for long-term placements, rehabilitative activities, and other treatment strategies. According to the plan, intake facilities and assessment centers will decrease the department's reliance on temporary spaces such as transitional houses and state office buildings.

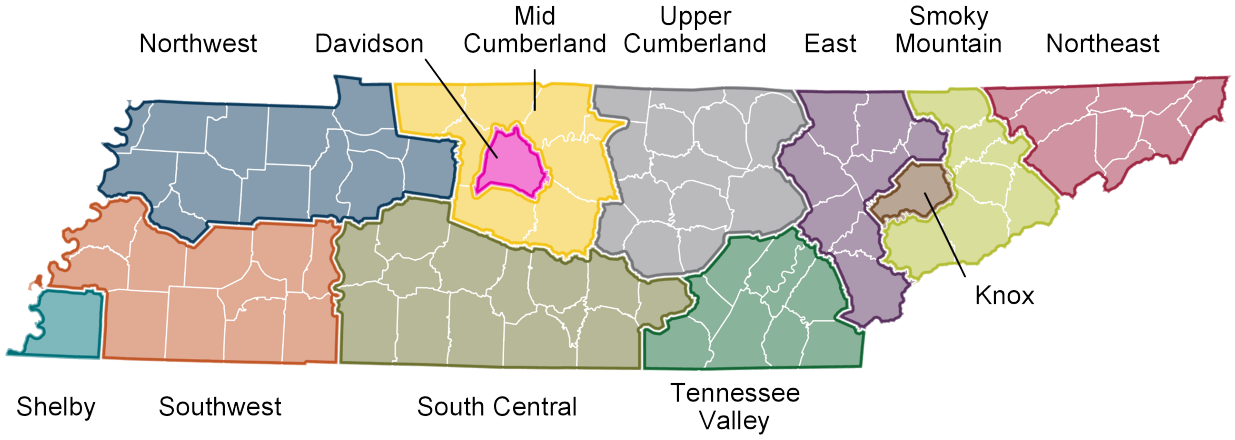
2025 Department Reorganization

In March 2025, the department reorganized to improve and standardize services across the state. For staff, the department wanted to increase collaboration across programs, ensure equitable distribution of workloads, and increase opportunities for career development.

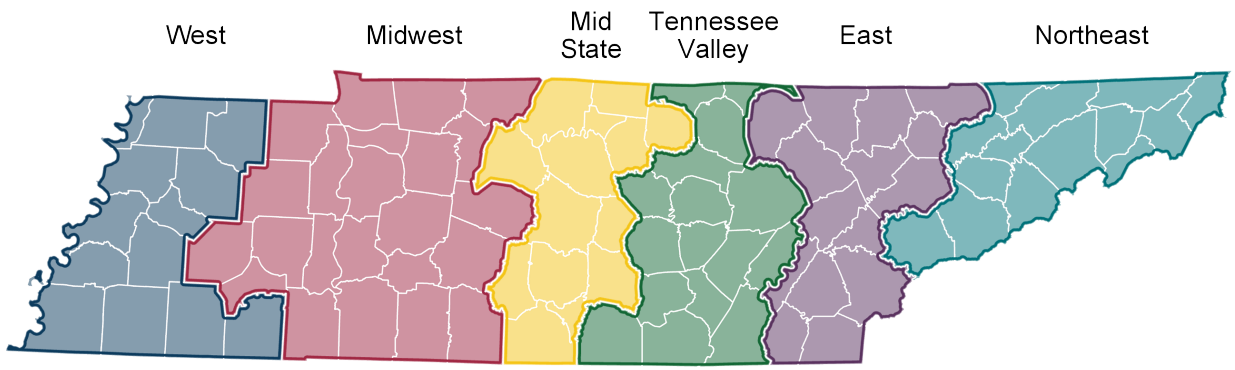
This reorganization changed the structure of the department's regions from 12 to 6. See **Figure 1** for changes to the department's regional structure that occurred in March 2025.

Figure 1: March 2025 Regional Realignment

Previous Regional Map – 12 Regions



New Regional Map – 6 Regions



Source: Regional reorganization documentation provided by department management.

Instead of reporting to separate regional leaders and Deputy Commissioners, Child Safety, Child Programs, and Juvenile Justice regional staff share leadership under the new **Regional Operations Division** and report to the same Regional Executive Directors and Assistant Commissioners, who in turn report to the Deputy Commissioner of Regional Operations.

The department also created the new **Statewide Services Division** to oversee specialty teams and programs. This new division combined Training, Prevention Services,[2] Health

2. Statewide Prevention Services includes Kinship, Resource Linkage/Community Advisory Boards/Volunteer Coordinator, and Court Liaisons.

and Education, the Child Investigative and Referral Unit,[3] Statewide Specialized Support Services, and Transportation Logistics under the umbrella of one Deputy Commissioner. **Statewide Specialized Support Services** was created to support every region in the following areas:

- adoption,
- the Interstate Compact on the Placement of Children,
- independent living, and
- foster care support.

Other changes included moving the department's Special Investigations Unit from Child Protective Services to the Office of Quality Compliance and moving the Child Abuse Hotline from Child Protective Services to the Statewide Specialized Child Investigative and Referral Unit under Statewide Services.

Interstate Compact for Juveniles

Since 2008, Tennessee has been a member of the Interstate Compact for Juveniles (ICJ),[4] which is a multi-state[5] legal agreement that governs the movement and supervision of juvenile delinquents[6] across state lines. The compact was first established in the 1950s and has evolved over the years into its current iteration, which was formalized in 2014.

The ICJ is overseen by the Interstate Commission for Juveniles, which promulgates and enforces rules to implement the ICJ. This commission includes representatives from all states and U.S. territories that are members of the compact, and is responsible for enforcing rules to implement the ICJ. An Executive Committee, made up of elected representatives from the commission, oversees the day-to-day operations of the compact and also has statutory power to act on behalf of the commission when the commission is not in session.

Each member of the compact has a Compact Administrator who is responsible for the administration and management of the state's supervision and transfer of juveniles subject to the compact. Tennessee's Compact Administrator is housed within the Tennessee Department of Children's Services' Office of Juvenile Justice.

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3. The Child Investigative and Referral Unit includes the Child Abuse Hotline, Drug Team, and Human Trafficking Team.
4. Section 37-4-101, *Tennessee Code Annotated,* established Tennessee's membership in the compact.
5. The compact includes all 50 states, the District of Columbia, and the U.S. Virgin Islands.
6. According to the ICJ's website, this includes juveniles who "are under court supervision or need to be returned to their home states as a probation/parole absconders, accused delinquents, escapees, or runaways."

AUDIT SCOPE

We have audited the Department of Children's Services (the department) and the Interstate Compact for Juveniles for the period September 1, 2022, through September 30, 2025. Our audit scope included assessments of program effectiveness, efficiency, and internal controls, as well as compliance with provisions of laws, regulations, policies, procedures, and contracts in the following areas:

- management's compliance with statutory requirements for **reporting child fatalities and near fatalities to the public**;
- evaluating the department's operations of the **Child Abuse Hotline**;
- the department's challenges in securing **adequate long-term placement options for hard-to-place children and youth** entering state custody;
- the status of the department's **replacement project for its case management system**;
- management's oversight of stipend eligibility and payments within the **Relative Caregiver Program**;
- management's process for **monitoring juvenile detention centers and contracted facilities** to ensure the safety of youth housed in these facilities; and
- the **Interstate Compact for Juveniles'** compliance with statutory requirements.

Additionally, our audit scope included follow-up on prior audit findings in the following areas:

- management's process for **investigating child abuse and neglect allegations**;
- management's process to identify placements for children in state custody and the department's use and **oversight of transitional housing** while securing appropriate long-term placements;
- management's enhancement of their **case management system** and the system's impact on case managers' ability to manage child cases;
- management's implementation of **information system controls** to safeguard data;
- management's process for ensuring that children in state custody receive **health and dental screenings**;
- management's actions to reduce **case manager turnover and vacancies**;
- management's compliance with statutory **caseload limits** for case-carrying staff;

- management's process to ensure that case managers conduct required visits in the **Juvenile Probation and Aftercare Programs**;
- management's **strategic planning and risk assessment** processes for developing goals and strengthening departmental controls;
- management's process for ensuring that reported Prison Rape Elimination Act **allegations of sexual abuse, sexual harassment, and lack of supervision in residential homes** where children were housed were properly addressed and, when necessary, investigated; and
- management's quality review process for **evaluating allegations involving provider employees**.

The information for our follow-up on prior audit findings can be found in the **Prior Audit Findings** section.

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

For any sample design applied in this audit, 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 and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

SINGLE AUDIT

As part of the annual Single Audit of the State of Tennessee, the Comptroller of the Treasury's Division of State Audit performs a risk assessment and audits certain federal programs administered by state agencies. We review the systems of internal control over federally funded programs and compliance with program regulations. The audit's objective is to determine the state's compliance with federal requirements regarding how those funds were used. For the audit period covered by this performance audit, the Department of Children's Services' Foster Care Title IV-E and Adoption Assistance programs were included in the state's fiscal year 2023 and 2024 Single Audits, as described in **Figure 2**:

Figure 2: Single Audit Findings
Department of Children's Services

Federal Program (*Division*)	**Number of Findings by Fiscal Year**	
	2023	**2024**
Adoption Assistance *(Office of Child Programs)*	0	0
Foster Care Title IV-E *(Office of Child Programs)*	0	0
Total Findings	**0**	**0**

Source: Single Audit Reports for fiscal years 2023 and 2024.

PRIOR AUDIT FINDINGS

Report of Action Taken on 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 2022 and contained 13 findings. The Department of Children's Services filed its report with the Comptroller of the Treasury on June 13, 2023.

We conducted a follow-up of the prior audit findings as part of the current audit and found that management had resolved 5 of the 13 findings. For the remaining 8 findings, we found continued issues and are reporting 4 findings[7] and 4 observations in the current audit. See **Figure 3.**

7. In the 2022 Department of Children's Services performance audit, there was one finding involving the Special Investigations Unit and Child Protective Services. In the current audit, we separated the conditions into **Finding 1** and **Finding 2.**

Figure 3: Current Status of December 2022 Audit Findings

Status	Prior Audit Finding	Current Audit Results
Resolved 5	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.	See the **Turnover, Vacancies, Overtime, and Caseload Management** section for related conclusions.
	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.	See the **Placements** sections for related conclusions.
	DCS [the department] did not ensure that reported allegations of sexual abuse, sexual harassment, or lack of supervision of custodial children living in residential facilities were investigated.	See **Appendix 1** for related conclusions.
	DCS has not developed an effective and efficient process to respond to sexual abuse and harassment allegations to keep children in residential facilities safe.	See **Appendix 1** for related conclusions.
	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.	See **Appendix 1** for related conclusions.
Partially Resolved 4	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.	See **Observation 2** in the **Tennessee Family and Child Tracking System** section.
	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.	See **Observation 3** in the **Turnover, Vacancies, Overtime, and Caseload Management** section.
	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.	See **Observation 5** in the **Juvenile Probation and Aftercare Programs** section.
	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.	See **Observation 6** in the **Strategic Plan and Risk Assessment** section.
Repeated 4	Children may have remained in unsafe situations because management did not meet certain key timelines for child abuse and neglect investigations.	See **Finding 1** and **Finding 2** in the **Child Safety Part 1** section.
	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 homes.	See **Mission Challenge** and **Finding 4** in the **Placements** sections.
	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.	See **Finding 5** in the **Tennessee Family and Child Tracking System** section.
	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 the need for follow-up health services.	See **Finding 6** in the **Child Health Screenings** section.

Source: Department of Children's Services December 2022 audit and current audit results.

AUDIT CONCLUSIONS

Child Safety

This chapter is organized into three sections, which begin with an informational box at the start of each section highlighting the objectives and focus areas for the section. The three sections are

- Special Investigations Unit and Child Protective Services Investigations,
- Child Fatality and Near-Fatality Public Notifications, and
- Operations of the Child Abuse Hotline.

Child Safety Part 1: Special Investigations Unit and Child Protective Services Investigations

The Department of Children's Services (the department) has an important responsibility to keep children and youth safe from harm. As Tennessee's statewide child welfare agency, the department is responsible for removing children and youth from unsafe environments, ensuring their safety while in state custody, and investigating allegations of abuse or neglect.

For the **Special Investigations Unit and Child Protective Services** investigations, our goal was to review the department's process for investigating child abuse and neglect allegations to ensure management conducted thorough and timely investigations to keep children and youth safe. See **Finding 1** and **Finding 2**.

Background

Tennessee law requires anyone with knowledge or suspicion of child neglect or abuse to report the suspected child abuse or neglect. 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. The Department of Children's Services (the department) operates the Child Abuse Hotline

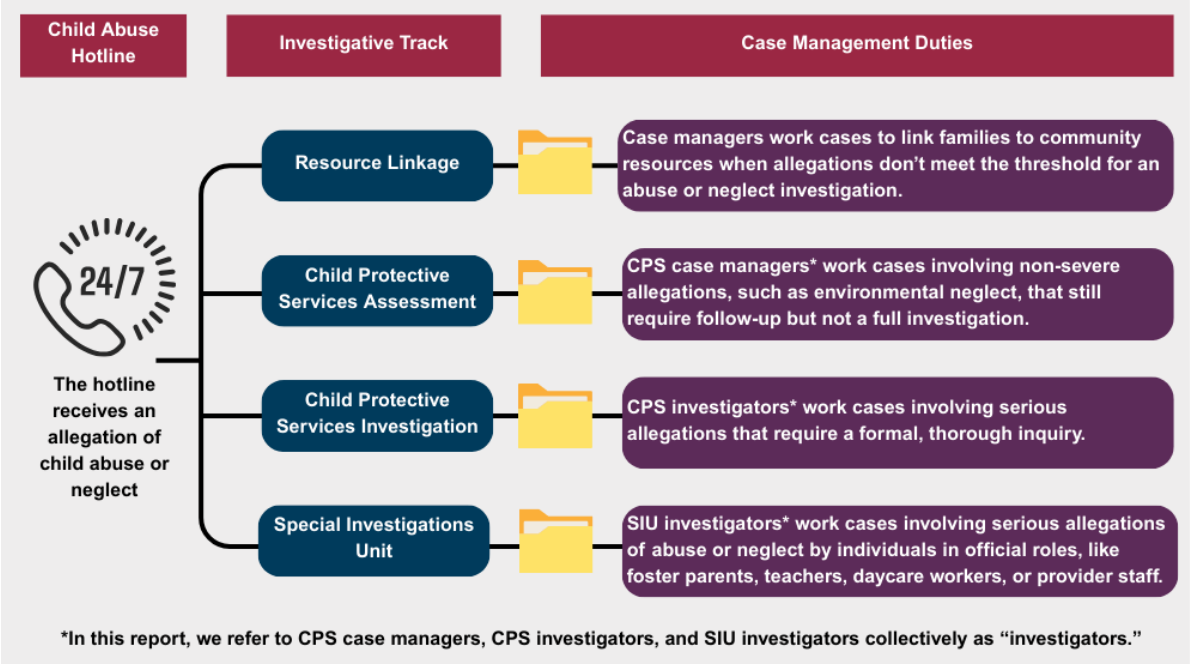
(hotline) 24 hours a day, 7 days a week for Tennesseans to report any signs of child abuse or neglect by phone,[8] email, or online.[9]

Child Abuse Hotline staff evaluate allegations of child abuse or neglect to decide if the allegation should be screened in[10] and assigned as a case to the proper investigative unit for the next steps.

Case Assignment Tracks

Hotline staff assign screened-in allegations to one of the following resource or investigation tracks so that the responsible group can open a case. See **Figure 4,** which explains the case assignment tracks.

Figure 4: Case Assignment Tracks



Source: This figure was created based on our review of department policies and procedures, and discussions with hotline and investigative staff.

8. In December 2024, the hotline transitioned to an online-only reporting system for the public from Friday at 11 p.m. CST through Sundays at 11 p.m. CST. The department's dedicated phone lines for law enforcement, medical personnel, and department case managers remain open during this time.
9. Section 37-1-406(a), *Tennessee Code Annotated*, states that "the department shall be capable of receiving and investigating reports of child abuse twenty-four (24) hours a day, seven (7) days a week."
10. Hotline staff use the Structured Decision-Making Tool to determine whether an allegation meets the definitions established by statute for child abuse or neglect. This tool contains specific guidance in the form of a written manual for staff to reference, in addition to the automated decision-making tool embedded in the Tennessee Family and Child Tracking System (TFACTS) to assign the case to an investigative track.

Child Protective Services (CPS) encompasses the department's group of investigators responsible for handling assessment and investigation cases, while the Special Investigations Unit (SIU) refers to the investigators who investigate cases of abuse or neglect by individuals in official roles.

Reorganization of CPS and SIU and Integration of Prison Rape Elimination Act Investigations

Prior to March 2025, SIU operated under the broader CPS umbrella. As part of the department's March 2025 reorganization, SIU was moved to the Office of Quality Compliance to enhance oversight of this specialized group. See the 2025 Department Reorganization information in the **Background** section of this report for more about the reorganization. In response to the 2022 prior audit finding related to the Prison Rape Elimination Act (PREA),[11] the department transitioned PREA investigations to SIU in July 2024. Since then, PREA cases have been handled as a subset of SIU investigations and follow SIU policies and procedures.

Child Abuse and Neglect Investigation Process

Both CPS and SIU groups must follow Chapter 14 of the department's policies, "Child Protective Services,"[12] which outlines the key investigative tasks that both investigators and supervisors must complete during child abuse investigations. Investigators must enter all investigative documentation into the Tennessee Family and Child Tracking System (TFACTS) to track the case's progress and record required tasks. TFACTS serves as the official case record, allowing staff to monitor progress, confirm completion of required tasks, and maintain a comprehensive history of decisions and actions.

Key Investigative Task #1 – Priority Response

The first task after receiving a case is to meet the priority response requirement. Child Abuse Hotline staff must assign a risk level to each allegation of abuse or neglect, which determines how quickly the investigator must meet face-to-face with the alleged child victim. The response timeframe begins as soon as the hotline receives the report—not when the investigator is assigned the case. The department categorizes cases into three priorities (see **Figure 5**).

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11. The Prison Rape Elimination Act of 2003 (PREA), administered by the U.S. Department of Justice, sets national standards to prevent, detect, and respond to sexual misconduct in all types of correctional facilities, including juvenile facilities. Juvenile Facility PREA Standards apply to all facilities that primarily house juvenile delinquents, consistent with the PREA definition of "juvenile facility" and with Section 37-1-116, *Tennessee Code Annotated*, which governs permissible placements for delinquent or unruly children.
12. Department Chapter 14 Policies, "Child Protective Services," includes all related policies, protocols, work aids, manuals, guides, tip sheets, and memos for the child abuse and neglect investigative process. This also includes information for the hotline, the Special Investigations Unit, staff working cases of Child Death and Near-Death, and other department groups related to investigations.

Figure 5: Priority Response Levels

Source: Department Policy 14.2, "Screening, Priority Response, and Assignment of Child Protective Services Cases."

Key Investigative Task #2 – Convening the Child Protective Investigative Teams

Key Terms

Classify – Determining whether the allegation is substantiated or not.

Substantiate – There was enough evidence to reasonably say that the allegation occurred.

Unsubstantiate – There was not enough evidence to reasonably say that the allegation occurred.

When a case involves an allegation of sexual abuse or severe abuse, the investigator must immediately notify the members of the Child Protective Investigative Team (CPIT). This multidisciplinary team, which is made up of department investigators, law enforcement, attorneys general, juvenile court representatives, and other professionals, works together to protect children, preserve evidence for possible criminal prosecution, and provide needed support and services to those affected. Once CPIT completes all investigative tasks, the team meets to collectively evaluate the evidence and determine whether to substantiate or unsubstantiate the allegation. The department also refers to this as "classifying" the allegation.

Key Investigative Task #3 – Conducting Safety Assessments

Next, investigators complete a safety assessment within the Family Advocacy and Support Tool[13] assessment to help determine safety concerns, underlying risks, needs, and strengths of families and children. The assessment is vital because it provides a structured, comprehensive evaluation of a family's safety, risks, needs, and strengths, enabling case managers to make informed decisions and create targeted service plans that protect children and support families effectively. Investigators also use this tool to determine whether the department needs to provide any immediate intervention. Investigators have five days to complete the safety assessment, and supervisors have three days to review the assessments.

Key Investigative Task #4 – Classifying Allegations

When an allegation involves someone in a position of authority, such as a foster parent, department employee, or residential facility staff member, the case must be referred to SIU. Because SIU does not have a service assessment track, every case it receives is opened as a full investigation from the outset, ensuring the department addresses all such allegations through the investigative process.

Regardless of whether SIU or other investigators are involved, CPIT is responsible for classifying allegations of sexual or severe abuse. These determinations are made using the evidence gathered during the investigation and through team discussions.

For allegations of non-severe abuse, CPS or SIU investigators independently classify cases using the information obtained during their investigative process. According to department policy, investigators must classify allegations in one of several defined categories, depending on the case type. These classification options are outlined in **Figure 6.**

13. The Family Advocacy and Support Tool contains several components, with the Safety Assessment being the first component for investigators to complete.

Figure 6: Allegation Classification Options by Case Type

Classification Decisions		Applicability by Case Type (●)		
Decision Category	**Decision Detail**	**Child Protective Services Assessments**	**Child Protective Services Investigations**	**Special Investigations Unit**
Allegation Substantiated	Perpetrator Substantiated		●	●
	Perpetrator Unsubstantiated		●	●
	Perpetrator Unknown		●	●
Allegation Unsubstantiated	Perpetrator Unsubstantiated		●	●
	Child with Sexual Behavior Problems		●	●
Service Dispositions	No Services Needed	●		
	Services Recommended	●		
	Services Needed	●		
	Services Needed, Court-Ordered	●		
Administrative Decisions	Unable to Complete	●	●	●
	Administrative Closure	●	●	●

Source: Department Policy 14.6, "Child Protective Services Case Tasks and Responsibilities."

Timelines for Allegation Classification

Statute[14] and department policy[15] both set timelines for completing the classification of abuse allegations. The department policy requires investigators to classify all allegations

14. Section 37-1-406(i), *Tennessee Code Annotated*, states, "No later than sixty (60) days after receiving the initial report, the department or team in cases of child sexual abuse or the department in all other cases shall determine whether the reported abuse was indicated or unfounded and report its findings to the department's abuse registry. Each member of the team shall be provided with a copy of the report in any case investigated by the team."
15. According to Department Policy 14.6, "Child Protective Services Case Tasks and Responsibilities," "A Child Protective Services (CPS) investigation case must be classified within thirty (30) calendar days of the Child Abuse Hotline (CAH) receiving a report."

within 30 calendar days of intake, except when child death investigations await autopsy results or when investigators handle severe abuse allegations. State law, however, caps all classification decisions at 60 calendar days. Divisional management requires CPS and SIU supervisors to review and approve all classification decisions within 3 business days of submission to ensure accuracy, timely intervention, and compliance with laws and policies.

Key Investigative Task #5 – Completing Monthly Investigative Tasks

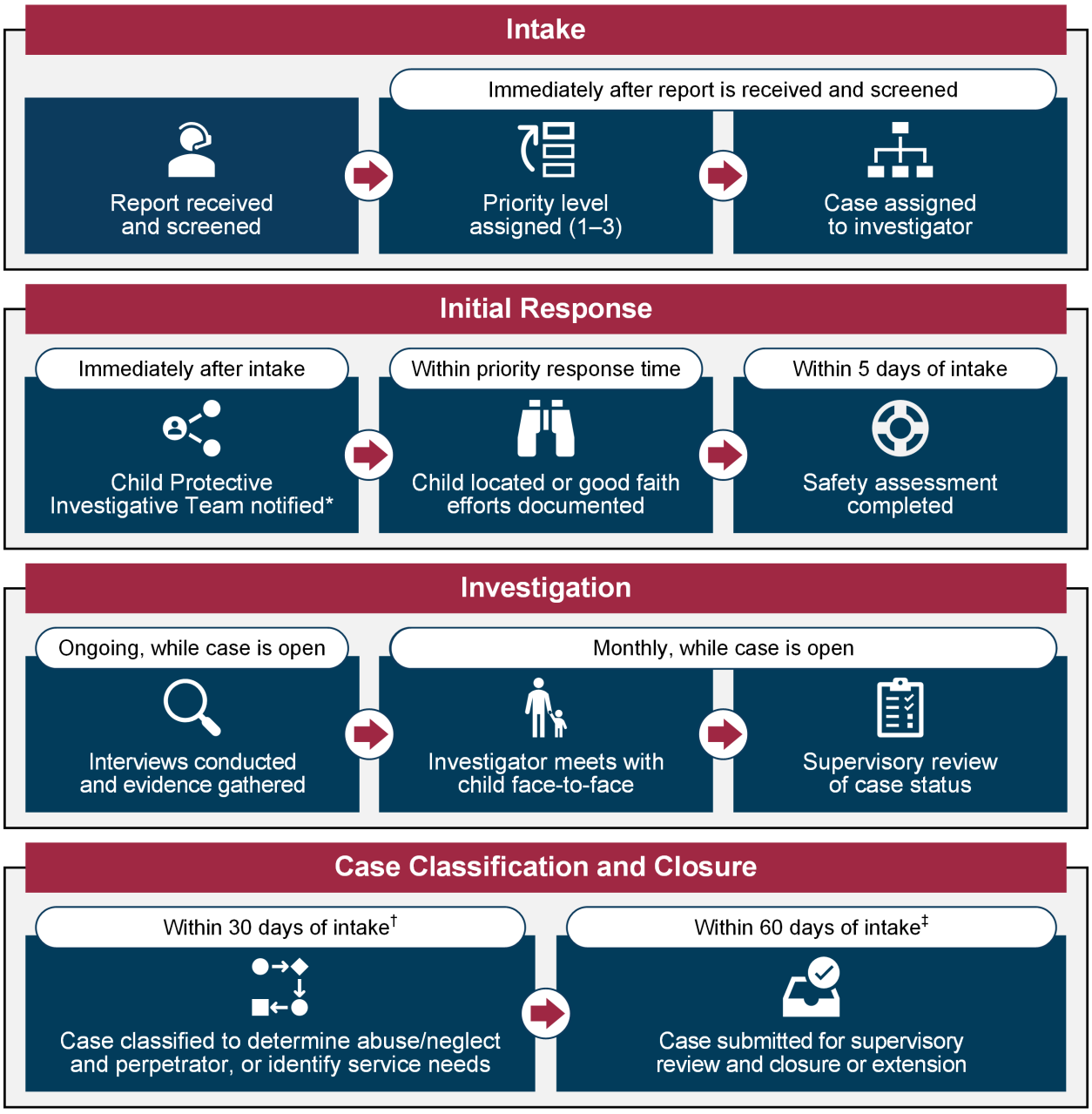
Investigators and supervisors must complete specific tasks each month while a case remains open. Policy[16] requires investigators to conduct a face-to-face visit with each alleged child victim every month and supervisors to review their staff's cases each month.[17] Both tasks are crucial for ensuring children's safety and for ensuring the case's timely progression in accordance with applicable laws and policies.

Key Investigative Task #6 – Closing Cases

Once investigators have completed all investigative tasks, they submit the case to their supervisor for review and closure. Department policy requires investigators to close investigative track cases within 60 calendar days and assessment track cases within 90 days.[18] If an investigator cannot close a case within the established timeframes, they may submit a written request with justification to their supervisor, who will approve or deny the extension request.[19] See **Figure 7** for a timeline of the investigative process.

16. Department Policy 14.6, "Child Protective Services Case Tasks and Responsibilities," states, "Interview/observation of the ACV [Alleged Child Victim]: a minimum of one (1) face to face contact with the ACV is required each calendar month."
17. Department Policy 4.4, "Performance and Case Supervision Practice Guidelines and Criteria," states, "Performance Briefings are held with all staff in the case management series on a monthly basis."
18. Department Policy 14.6, "Child Protective Services Case Tasks and Responsibilities," states, "An investigation is concluded within sixty (60) calendar days with a decision to close the case, provide or refer to community services or transition to a Family Service Case Manager (FSW) prior to day 60 for investigation track or day 90 for assessment track."
19. Department Policy 14.6, "Child Protective Services Case Tasks and Responsibilities," states, "If one (1) or more investigative responsibilities cannot be completed within the established times and prior to case closure, justification detailing why the responsibility could not be completed must be documented in TFACTS as an Administrative Review and Team Leader approval must be provided."

Figure 7: Timeline of the Investigative Process



* The Child Protective Investigative Team is convened only for cases involving allegations of severe or sexual abuse.
† The case classification timeline increases to 60 days for severe allegations.
‡ The closure timeline increases to 90 days for assessments.
Source: Created by the auditor based on interviews with department management and staff.

Monitoring Efforts and Internal Quality Control

According to management, they monitor investigative practices and outcomes using several tools. They evaluate substantiation rates, which reflect the percentage of abuse

and neglect investigations that result in confirmed findings. They also conduct quality assurance reviews to assess whether investigative work is consistent, timely, and complete in accordance with departmental policies, accreditation standards, and laws.

Substantiation Rates

Investigators substantiate a finding when, based on a preponderance of evidence,[20] they determine that the reported allegation occurred. Tracking substantiation rates allows management to detect significant changes or persistent patterns—such as unusually high or low rates—that may warrant reviewing investigative practices, adjusting workloads, or improving training and resources.

Quality Assurance Review

Department Policy 14.21,[21] "Internal Quality Control for the Office of Child Safety," previously required staff in the Office of Child Safety to conduct quarterly quality assurance reviews of a sample of both CPS and SIU investigations.

In January 2025, the department transferred responsibility for these reviews to the Office of Continuous Quality Improvement. This change integrated the reviews into a broader quality improvement framework, creating a unified approach to monitoring performance, identifying trends, and making operational adjustments across all child protection functions.

The Office of Continuous Quality Improvement now tracks investigative outcomes, conducts systematic casework reviews, and identifies patterns or discrepancies. The office then uses this information to support data-informed decision-making and improve child welfare investigations.

Results of the Prior Audit

In the 2022 performance audit report, we reported that children may have remained in unsafe situations because management did not meet key timelines for child abuse and neglect investigations. Management's corrective action to this finding included moving the Family Advocacy and Support Tool assessment from RedCap[22] to the current information system, TFACTS. This move allowed management to add capabilities for tracking the

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20. Department Policy 14.6 defines a preponderance of evidence as "the greater weight of the evidence required in a civil (non-criminal) lawsuit for the trier of fact (jury or judge without a jury) to decide in favor of one side or the other. This preponderance is based on the more convincing evidence and its probable truth or accuracy, and not on the amount of evidence."
21. Management has confirmed that this policy is no longer in use and will incorporate this review into Policy 1.3, "Continuous Quality Improvement," during its next revision.
22. The department worked 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. As of October 2023, the department no longer uses RedCap.

submission and review of the assessment. Management also reviewed and revised policies related to the investigative processes. While these improvements helped with tracking the cases, they did not address all prior audit finding conditions and were not enough to ensure that investigators completed the critical investigation milestones within established timeframes. See **Finding 1** and **Finding 2**.

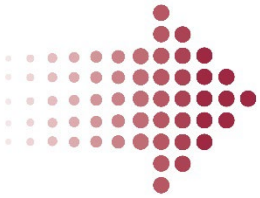
Budget Hearings and Staffing Requests

During the fiscal year 2024–2025 budget hearing, the Commissioner requested 19 new SIU investigator positions to handle special cases involving authority figures such as foster parents, provider staff, teachers, and daycare workers. The Commissioner reported that SIU investigators carry an average of 28 cases, and each case takes about 82 days to investigate and close. According to the Commissioner, the additional positions would reduce average caseloads and shorten investigation times, enabling investigators to resolve cases more quickly; however, the department did not receive funding for these positions in the fiscal year 2024–2025 budget.

At the fiscal year 2025–2026 budget hearing, the Commissioner did not request additional investigator positions.

Current Audit

We concentrated our review on the Special Investigations Unit and Child Protective Services investigations, examining the conditions highlighted in previous audit findings. Additionally, we expanded our scope in the current audit to include new investigative tasks that we did not evaluate in the prior audit. Our review resulted in **Finding 1** (Special Investigations Unit) and **Finding 2** (Child Protective Services). See **Appendix 1** for our detailed audit objectives, methodologies, and conclusions.



Repeat Conditions and New Conditions

Finding 1: A lack of management oversight in the Special Investigations Unit allowed for insufficient and untimely investigations of child abuse and neglect by adults in authority roles, increasing the risk that children are not protected from abuse or neglect

In the current performance audit, we found that the Department of Children's Services (the department) has continued to face challenges in completing timely and thorough Special Investigations Unit (SIU) investigations to comply with statute and department

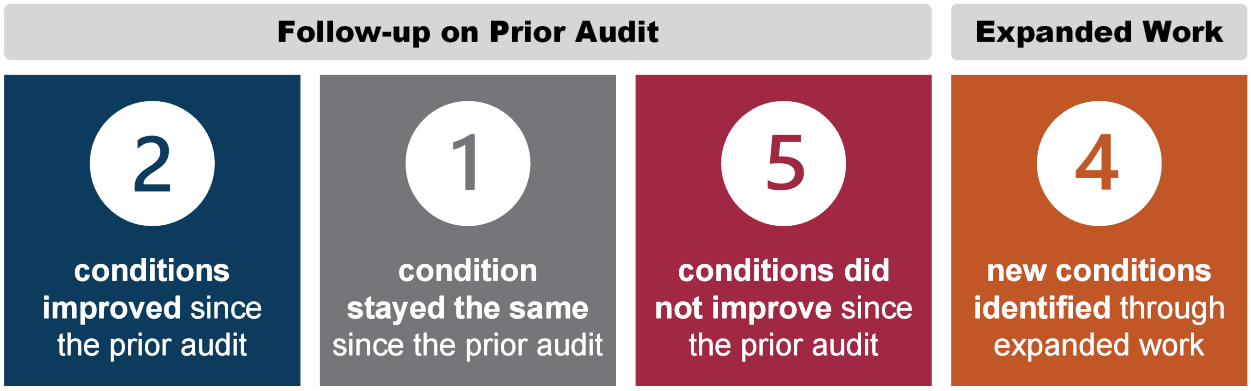
policies. See **Figure 50** in **Appendix 4** for a complete list of all criteria we reviewed to support the conditions in this finding. We have noted similar issues in multiple previous performance audits.

The goal of the department must always be to act in the best interests of children and youth, with a core responsibility to keep them safe from abuse, neglect, and mistreatment.

Follow-up on Prior Audit Finding and New Conditions Identified

We followed up on the 2022 performance audit finding and expanded our work to include our analysis of additional investigative tasks, supervisory reviews, and substantiation rates. We examined the SIU investigative process based on the key tasks that investigators must complete during each investigation. Each task in the investigative process represents a critical safeguard designed to progress the investigation and protect a child's safety and well-being. This broader review allowed us to evaluate not only whether SIU was meeting policy requirements, but also whether the unit was conducting consistent, high-quality investigations to protect children. **Figure 8** provides a summary of the results from our audit work.

Figure 8: Prior Finding and Expanded Work Results, SIU Investigations



Source: Auditor testwork.

Our testwork showed improvements in two conditions, and no change in one condition since the prior audit. SIU investigators completed all required safety assessments, and supervisors increased the percentage of timely supervisory reviews of those assessments. Investigators also maintained Child Protective Investigative Team (CPIT) meeting forms in the Tennessee Family and Child Tracking System (TFACTS).

Despite these improvements, SIU investigators did not meet key timeline benchmarks during investigations. In several critical areas, SIU's performance did not improve, as investigators and supervisors failed to complete essential tasks, including

- **conducting the initial face-to-face visit** with alleged child victims within the priority response timeframe to ensure their safety,
- **notifying CPIT members** of new allegations involving sexual or severe abuse,
- **completing safety assessments** within required timeframes,
- **making substantiation (classification) decisions** in a timely manner, and
- **providing timely justifications** and **obtaining approvals** for case closure extensions.

See **Figure 9** for the results of our testwork for prior conditions and **Figure 10** for the results of our expanded review, discussed below.

Figure 9: Comparison of Error Rates for the Special Investigations Unit Based on the Prior Audit Results and the Current Audit Results

Condition		2022 Audit		2025 Audit	
		# of Cases Reviewed	Error Rate	# of Cases Reviewed	Error Rate
▲	Missing safety assessment	25	8%	65	0%
▲	Untimely supervisory review of safety assessment*	25	80%	65	15%
■	Missing or incomplete CPIT forms†	8	25%	16	25%
▼	Untimely priority response	25	0%	65	8%
▼	Untimely notification of CPIT‡	8	0%	16	25%
▼	Untimely safety assessment (not submitted within 5 days)	25	0%	65	23%
▼	Untimely classifications	25	32%	65	34%
▼	Untimely or undocumented case closure, transfer, or extension§	25	48%	65	51%

Comparison to prior audit:

- ▲ Performance improved since the 2022 audit (error rate decreased).
- ■ Performance stayed the same since the 2022 audit (no change).
- ▼ Performance did not improve since the 2022 audit (error rate increased).

* During the 2022 audit, the department did not document supervisory reviews in TFACTS, and as a result, could not provide the dates those reviews occurred. In October 2023, the department started documenting supervisory reviews in TFACTS, which provided the dates the reviews occurred.

† In 2022, investigators did not upload the CPIT forms in TFACTS. In the 2025 audit, we found all but 1 CPIT form in TFACTS. Three forms, however, were missing CPIT participant signatures that indicate they agreed with the team's classification decision. According to management, the department does not control who attends CPIT meetings. Those signatures we noted as missing were from key CPIT participants, including participants from law enforcement, the district attorneys, and the Child Advocacy Centers. We noted that several CPIT Review Forms were also missing participant signatures from the juvenile courts, but we did not include those items in the error rate because management indicated that not all CPITs have juvenile court representation.

‡ In 2022, only 8 of the 25 SIU cases in our sample were CPIT cases. Since the statute does not define immediate notification of CPIT partners, we held the department to the same timeframe requirements as priority responses—24 hours for priority 1, 2 business days for priority 2, and 3 business days for priority 3 cases.

§ During the 2022 audit, our results found that case closures were untimely due to missing case recordings for case extensions. In the 2025 audit, our results found that the case recordings were in TFACTS but lacked justifications and supervisory approvals. See the new condition in **Figure 10**.

Source: We created this table based on the results of our testwork.

In addition, management's quality review process for SIU cases did not address the unit's investigative weaknesses, and management lacked awareness of overall substantiation rates across SIU investigations.

Results of Our Expanded Testwork

Based on the issues noted in our analysis of current case files, we expanded our work to include new investigative tasks. We reviewed case files for additional key investigative tasks and identified four new areas of concern. We found that investigators were

- **classifying cases incorrectly** and not substantiating allegations when they had sufficient evidence to do so with supervisory approval, and
- **missing required monthly face-to-face visits** with alleged child victims—visits intended to ensure child safety.

Additionally, we found that supervisors were not

- **reviewing and approving** their staff's classification decisions on time, and
- **completing monthly administrative reviews** of their staff's cases, which are meant to signify that all investigative tasks are done timely and thoroughly.

Timely supervisory reviews ensure child safety, maintain compliance with requirements, improve investigative quality through real-time feedback, and hold investigators accountable for thorough and prompt casework. See **Figure 10** for our results.

Figure 10: New Conditions Identified with the Special Investigations Unit

New Condition	# of Cases Reviewed	Error Rate
Incorrect classifications*	65	3%
Missed monthly face-to-face visits	65	25%
Untimely supervisory review of classification	65	6%
Missed monthly administrative reviews†	65	38%

* In addition to the errors noted in this testwork, we identified 2 additional cases that were incorrectly classified during our review of the Provider Quality Team review process.

† Administrative reviews signify that a team leader has met with the investigator to discuss the case and next steps.

Source: We created this table based on the results of our testwork.

Supervisory Review of Investigative Tasks

According to current SIU management, the issues noted above reflect a lack of investigative thoroughness by both the investigators and their supervisors. As noted in

Figure 10 above, we found that **supervisors did not complete monthly supervisory reviews (administrative reviews) in 38% of the cases in our sample.** Management acknowledged that the reviews conducted were frequently insufficient. Thorough supervisory reviews could have helped identify areas where investigative practices needed improvement. This lack of oversight undermines the department's ability to ensure that investigators complete and document essential investigative steps.

Investigating to Substantiate or Unsubstantiate

In addition to timeliness and oversight concerns, we also examined how SIU classifies allegations and determines substantiation rates.

Allegation Classification and Substantiation Rates

As part of our expanded audit work, we reviewed SIU's substantiation rate, which measures how often investigators find a preponderance of evidence to confirm that the allegation of abuse or neglect occurred. Monitoring substantiation rates over time allows the department to identify patterns and ensure that investigative decisions remain balanced, evidence-based, and focused on child safety.[23] Out of our random sample of 65 SIU cases, SIU only substantiated 4 allegations— a 6%[24] substantiation rate. The Commissioner also acknowledged during our fieldwork meeting in May 2025 that the substantiation rate was lower than expected since the nationwide standard for substantiation rate is 20.9%.[25]

Quality Assurance Review of Closed Investigations

Our review and discussions with management showed that the department's previous quality review process for ensuring thorough and consistent investigations was ineffective.[26] In January 2025, the department transferred quality control responsibilities

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23. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book), Principle 16.09, states, "Management evaluates and documents the results of ongoing monitoring and separate evaluations to identify internal control issues [documentation required]. Management uses this evaluation to determine the effectiveness of the internal control system."
24. We calculated this rate by dividing the total number of cases with any substantiation allegation (4) by the total number of cases in our sample (65).
25. We obtained this average from the National Survey of Child and Adolescent Well-Being (NSCAW III) Baseline Report, Administration for Children and Families, U.S. Department of Health and Human Services, from July 2024.
26. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book), Principle 12.05, states, "Management reviews policies, procedures, and related control activities on a periodic and ongoing basis for continued relevance and effectiveness in achieving the entity's objectives or mitigating 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."

from Child Protective Services to the Office of Continuous Quality Improvement to strengthen oversight.

The Office of Continuous Quality Improvement completed its first quarter quality reviews of CPS and SIU cases for 2025. As of August 2025, the second-quarter review was still in progress.

In the next sunset audit, we will review the Office of Continuous Quality Improvement's new quality review process to determine its effectiveness.

Management's Review of the Special Investigations Unit

According to the Commissioner, when management became aware of the low substantiation rate, they began taking steps to improve how they were tracking and evaluating cases. In February 2025, at the Commissioner's request, the department conducted an in-depth internal review of 150 SIU investigations statewide. Based on the internal review, SIU leadership told us that they found investigative weaknesses and a tendency for SIU investigators to classify allegations as unsubstantiated based on limited documentation or subjective judgment. Management stated that these issues were more egregious in one region of the state. The Commissioner instructed the department to expand the review in that region to verify the accuracy of case decisions and determine whether staff needed to reopen any cases for further investigation. As of July 2025, the department was still conducting the expanded review.

In our effort to collaborate with management, we shared our current audit results. We identified 31 cases[27] where it was unclear whether the classification was correct. Management agreed that their classification decision was incorrect for 4 cases, and management gave examples of their rationale to support their remaining classification decisions.

We found that even when investigators made the correct substantiation decision, the case documentation often lacked enough detail for a reader unfamiliar with the case to understand how and why the decision was reached. We noticed a pattern of cases where the investigator did not substantiate the allegation because the resulting consequences of a "substantiation" did not allow for the full context of the situation to be considered. By policy,[28] investigators only have two options—either to substantiate or unsubstantiate—

27. This included 25 cases from our sample of SIU investigations and 6 cases from our sample of SIU cases reviewed by the Provider Quality Team.
28. Department Policy 14.6, "Child Protective Services Case Tasks and Responsibilities" outlines the current investigative track classification options. According to management, when the department transitions to the new electronic case management system, they will reconsider which classification options are available to investigators.

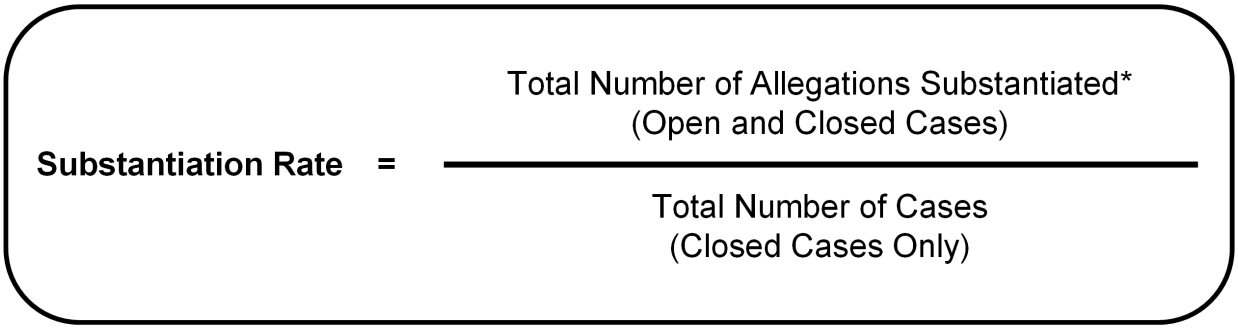
even though the investigative leadership may prefer to recommend other resolutions based on the merits of the allegation. Management explained that in cases involving non-severe abuse, a third option, such as assigning training or services to address concerns, would have been more appropriate if that choice had been available under policy.

Following the internal review, the Commissioner took action in March 2025 to comprehensively overhaul SIU. This included appointing new leadership, such as Team Coordinators, a Director, and an Executive Director. Additionally, the unit moved from the Office of Child Safety to the Office of Quality Compliance and is now under the supervision and guidance of a new Deputy Commissioner. Because of these changes, SIU now has an entirely new leadership team.

Management's Substantiation Rate Methodology

According to management, since the department began examining substantiation rates within SIU in March 2025, the overall substantiation rate for SIU increased from 6% to 17% in June 2025. While SIU leadership has started examining substantiation rates, and this is a step in the right direction, management's method for calculating this rate raises concerns about the accuracy and consistency of these figures. See **Figure 11**.

Figure 11: SIU Management's Substantiation Rate Calculation



* Includes Allegation Substantiated, Perpetrator Substantiated (ASPS) Only.
Source: Created based on discussions with management.

We reviewed the reasonableness of the formula described in **Figure 11**. Based on that review, we believe the formula creates a mismatch because it compares the number of allegations, of which there can be multiple in each case, to the total number of cases. Another inconsistency is that the calculation includes open and closed cases for allegations in one instance but not the other, and allegations and cases are not interchangeable. A single case can contain multiple allegations, each with a different substantiation decision. This methodology could lead to unintended inflated or deflated substantiation rates. Also, according to the former SIU leadership, the SIU leadership team did not have reliable and easily accessible data to consider a substantiation rate calculation.

In October 2025, we met with department management to discuss the most appropriate formula for calculating the substantiation rate. Management agreed that the calculation should represent the percentage of cases with at least one substantiated allegation out of the total number of cases within a given time period.

In the next audit, we will evaluate the substantiation rate formula to determine whether the calculation method and resulting rate provide management with a reliable and useful tool for monitoring trends in substantiation decisions.

Contributing Factors That Caused Deficiencies

According to the new SIU leadership, there were several issues within SIU's former leadership and staff that contributed to its low substantiation rate and lack of quality case management:

- **High Caseloads:** Investigators carried heavy caseloads, and team leaders also managed cases, leaving little time for supervisory reviews.
- **Misinterpretation of Substantiation Policies:** Some investigators and supervisors believed they could only substantiate allegations if the child had a physical injury, such as a broken bone or visible bruises.
- **Sympathy Toward Alleged Perpetrators:** Staff hesitated to substantiate non-severe cases due to concerns about the impact on the alleged perpetrator's livelihood. For example, substantiating a dirty foster home could result in a foster parent, who may also be a registered nurse, losing both roles.
- **Reliance on Other Units:** Investigators often deferred safety concerns to the department's Provider Quality Team instead of addressing them during the investigation.
- **Appeal Avoidance:** Some investigators avoided substantiating cases out of concern that alleged perpetrators would appeal the decision and overturn the substantiation rather than relying on the sufficiency of the investigation's evidence.
- **Limited Outcome Options:** SIU can only classify cases as substantiated or unsubstantiated. Investigators had no option to classify cases as services recommended or services needed, which are currently only available for CPS assessment track cases. Management stated that this option would be helpful for allegations where there is less threat of serious or immediate harm, but services may be needed.

According to the new SIU management, they have worked with field staff and supervisors to recalibrate thought processes and expectations to focus on investigative priorities.

PREA Investigations

In the prior audit, we reported that the department was not investigating some Prison Rape Elimination Act (PREA) allegations. During our current audit scope period, we found that SIU investigators began handling PREA cases.

Our audit results showed that PREA investigations mirrored the same weaknesses we identified in SIU casework—untimely documentation in TFACTS, delayed case closures, and inconsistent adherence to investigative protocols. Because PREA investigations must follow both SIU policies and federal requirements, weaknesses in SIU practices compromise the timeliness and quality of PREA investigations.

SIU's Impact Across Critical Functional Areas

Several critical functional areas within the department rely on SIU to carry out their work. These areas play a significant role in safeguarding children, ensuring accountability, and upholding compliance with federal and state requirements.

During our audit, we observed the ripple effect of SIU practices across multiple departmental areas, including the Provider Quality Team and the Foster Home Quality Team. SIU investigations have the potential to impact the availability of placements for custodial youths.

For the Provider Quality Team, we found that SIU often closed cases with unresolved safety concerns.[29] When allegations were not substantiated, responsibility was shifted to the team to address safety issues involving contract providers. Closing cases before resolving safety issues and transferring accountability to the Provider Quality Team may increase the risk of gaps in oversight and may delay the corrective action needed to protect children.

Like the Provider Quality Team, the Foster Home Quality Team depends on timely and accurate SIU investigations. When SIU investigates severe allegations involving foster homes, it requests that the Foster Home Quality Team place the homes on suspended admissions status until management deems it appropriate to lift the suspension. While suspending foster homes is not itself a concern, SIU's lengthy investigation process prolongs the suspended status and strains placement resources because no additional children can be placed in those homes.

Together, these ripple effects reduce accountability systemwide and increase the risk that children will remain in unsafe situations without timely intervention.

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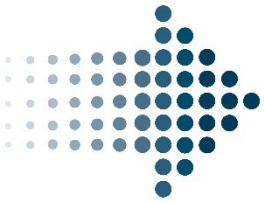
29. See **Figure 51** in **Appendix 5** for a full list of safety concerns that SIU investigators deferred to the Provider Quality Team to resolve.

Overall Effect

When investigators do not perform tasks thoroughly and within critical timeframes, the quality and outcomes of SIU investigations may be compromised, leaving vulnerable children in unsafe or potentially abusive situations. Without consistent supervisory monitoring at all levels of management, management's risk of incomplete investigations is high, and case determinations may not accurately reflect the evidence—potentially leaving children unprotected. The quality and quantity of case documentation and the thoroughness of the investigation are very closely related. Therefore, without quality documentation, management cannot ensure that investigative staff conduct thorough and timely investigations, which are crucial for making informed decisions about children's safety.

See **Observation 6** in the **Strategic Plan and Risk Assessment** section for additional information on risks related to SIU that management did not identify in their risk assessment.



Recommendation: Management should strengthen internal controls over child abuse and neglect investigations by enhancing training that reinforces an investigative mindset, emphasizes evidence-based decision-making, and requires thorough documentation from intake to closure. Investigators should also adhere to established time benchmarks for completing and documenting cases to protect children and ensure compliance with policy requirements.

The department should further strengthen monitoring controls by reviewing the additional SIU cases in the identified region and assessing whether to expand the review statewide to detect similar issues. Supervisors should exercise oversight controls by consistently reviewing cases, documenting their reviews, and providing real-time guidance to prevent recurring problems. Finally, the department should establish clear procedures for calculating substantiation rates to ensure consistent application and reliable results for management oversight. By providing training and accountability measures to improve compliance with investigative policies, management can create the consistent and reliable

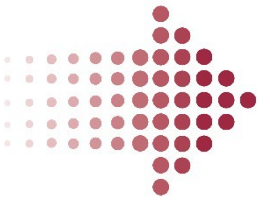
foundation necessary for other oversight teams to carry out their responsibilities effectively.

Management's Comment

Management concurs. Since identifying concerns with SIU oversight and case processing, we have:

- Restructured SIU leadership and instituted case quality reviews for cases with prior involvement by former supervisory leadership.
- Strengthened training delivery on timely initiation, thorough documentation, evidence preservation, and findings for SIU cases.
- Additionally, the department monitors timeliness and documentation through routine supervisory reviews and targeted quality assurance checks.

Child Protective Services (CPS) is responsible for investigating allegations of child abuse and neglect and ensuring the safety and well-being of children across the state. CPS investigations represent the vast majority of the department's investigative workload, accounting for about **95% of all cases**. Because of this scope, any deficiencies in CPS processes, such as untimely investigations, incomplete documentation, or insufficient supervisory oversight, can affect a large number of children and families and hinder the department's ability to protect vulnerable populations.



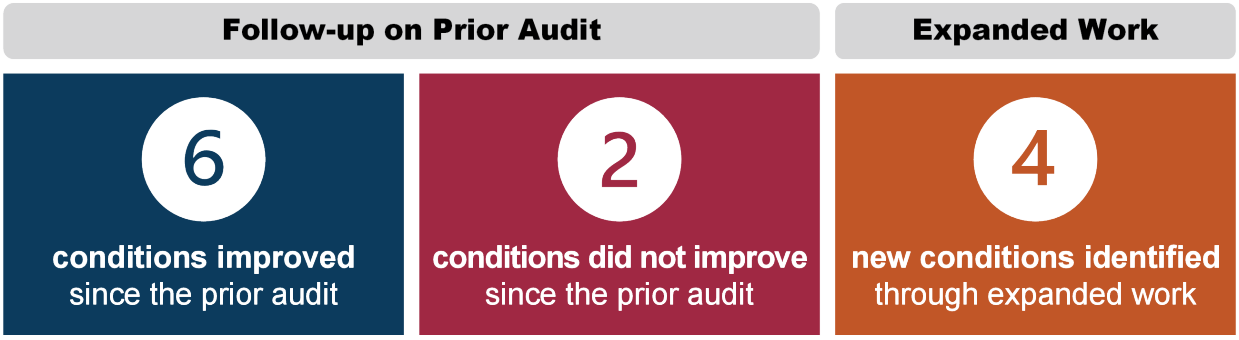
Repeat Conditions and New Conditions

Finding 2: Management must strengthen its investigative oversight of Child Protective Services to ensure staff meet key timelines for investigating child abuse and neglect

Follow-up on Prior Audit Finding and New Conditions Identified

In our current audit, we followed up on the 2022 performance audit finding related to Child Protective Services (CPS) investigations and key investigative tasks. Consistent with our approach to the Special Investigations Unit, we also expanded our work to evaluate additional investigative tasks and supervisory reviews. **Figure 12** summarizes the results of our audit work, showing both the status of prior conditions and the new conditions. See **Figure 50** in **Appendix 4** for a complete list of all criteria we reviewed to support the conditions in this finding.

Figure 12: Prior Finding and Expanded Work Results
CPS Investigations and Assessments



Source: Auditor testwork.

We identified six areas of improvement since the prior audit. Of these six areas of improvement, however, two areas were not improved enough to resolve the issues. The untimely submission of safety assessments and untimely case classifications (substantiate or unsubstantiate) still had error rates of 11% and 12%, respectively. See **Figure 13** below.

For the same audit time period, staff noncompliance did not improve in 2 areas. Investigators missed more Child Protective Investigative Team (CPIT) forms,[30] and supervisors completed fewer timely reviews of safety assessments. For the CPIT forms, Section 37-1-607, *Tennessee Code Annotated*, requires the Department of Children's Services (the department) to collaborate with CPIT partners on investigative tasks and substantiation decisions. Within our sample, we noted that 11 CPIT forms were missing signatures from key participants, including law enforcement, the district attorneys, and the Child Advocacy Centers, as applicable. Based on the documentation, it was unclear whether the partners were present and participated in the classification decision or if they just failed to sign the forms.

While the department may not have any control over whether CPIT partners show up and participate in these meetings, without all partners participating and documenting their participation, department management is challenged to maintain evidence of such a key collaborative decision-making process that affects the lives of potential perpetrators and the children who may be at risk. See **Figure 13** below for the results of our testwork related to

The goal of the department must always be to act in the best interests of children and youth, with a core responsibility to keep them safe from abuse, neglect, and mistreatment.

30. These forms document participation by CPIT members in the classification decision.

the prior audit finding conditions. See the **Results of Our Expanded Testwork** in the next section for the results from our expanded review.

Figure 13: Comparison of Error Rates for Child Protective Services Investigations and Assessments Based on the Prior Audit Results and the Current Audit Results

Condition		2022 Audit		2025 Audit	
		# of Cases Reviewed	Error Rate	# of Cases Reviewed	Error Rate
▲	Missing safety assessment	50	4%	85	0%
▲	Untimely priority response	50	6%	85	4%
▲	Untimely notification of CPIT*	18	11%	57	2%
▲	Untimely or undocumented case closure, transfer, or extension†	50	14%	85	1%
▲	Untimely safety assessment (not submitted within 5 days)	50	16%	85	11%
▲	Untimely classifications	50	24%	85	13%
▼	Missing or Incomplete CPIT forms‡	18	17%	57	39%
▼	Untimely supervisory review of safety assessment	50	0%	85	5%

Comparison to prior audit:

▲ Performance improved since the 2022 audit (error rate decreased).

▲ Performance improved since the 2022 audit, but not enough to resolve the condition.

▼ Performance did not improve since the 2022 audit (error rate increased).

* In 2022, only 18 of the 50 CPS cases in our sample were CPIT cases. Since the statute does not define immediate notification of CPIT partners, we held the department to the same timeframe requirements as priority responses: 24 hours for priority 1, 2 business days for priority 2, and 3 business days for priority 3 cases.

† During the 2022 audit, our results found that case closures were untimely due to missing written case recordings for case extensions. In the 2025 audit, our results found that the case recordings were in TFACTS but lacked justifications and supervisory approvals. See the new condition in **Figure 14**.

‡ In 2022, investigators did not upload the CPIT forms in TFACTS. In the 2025 audit, we found that 11 CPIT agreement forms were not in TFACTS. Additionally, 11 were missing CPIT participant signatures to demonstrate that they participated in the meeting decision.

Source: We created this table based on the results of our testwork.

Results of Our Expanded Testwork

We also expanded our review of Child Protective Services investigations and assessments to include new investigative tasks and identified **four new areas of concern**. We found that investigators were

- **not substantiating allegations** correctly, and
- **missing required monthly face-to-face visits** with alleged child victims.

Additionally, we found that supervisors were not

- **reviewing and approving** their staff's classification decisions on time, and
- **completing monthly administrative reviews** of their staff's cases.

These new deficiencies are similar to those we identified within the Special Investigations Unit.

Timely supervisory reviews ensure child safety, maintain compliance with requirements, improve investigative quality through real-time feedback, and hold investigators accountable for thorough and prompt casework. See **Figure 14** for our results.

Figure 14: New Conditions Identified with Child Protective Services

New Condition	# of Cases Reviewed	Error Rate
Incorrect classifications*	85	4%
Missed monthly face-to-face visits	85	11%
Untimely supervisory review of classification†	85	5%
Missed monthly administrative reviews	85	20%

* Assessment workers do not make substantiation decisions but rather conclude on whether the family needs services. All cases with errors were due to assessment workers incorrectly choosing that no services were needed.
† Supervisory reviews signify the case manager made the correct classification decision.
Source: Auditor testwork.

Quality Assurance Review of Closed Investigations

Having a quality case review process is important for child abuse investigations because it helps ensure that investigations are thorough, accurate, and consistent, which is critical for protecting children and supporting families. We found that the department's previous process for ensuring quality investigations was ineffective.[31] As mentioned in **Finding 1**,

31. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book), Principle 12.05, states, "Management reviews policies, procedures, and related control activities on a periodic and ongoing basis for continued relevance and effectiveness in achieving the entity's objectives or mitigating 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."

the quality assurance review process for CPS investigations and assessments is new, and we will review it in the next sunset audit.

Contributing Factors That Caused Deficiencies

CPS leadership identified high vacancies and turnover rates as the primary causes of the deficiencies noted above. When vacancies and turnover reduce the number of case-carrying staff, the remaining investigators must carry higher caseloads. With fewer available investigators, supervisors take on cases in addition to their review responsibilities. According to CPS leadership, supervisors prioritize their active cases when this occurs, which causes them to miss or delay supervisory reviews. For more information on turnover, vacancies, and caseloads, see **Observation 3** in the **Turnover, Vacancies, Overtime, and Caseload Management** section.

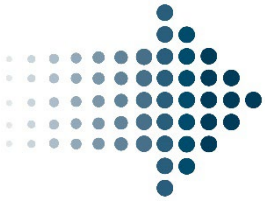
Impact on CPS Investigations

Management also assigns CPS investigators to supervise children housed in transitional homes. These assignments further burden CPS staff, who already struggle with turnover, vacancies, and high caseloads. In some regions, the demand for supervision in transitional homes is so great that **investigators spend the equivalent of one week each month sitting with children instead of performing their core investigative work**. For more information on children and youth staying in transitional homes, see the **Mission Challenge** in the **Placements Part 1** section and **Finding 4** in the **Placements Part 2** section of this report.

Overall Effect

When CPS investigators and supervisors do not complete important key steps of an investigation and do not adhere to critical timeframes, vulnerable children may remain in potentially abusive situations.

See **Observation 6** in the **Strategic Plan and Risk Assessment** section for additional information on risks related to CPS that management did not identify in their risk assessment.



Recommendation: Management should strengthen internal control activities over Child Protective Services investigations and assessments by ensuring investigators and supervisors carry out thorough investigations, maintain complete and accurate documentation, and comply with all required deadlines supported by timely supervisory review controls. Management should also improve its monitoring controls by

enhancing the quality review process for key investigation activities.

In addition, management should reassess policies and procedures related to staffing practices, including the use of case managers and investigators in transitional homes, to reduce strain on core investigative responsibilities and ensure resources remain focused on the department's mission of child protection.

Management's Comment

Management concurs. To address this finding, the department is reinforcing expectations and accountability across multiple levels of supervision and case management. The actions below reflect examples of our commitment to improving timeliness, documentation, and service delivery in CPS investigations, ensuring children are seen, assessed, and supported in accordance with policy and best practice.

- Face-to-Face (F2F) Contacts: Team Leaders conduct monthly administrative reviews, while Team Coordinators and Regional Directors monitor F2F compliance and ensure performance expectations are reflected in staff Individual Performance Plans.
- Response Time Compliance: Case managers receive real-time notifications for priority 1 cases. After-hours protocols are in place for urgent intakes. Safe Measures reports are reviewed weekly to monitor response time compliance, and all efforts to meet response deadlines are documented per policy.
- Case Closure Timeliness: Overdue cases are reviewed in Safe Measures, with administrative reviews documenting delays. Directors monitor overdue case percentages quarterly and proactively review cases nearing overdue status.
- The Department has requested 125 new DCS [department] Case Management positions through the budgetary process and 305 privatized case management positions to further reduce case file averages for DCS CPS case managers.

Child Safety Part 2: Child Fatality and Near-Fatality Public Notifications

State law requires the Department of Children's Services (the department) to publicly release information about child fatalities and near fatalities to promote transparency and accountability in cases where the department has been involved with the family. Sharing this information helps the public understand how the department responds to these critical incidents and supports efforts to improve child safety. Our goal was to evaluate how the department tracks and reports these incidents and to identify any factors that may contribute to delays in reporting. See **Finding 3.**

Background

The Department of Children's Services (the department) is statutorily[32] obligated to ensure transparency and accountability regarding child fatalities and near fatalities.[33] Section 37-5-124(a), *Tennessee Code Annotated*, requires the department to report on the fatality or near fatality of

> (1) Any child in the custody of the department;
>
> (2) Any child who is the subject of any ongoing investigation by child protective services or has been the subject of an investigation by child protective services within the forty-five (45) days immediately preceding the child's fatality or near fatality; or
>
> (3) Any child whose fatality or near fatality resulted in an investigation of the safety and well-being of another child in the home;
>
> within ten (10) business days of the fatality or near fatality of such child to the members of the senate and house of representatives representing the child. The district attorney for the judicial district in which the child was located must also receive a copy of the report provided to the legislators and may communicate with the legislators representing the child about the report and its contents or about any

32. Section 37-5-107, *Tennessee Code Annotated*, requires the department to report on the fatality or near fatality of a child.
33. According to Section 37-5-107(c)4(A), *Tennessee Code Annotated*, a "'near fatality' means a child had a serious or critical medical condition resulting from child abuse or child sexual abuse, as reported by a physician who has examined the child subsequent to the abuse."

other otherwise confidential information that the legislators may have acquired pursuant to § 37-5-107(d).

In addition to providing the information above to members of the Senate and House of Representatives, the department also publicly releases, on its website, certain information related to child fatalities and near fatalities in accordance with Section 37-5-107(c)(4), *Tennessee Code Annotated.* This information includes information on the custody of the child, age, gender, prior history with the department, investigative findings, whether the case meets criteria for a death review, and redacted case files.

Fatality and Near-Fatality Investigations

Both the Special Investigations Unit and Child Protective Services conduct fatality and near-fatality investigations. The department has developed internal protocols, such as the "Protocol for Child Death/Preliminary Near Death Assignment and Review" (supplement to Policy 14.6, "Child Protective Services Case Tasks and Responsibilities") and the "Protocol for Death of a Child/Youth in DCS Custody/Guardianship," to clarify the additional processes that take place in child fatality and near-fatality cases. These protocols require case managers, team leaders, team coordinators, and the Director of Child Fatality Monitoring to document cases, obtain autopsy reports, convene Child Protective Investigative Teams (CPIT),[34] conduct investigations, and close cases in accordance with policies and procedures.

According to these protocols,[35] case managers prepare a "death summary" once they complete all investigative tasks. Multiple levels of management, including team leaders, team coordinators, and the Executive Director,[36] review and approve the summary before the department incorporates it into the case closing summary in the Tennessee Family and Child Tracking System. The case closing summary then becomes part of the redacted case file that is shared publicly. **The department must complete all of these steps before it can post finalized child fatality and near-fatality information on its website**.

Reporting Process

The department's Director of Child Fatality Monitoring uploads initial information on child fatalities, such as the case number, case type, and basic demographic details, such as

34. CPIT teams are multi-disciplinary teams that include representation from the department, law enforcement, district attorneys, juvenile courts, and others who collaborate on investigations of severe and sexual child abuse.

35. According to the "Protocol for Child Death/Preliminary/Near Death Assignment and Review," once the department investigates the case, the autopsy has been received, and the case has been presented to CPIT, the case manager must submit the closing summary for review and approval by the team leader, team coordinator, and executive director.

36. This refers to the Executive Director of Child Protective Services within each region and the Executive Director of the Special Investigations Unit, depending on which unit is conducting the investigation.

age and gender, to the department's website within five business days of the child's death.[37] After investigators close the case, the director updates the site with the investigation results and the redacted case file.

For near-fatality determinations, department policy[38] requires a physician reviewer to confirm the case before the department can post it publicly. As a result, the director does not report near-fatality information until the physician reviewer makes this confirmation.

Child Fatality and Near-Fatality Internal Reviews

During our audit, the department was updating its process for child fatality and near-fatality internal reviews. Under the updated policy,[39] the department's Safety Action Team must review the circumstances of fatalities or critical incidents involving children in the department's custody, with open cases, or with recent department involvement, to recommend system improvements.

In the next sunset audit, we will audit the department's process for internal child fatality and near-fatality reviews to determine whether the reviews are conducted in accordance with the department's updated policies and procedures.

Current Audit

Our review focused on pending child fatality investigations from calendar years 2023 and 2024 and near-fatality investigations from October 2023 through May 2025 to determine what internal and external factors affected the department's ability to publicly report information related to child fatalities and near fatalities in a timely manner.[40] Our review resulted in **Finding 3**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.

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37. Section 37-5-107(c)(4)(B), *Tennessee Code Annotated*.
38. Department Policy 20.28, "Child Death/Near-Death Review" states that "near deaths are considered preliminary until confirmed by DCS. All confirmed near-death deaths receive a review. A near death is confirmed when: a) a child has a serious or critical medical condition resulting from child abuse or child sexual abuse as reported by a physician who has examined the child subsequent to the abuse, as defined by TCA 37-5-107, or b) upon substantiation, the case is submitted for physician review and the physician determines the child was in a serious or critical medical condition."
39. The department finalized updates to Policy 20.29, "Child Death and Safe Systems Analysis Review," on July 24, 2025.
40. We did not include the department's process for reporting fatalities and near-fatalities to members of the legislature within 10 days in the scope of our review. We focused instead on the department's process for publicly posting information on fatalities and near-fatalities on their website.

Finding 3: Prolonged investigative tasks, delayed supervisory reviews, and the lack of a physician reviewer impacted the department's ability to update information on its website regarding child fatalities and near fatalities

The Department of Children's Services (the department) must complete critical steps before it can post finalized child fatality and near-fatality information on its website. Delays in the investigations, including supervisory reviews and required physician reviews, when necessary, can result in delayed public posting of required information on child fatalities and near fatalities. As a result, the public may lack critical information needed to evaluate the effectiveness of Tennessee's child protection system in a timely manner.

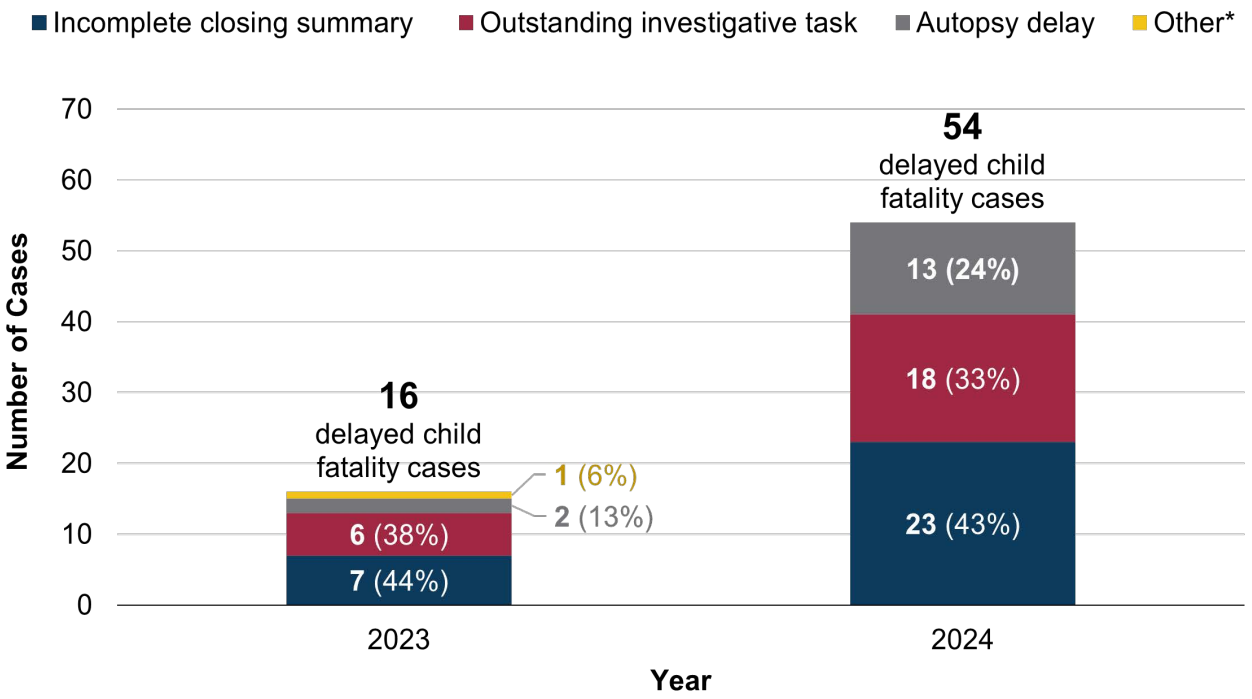
Factors Causing Delays in the Public Reporting of Child Fatalities

Our review of a nonstatistical, haphazard sample of 70 pending child fatality cases from calendar years 2023 and 2024 showed that the department had not updated the case result or posted the redacted case file on its website for these fatalities. Management provided the following reasons:

- **Outstanding investigative tasks:** Child Protective Services and Special Investigations Unit investigators received the autopsy report but still had unresolved investigative tasks to complete before they could close the case.
- **Incomplete closing fatality summaries:** The department had the autopsy report and had completed investigative tasks, but investigators had not prepared, or supervisors had not reviewed, the required closing fatality summaries.
- **Autopsy delays:** Local medical examiners' offices, particularly in the West Region of the state, had backlogs that left autopsy reports outstanding for one to two years.

See **Figure 15** for a summary of our results.

Figure 15: Delayed Child Fatality Reporting by Cause and Year, 2023 to 2024



* Other reasons that impacted public reporting include law enforcement requests to pause the department's investigative tasks while staff complete their reviews.
Source: This chart was created based on the results of our analysis.

Other Contributing Factors

Management also reported that turnover and vacancies contributed to child fatality or near-fatality incident investigative delays because cases required reassignment, and in some instances, investigators had to restart work due to lack of sufficient documentation (see **Observation 3** in the **Turnover, Vacancies, Overtime, and Caseload Management** section for more information regarding turnover and vacancies within Child Protective Services and the Special Investigations Unit). We also saw instances where no investigative tasks were documented for months. According to management, they recognized this was an issue and they were working toward completing the investigative tasks and closing the cases.

Additionally, management stated that fatality closing reviews are lengthy and require multiple levels of review to ensure accuracy since the department must redact and publicly post the case file.

Of the 70 cases we reviewed, 63% were from the West Region, with an autopsy report pending in all those cases. Management explained that the West Region experiences a higher crime rate and that local medical examiners' offices face persistent delays in

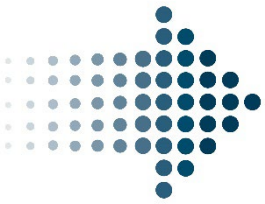
conducting autopsies, even after a 2024 statutory[41] change requiring medical examiners and facilities that perform autopsies to prioritize autopsies for certain child fatalities.

Turnover Causing Delays in the Public Reporting of Child Near Fatalities

Our review and discussions with management revealed that **the department has not publicly disclosed on its website any information on child near fatalities since October 2023**. From December 2023 to August 2025, the department lacked a physician reviewer to make required near-fatality determinations. **At the time of our review, all 58 preliminary near-fatality cases from October 2023 through May 2025 remained pending physician review.** Management explained that the department's former Deputy Commissioner of Child Health, who previously conducted these reviews, left the department in December 2023. Afterward, management was not successful in finding another physician reviewer through the department's prospective vendors portal[42] because few physicians expressed interest.

In **August 2025**, management reported that they had filled the position and that the new physician reviewer had begun reviewing the backlog of cases. Until the department contracted this reviewer, it could not finalize near-fatality cases or share information with the public, creating a prolonged gap in reporting.

See **Observation 6** in the **Strategic Plan and Risk Assessment** section for additional information on risks related to fatality and near-fatality reporting that management did not identify in their risk assessment.



Recommendation: The Commissioner and executive leadership should strengthen internal control activities to ensure timely public reporting of child fatalities and near fatalities. Specifically, leadership should implement monitoring controls over investigative tasks and fatality closing summaries to ensure they are completed and approved without delay, continue to coordinate with medical examiners to receive autopsy reports in a timely manner, and maintain control procedures for physician

41. Section 37-5-124(d), *Tennessee Code Annotated*, states, "The department of children's services, county medical examiners, chief medical examiners, and facilities that perform autopsies, pursuant to Section 38-7-105, must establish policies and procedures for the prioritization of the completion of final autopsy reports for fatalities described in subsection (a)."

42. According to management, the department's vendor portal is an online portal where prospective vendors can express interest in providing services to children and families through the department.

reviewer coverage, including contingency plans, to prevent lapses in near-fatality determinations.

Management's Comment

Management concurs. Investigations pending autopsies, criminal investigations by law enforcement, and the procurement process in order to secure a physician reviewer contributed to delays in management's public reporting of the redacted summary of child fatality and near fatalities. A Child Death team is being created to investigate only child fatality and near fatality cases, which will streamline investigative and related tasks. A physician reviewer has been secured and has reviewed approximately half of the near-fatality cases in queue. These efforts will allow child fatality and near-fatality investigations to be conducted thoroughly and timely, which prompts timely reports to be posted to the public web page.

Child Safety Part 3: Operations of the Child Abuse Hotline

The Tennessee Child Abuse Hotline serves as the primary point of contact for reporting suspected child abuse or neglect statewide. It operates 24/7 to ensure that concerns about a child's safety are promptly received, documented, and referred for investigation or assessment. Because the hotline is often the first step in protecting children from harm, it is critical that calls are answered quickly, call wait times remain low, and online reports are promptly screened so that potential risks to children are identified and addressed without delay. Our goal was to determine whether the Department of Children's Services effectively staffed and managed the Child Abuse Hotline, monitored key hotline performance statistics, and ensured timely response to reports of child abuse and neglect. See **Observation 1.**

Background

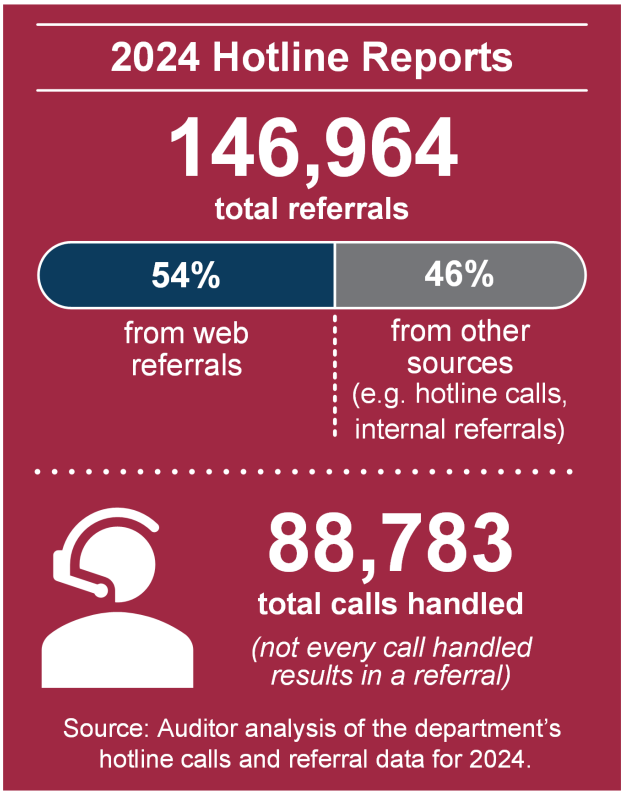
The Department of Children's Services' (the department's) Statewide Specialized Child Investigative and Referral Unit operates the Child Abuse Hotline (the hotline) to receive reports of allegations of child abuse and neglect 24 hours a day, 7 days a week. Under Section 37-1-406, *Tennessee Code Annotated*, the department must always be capable of receiving and investigating reports.

To accomplish this responsibility, the hotline operates with 7 teams working staggered shifts around the clock. Each team includes a team coordinator, team leader, and a mix

of intake supervisors, analysts, specialists, and associates. Hotline staff receive reports through a dedicated call center,[43] online web reporting form,[44] fax, mail, or email. The hotline maintains 5 separate phone lines: 2 for the public, 1 for law enforcement and medical professionals, 1 for school personnel, and 1 for case managers. Most calls come through the public lines.

In calendar year 2024, management reported that the hotline received **146,964 allegations,** and reporters submitted approximately half of these allegations through the department's online process. The average number of Child Abuse Hotline allegations has remained consistent from 2022 to 2024. See **Figure 16** for statistics of hotline reports for the most recent calendar year.

Figure 16: Child Abuse Hotline Reports for Calendar Year 2024



Decision Tree Tool

Hotline staff use the Structured Decision-Making Tool within the Tennessee Family and Child Tracking System (see **Appendix 6** for a diagram of the tool). A contracted vendor

43. The department utilizes a statewide contract with Cisco for the call center platform and call center metric reporting.
44. The public can submit reports online through the department's Child Abuse Referral and Tracking (CARAT) system at https://carat.app.tn.gov/carat/.

maintains the online tool,[45] which guides staff through a series of questions to decide whether a report should be screened in for investigation and, if so, how quickly investigators must respond. Supervisors review each screening decision to ensure accuracy and consistency.

The Structured Decision-Making Tool is designed to promote consistency and accuracy in screening decisions by reducing reliance on individual staff judgment. This ensures that similar reports receive the same priority level and timely response, regardless of which hotline staff member takes the call.

Monitoring Hotline Performance

Hotline management reviews call center performance daily and monthly using data reports generated by the Cisco communication network.[46] These reports track key performance metrics such as queue time (the time a caller waits before reaching hotline staff) and the abandonment rate (the percentage of calls that disconnect before reaching staff). Hotline management also monitors the overall volume of reports submitted to the hotline.

Current Audit

We examined call center data, such as abandoned call rates and queue times, and hotline vacancy and turnover data. Our review of hotline call data showed abandoned call rates and queue times peaked in September 2024 but have since improved due to management's operational changes and increased staffing. We also reviewed the Structured Decision-Making Tool to understand how staff use it for screening decisions. Our review resulted in **Observation 1**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.

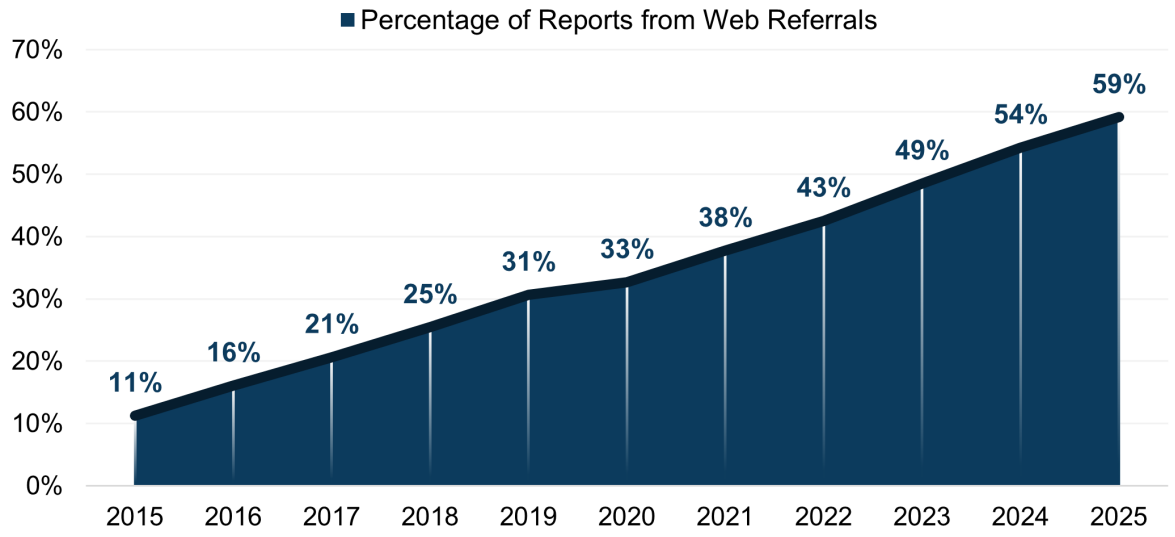
Observation 1: The Child Abuse Hotline has improved call abandonment rates and wait times since they peaked in September 2024; however, further work is needed to strengthen screening tools and online report monitoring

For approximately the last 10 years, the Child Abuse Hotline (the hotline) has shifted from phone-based reporting to online reporting. Today, more allegations come through the web

45. Evident Change is the vendor that maintains the Structured Decision-Making Tool.
46. The State of Tennessee has a statewide services contract with Cisco Communications Network for phone systems throughout the state.

portal than through traditional phone lines. **Figure 17** shows a decade of steady increase in web referrals.

Figure 17: Web Referrals as a Percent of Total Reports to the Child Abuse Hotline by Calendar Year, January 2015 to April 2025



Source: Department of Children's Services management provided statistics from their monthly tracking spreadsheet.

While online reporting reduces caller wait times and eases pressure on hotline staff, it also changes how intake staff perform their work. Unlike phone calls, web reports arrive without real-time interaction, requiring staff to carefully review and follow up with reporters to avoid missing critical details.

At the time of our review, management had not established benchmarks[47] or performance metrics to measure how quickly hotline staff processed a web report. **Without the benchmarks, hotline staff could cause a delay in responses and increase risks to child safety**.

Hotline Call Center Performance

When callers to the Child Abuse Hotline face long waits or abandon calls before reaching staff, reports of potential child abuse may be delayed or lost. Longer wait times can discourage callers, such as teachers, doctors, or neighbors, from completing a report,

47. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) states that department management is responsible for the design, implementation, and operating effectiveness of internal controls, even when services are provided by third parties. Agencies engaging external service organizations must understand risks, define performance expectations, and monitor controls to ensure they remain effective.

while higher call abandonment rates may mean some concerns may never reach investigators.

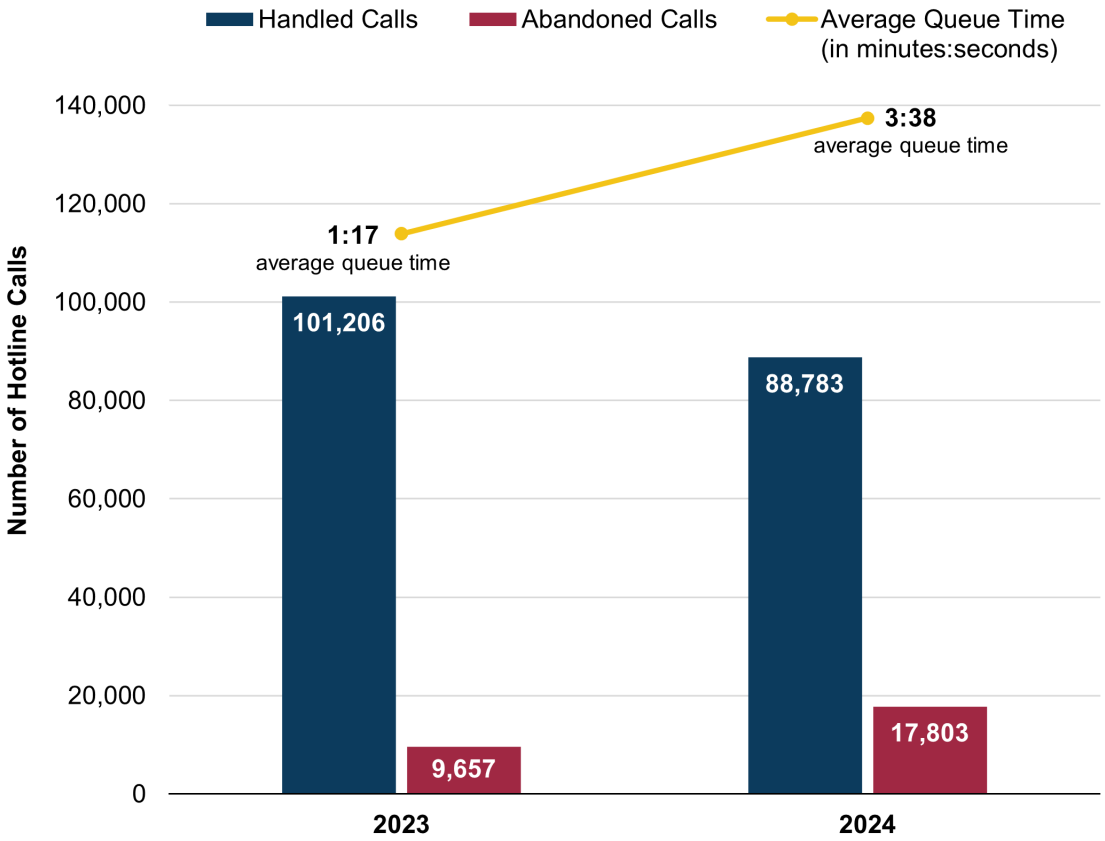
Because the hotline is often the first point of contact for protecting children, staff must respond to calls as quickly and efficiently as possible. Our review of hotline call center data showed that **hotline performance declined in 2024 compared to 2023**. Specifically, we found the following:

- The overall average abandoned call rate **increased from 9% in 2023 to 16% in 2024,** exceeding the industry standard of 5–10%.[48]
- Call abandonment on the public lines reached as high as **25%** in September 2024.
- The average wait time on the main public line increased from 1 minute 17 seconds in 2023 to 3 minutes 38 seconds in 2024—**a 183% increase**—even though overall call volume fell slightly.

See **Figure 18** for a summary of our results.

48. According to the Service Quality Measurement (SQM) Group, a company that specializes in call center quality assurance, the industry standard and benchmark for call abandon rate is 5%, with some instances allowing the benchmark to be between 5% and 10%. https://www.sqmgroup.com/resources/library/blog/call-abandonment-rate-comprehensive-guide.

Figure 18: Child Abuse Hotline Statistics by Calendar Year, 2023 and 2024



Source: Auditor analysis of hotline call data obtained from department management.

Management reported that staffing shortages caused much of the decline in performance related to abandoned calls and call wait times. Vacancy rates increased from 5% in July 2023 to 30% in July 2024, and hotline turnover reached nearly 40% in 2024.

By comparison, industry data showed call center turnover rates of 30-40% during 2021 and 2022[49] in the post-pandemic period. According to management, mandatory overtime, night and weekend shifts, and the stress of hotline work contributed to high turnover and vacancy rates.

By late 2024, the department implemented operational changes to address these issues. In December 2024, the hotline shifted to online-only reporting for the public on weekends, while law enforcement and medical staff continued using dedicated phone lines.

The department also launched a hiring initiative, adding 19 new intake staff by March 2025. These steps coincided with early improvements in 2025, as overall call

49. The SQM group benchmarked the industry standard for call center turnover, which was between 30 and 40% in 2021 and 2022. https://www.sqmgroup.com/resources/library/blog/call-center-attrition-rate.

abandonment dropped to 8–12% and queue times decreased. While these results demonstrate progress, sustained performance will depend on management's ability to maintain appropriate staffing levels.

Outdated Staff Screening Tool

We also observed workarounds in the hotline's allegation screening tool, which the department has not consistently updated since 2015. Hotline staff reported that some questions in the Structured Decision-Making Tool are outdated and no longer align with current policy. As a result, hotline staff often must deviate from the tool or rely on a separate "screening protocol manual" to arrive at the correct screening and assignment of priority. These workarounds, which require staff to use individual judgment rather than a more automated screening process, increase the risk that staff will make inconsistent decisions or errors when analyzing the reported details.

Management explained that the department has not invested in updating the Structured Decision-Making Tool because it is preparing to replace the Tennessee Family and Child Tracking System with a new Comprehensive Child Welfare Information System. Management acknowledged that the tool does not reflect current policy but stated the department cannot justify the cost of updating both the old and new systems. In the meantime, staff must rely on external guidance and manual workarounds to complete the hotline screenings.

See **Observation 6** in the **Strategic Plan and Risk Assessment** section for additional information on risks related to the Child Abuse Hotline that management did not identify in their risk assessment.

Management should design and implement internal controls such as clear policies, standardized procedures, and defined performance measures to ensure staff process online reports consistently, timely, and with the same rigor as phone-based reports. Management should continue to stabilize hotline staffing and monitor abandoned calls and queue times against industry standards. Finally, given that the hotline is the department's primary allegation-receiving process, department management should ensure that decision-making tools reflect all policy and procedures so that even during system transitions, hotline staff can consistently and accurately screen allegations so risks to children can be mitigated.

Management's Comment

Acknowledge – No management comment required.

Placements Part 1: Children and Youth Placement Challenges

Management acknowledged that some children and youth are harder to place and that this remains one of the department's greatest challenges. These children and youth often have complex behavioral, medical, or emotional needs that few foster families or treatment providers are equipped to manage. The limited availability of specialized placements, combined with growing demand, has led the Department of Children's Services to rely on temporary housing options more frequently than intended. See the **Mission Challenge**.

Background

When a child cannot safely remain in their home, a juvenile court may place the child in the custody of the Department of Children's Services (the department). According to Section 37-1-130(a)(2), *Tennessee Code Annotated*, the court may "transfer temporary legal custody to or grant permanent guardianship" to the department when that decision serves the child's best interest. Once the court vests legal custody in the department, Section 37-1-140(a), *Tennessee Code Annotated*, authorizes the legal custodian to determine the child's care and treatment and imposes the duty "to provide for the care, protection, training and education, and the physical, mental and moral welfare of the child."

Additionally, federal child welfare laws[50] require state child welfare agencies to ensure that children in foster care are placed in the least restrictive, most family-like and home-like setting available, consistent with the child's safety, best interests, and special needs.

Through these authorities, the department serves as both custodian and service provider and must place each child in the safest, most appropriate environment available. Under Sections 37-5-105(3) and (5), *Tennessee Code Annotated*, the Commissioner manages programs for the care of children and directs their placement in appropriate state or contracted facilities.

50. The Adoption Assistance and Child Welfare Act of 1980, the Adoption and Safe Families Act of 1997, and the Families First Prevention Services Act of 2018.

Long-Term Placement Landscape

The department maintains a continuum of placements to meet the diverse needs of children and youth in custody. Based on each child's needs, the department's staff assigns the child to one of four levels of care:[51]

- **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.

This continuum includes foster homes, Department of Disability and Aging family-based model homes, group homes, and residential treatment centers;[52] for juvenile delinquents requiring higher levels of supervision, the department utilizes juvenile detention centers or hardware-secure facilities.[53]

Placement Trends (Permanent and Temporary Settings)

The federal Administration on Children and Families (ACF) publishes data profiles twice a year that measure permanency outcomes of each state's child welfare system.[54] Department leadership identified 2 key performance indicators from these profiles that reflect the success of the department's foster care placement practices:

1) **Average Time to Permanency** – Measures the percentage of children who exited foster care through reunification, adoption, guardianship, or placement with relatives within 12 months, 12 to 23 months, or 24 months or longer.
2) **Placement Stability** – Measures the number of placement moves per 1,000 days in foster care for children who entered care during a 12-month period.

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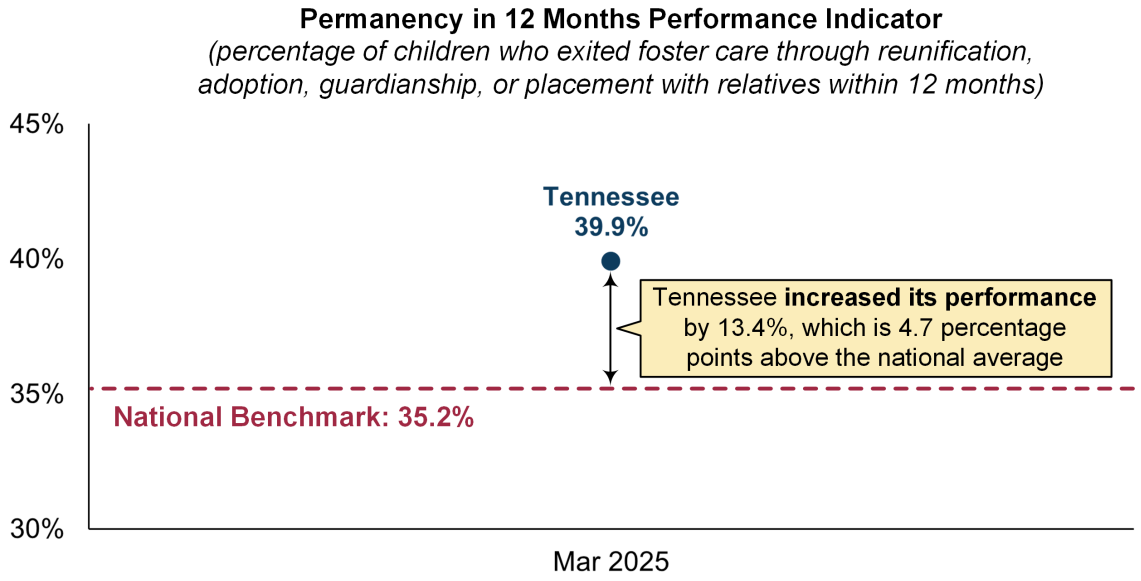
51. These levels are defined in the department's *Contract Provider Manual.*
52. Residential treatment provides thorough clinical services, including psychiatric and educational assessment, and therapeutic treatment program in a 24-hour-a-day residential facility for children and youth with significant emotional and/or psychological treatment needs.
53. Hardware-secure facilities are physically secure settings, such as youth development centers or juvenile detention centers, designed to restrict a youth's freedom of movement through locked doors, secure perimeters, or other physical barriers.
54. The Adoption and Foster Care Analysis and Reporting System (AFCARS) is a federally mandated report that public child welfare agencies use to submit data to the ACF twice each year. ACF analyzes the data and produces a report that compares each state's data to the national average.

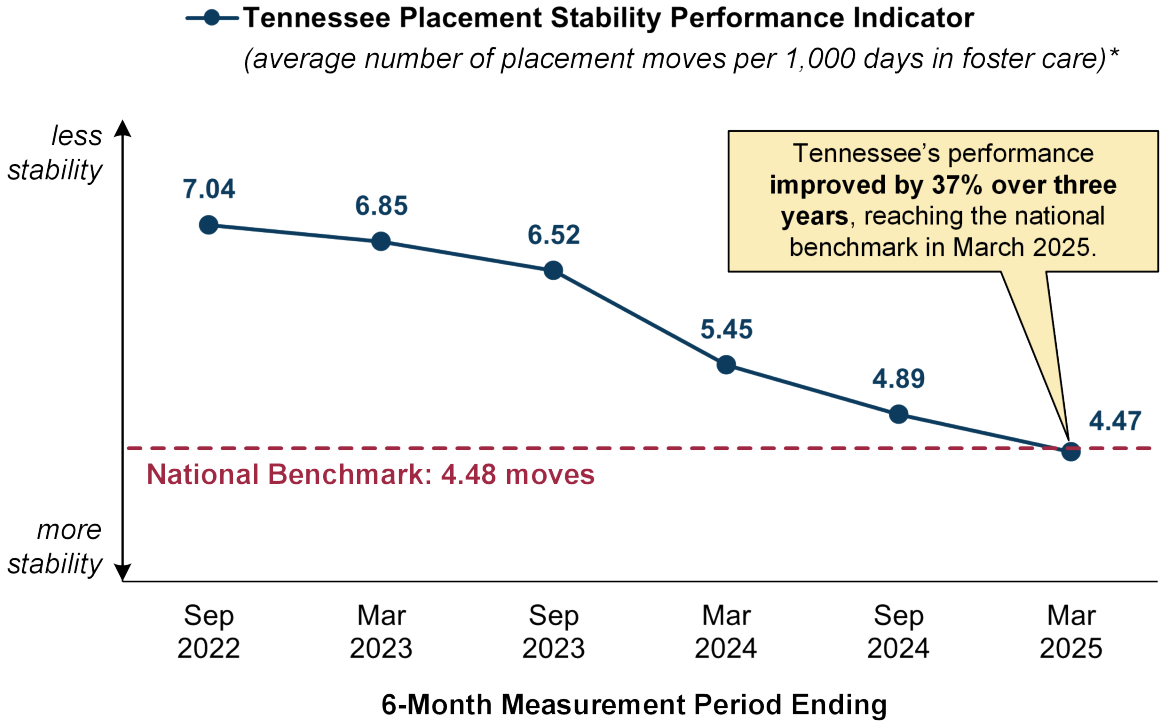
According to the department's August 2025 data profile, the department has improved in 2 areas over the last 3 years. For average time to permanency, Tennessee increased its performance by 13.4%, which is 4.7 percentage points above the national average (see **Figure 19**). For placement stability, Tennessee's performance improved by 37% over 3 years, reaching the national benchmark in March 2025 (see **Figure 20**).

Figure 19: Tennessee's Average Time to Permanency Performance, March 2025



Source: Administration for Children and Families, Tennessee Child and Family Services Review, August 2025. (*unaudited*)

Figure 20: Tennessee's Placement Stability Performance, September 2022 Through March 2025



* This data excludes temporary housing placement for a child or youth who is placed in a juvenile justice facility, a transitional house, or a state office building.

Source: Administration for Children and Families, Tennessee Child and Family Services Review, August 2025. (*unaudited*)

According to management, the placement data they submit to ACF only accounts for children and youth from the point they enter a foster care living arrangement, and excludes placements in offices and transitional houses. It is important to note that ACF includes temporary settings in its definition of placements.[55] In the next sunset audit, we will review the department's process to report this data.

55. AFCARS 2020, Technical Bulletin 20: Data Elements for Out-of-Home Care & Adoption and Guardianship Assistance Data File from June 10, 2024, Element 112: Date of Living Arrangement states, "For children who are in a short-term or interim location not designed for youth in out-of-home care (e.g., hotel room, office space, short-term rental property), the agency should enter each of these locations as a separate living arrangement. It would be reported as one placement for however many days the child stays at that location. However, if the child has to pack up their belongings after the night's stay and then go back to the location for the next night, the agency would report that as two separate living arrangements." Due to the federal government shutdown, we were unable to contact ACF to confirm how they intend the requirements to be applied.

Custody Trends

According to management, the overall number of children and youth entering custody has declined; however, those who do enter the department's custody increasingly present intensive behavioral, developmental, or mental health needs. Many of these youth require specialized or closely supervised environments, making it more difficult to match them with available foster families or long-term providers.

The Average Number of Children and Youth in Custody:

2022: 8,966
2025: 8,609

The number of children and youth in custody has decreased by 4%.

Source: Auditor created using the data presented in the department's custody dashboard.

Evolving Needs of Children and Youth in Custody

Children and youth entering the department's custody often do so because of neglect, abuse, or unsafe living conditions. The department's custodial youth include children and youth who are categorized as

- **dependent and neglected** children who are abused, abandoned, or lack proper care or supervision;[56]
- **unruly** youth who have not committed crimes, but who habitually disobey rules, run away from home, are truant, or engage in risky behavior;[57] and
- **juvenile delinquent** youth who have committed an act that would be a crime if committed by an adult.[58]

56. See Section 37-1-102(b)(13), *Tennessee Code Annotated*, for the different situations that can cause a child or youth to be dependent and neglected.
57. Section 37-1-102(b)(34), *Tennessee Code Annotated*, states that "unruly child" means "a child in need of treatment and rehabilitation who: A. Habitually and without justification is truant from school while subject to compulsory school attendance under TCA 49-6-3007; B. Habitually is disobedient of the reasonable and lawful commands of the child's parent(s), guardian, or other legal custodian to the degree that such child's health and safety are endangered; C. Commits an offense which is applicable only to a child; or D. Is away from the home, residence, or any other residential placement of his parent(s), guardian, or other legal custodian without their consent. Such child shall be known and defined as a 'runaway.'"
58. According to Section 37-1-102(b)(11), *Tennessee Code Annotated,* "delinquent child" means a child who has committed a delinquent act and is in need of treatment or rehabilitation.

Management stated that children and youth entering custody, in all three of these categories, have increasingly had higher behavioral issues and mental health needs.[59]

Temporary Housing

In the context of child welfare, *temporary housing* refers to settings used to house children when a foster home, group home, or other appropriate placement is not immediately available. When staff are unable to immediately secure a suitable long-term placement, such as in situations with difficult placements, the department must continue to rely on temporary housing options, such as community-based organizations,[60] department-leased dormitory-style housing, churches, and state office buildings,[61] to house children for as long as it takes management to find and secure the placement. See **Figure 21**.

Figure 21: Department-Approved Temporary Housing

Source: Auditor created based on temporary setting data provided by management.

According to management, neither transitional houses nor office buildings are intended to serve as official placements for any child. Instead, they are considered last-resort, short-term options used when a child first enters custody or is temporarily between

59. In certain situations, juvenile courts have adjudicated a child or youth as dependent and neglected, rather than delinquent, because they are not competent to stand trial when their behaviors stem from a mental health condition requiring treatment rather than confinement. These determinations are made under Rule 207: "Procedures Related to Child's Mental Conditions," *Rules of Juvenile Practice and Procedure*, which establishes procedures for evaluating a child's mental condition and competency to proceed in juvenile court.
60. An example of a community-based organization would include the 19 houses owned and operated by Isaiah 117 House across the state as of October 2025.
61. As noted in a 2023 presentation of the department's Real Estate Strategic Plan, when beds are not available for immediate placement, children and youth have slept in department offices, which are not intended for dormitory use. At the time of publication, it was noted the Fire Marshall had disallowed this practice. The department subsequently provided an interagency agreement for periodic fire inspections for state-owned and -leased buildings and facilities.

placements.[62] Because state office buildings do not qualify as transitional houses, they fall outside the department's protocol for housing children in transitional spaces. Even so, regional case managers work to ensure all temporary settings, including the state office buildings, provide appropriate amenities and maintain a safe environment for children. The department also assigns case managers, contracted sitters, and security personnel to supervise children staying in state office buildings, using the same supervision model applied to youths housed in transitional houses.

The department's reliance on office buildings underscores the ongoing systemic placement challenges that force staff to choose between housing a child or youth in an unsuitable facility or leaving them without shelter.

Transitional Housing Requirements

The department follows its "Protocol for Accessing and Working in a Transitional House" to guide staff's use of transitional houses. The protocol requires staff to ensure that any child waiting at the transitional house has access to the following minimum amenities:

- restroom/toilet;
- shower/bathing facilities;
- adequate sleeping space;
- linens (such as towels, bedding, and pillows);
- personal care items/toiletries; and
- regular meals and snacks.

The department also directs staff to follow specific procedures to ensure safety in temporary settings. The "Protocol for Accessing and Working in a Transitional House" and Department Policy 20.15, "Medication Administration, Storage, and Disposal," require staff to store medications in a double-lock system and administer them according to prescribed guidelines. The protocol outlines expectations for day-to-day care, support, and supervision for children in these spaces.

62. The department's "Protocol for Establishing a Transitional House" states, "Transitional Houses are community-based locations where a custodial child awaiting placement in a foster home or facility may, for a short period of time, wait in a home-like setting, while still under the direct supervision of Department staff."

Children and Youth Who Are Hard to Place

Management explained that the department is serving an increasing number of hard-to-place youth; specifically, acuity of care[63] has increased with the juvenile delinquent, dependent, and neglected populations. Additionally, management stated that the severity of juvenile crimes has continued to increase in Tennessee and across the United States.

For this population, traditional placement options, such as foster homes, treatment facilities, or juvenile justice facilities,[64] are often unavailable or cannot meet the child or youth's needs. As a result, management has limited housing options to meet their needs. These children and youth often remain in temporary settings longer than intended while staff search for suitable placements. These environments, however, are difficult to manage because many of these youth exhibit significant behavioral challenges and require constant supervision.

Most of these children are older youth with extensive trauma histories, multiple prior placement disruptions, and complex behavioral and medical needs that few foster families or treatment providers are equipped to handle.

24-Hour Supervision ("Sitting") of Children in Temporary Housing by Department Staff

Because the department must often rely on temporary settings to house children for extended periods, it is required to maintain continuous, 24-hour supervision for the duration of each child's stay. To accomplish this, the department assigns daytime, overnight, and weekend *sitting shifts* to regional staff, including case managers, Child Protective Services investigators, and juvenile justice staff. These employees work alongside contracted sitters, security staff, and, in some transitional houses, on-site mental health personnel to ensure adequate supervision.

Staff overtime hours have increased by 11% since 2024.

The percentage of staff working overtime has increased from 55% in fiscal year 2023 to 86% in fiscal year 2025.

Source: See **Observation 3** in the **Turnover, Vacancies, Overtime, and Caseload Management** section.

Employee Survey

To better understand how the department's current environment affects its ability to meet its mission, we conducted an employee survey in May 2025 for all staff with valid email addresses. The survey asked employees to describe how departmental changes, including

63. Management described "acuity of care" (level of severity and level of care needed) for these children and youth as high because they often have severe behavioral health issues, are medically fragile, or are non-verbal.
64. Juvenile justice facilities include hardware-secure and staff-secure placements for juvenile delinquents.

staffing demands and operational pressures, have influenced their work since the 2022 performance audit. We share excerpts of survey responses in the **Mission Challenge** and a summary of the complete survey and responses in **Appendix 7**.

Current Audit

Our review focused on management's placement challenges and their plan to expand long-term permanent placement capacity for hard-to-place children and youth. See the **Mission Challenge**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.

In this context, a **Mission Challenge** involves circumstances that management has experienced through no fault of their own, but which present roadblocks to achieving the department's goal "to provide for the care, protection, training and education, and the physical, mental and moral welfare of the child," as required by federal and state laws.

> **Mission Challenge:** The department is challenged to meet the needs of children and youth in its custody with complex behavioral and mental health needs who must remain in temporary housing settings for extended periods of time

Challenges in Housing Hard-to-Place Children and Youth

Children who are the hardest to place often arrive at settings only intended to keep them safe for a single night, a "home" that is not truly a home. Many of these children are older youth with histories of trauma, repeated placement disruptions, or complex behavioral and medical needs that few foster families can manage. When foster or treatment beds are unavailable, staff house these youth in transitional houses or, in emergencies, in state office buildings that have been converted into temporary sleeping spaces.

As discussed in the background, transitional houses were originally designed as short-term placements where children could sleep, shower, and stabilize while staff worked to locate a more appropriate placement. Although the Department of Children's Services (the department) has not defined "short term" in policy, in practice, many hard-to-place youth remain in these crisis settings for weeks or even months while staff continue searching for houses or treatment programs that can meet their needs.

This challenge is not unique to Tennessee; many states report using hotels, offices, or other improvised spaces to provide temporary supervision when no other placement options are available.

Impact on Hard-to-Place Children and Youth Staying in Temporary Housing

According to the Casey Family Programs[65] brief from May 2023 on *Placement Stability Impacts*,

> Children in out-of-home care need stable adult connections to support their well-being. These secure attachments are best formed in stable placements that help young people maintain connection with their family and community, and transition into permanency without delay.

Additionally, the brief identifies that

> The possibility of safety risks increases with every move; permanency is delayed when a child experiences multiple placements; and well-being is affected in many ways, including poorer educational outcomes and increased behavioral and mental health issues. The trauma that accompanies placement changes puts children at risk for negative outcomes such as aggression, delinquency, and depression. Multiple placements have also been found to lead to delayed permanency, academic difficulties, and challenges developing meaningful attachments.

Extended stays in temporary housing can further expose children and youth to significant emotional, behavioral, and safety risks. These settings often lack the stability, comfort, and routine that children in state custody need to recover from trauma and build trust with caregivers.

Because temporary settings are not designed for childcare, they often present safety and developmental challenges. Limited supervision consistency, lack of privacy, and inadequate facilities increase the risk of unsafe incidents and unmet physical or medical needs, which delay effective treatment plans for children and youth in the state's custody. Educational routines are also disrupted, as children may miss school or struggle to focus amid instability.

While the need for short-term stays in temporary placements may be necessary, prolonged use of temporary housing delays progress toward permanency and can lead to lasting effects on well-being. Youth who remain in these settings for weeks or months are more likely to experience behavioral regression, emotional distress, and poorer long-term outcomes. Ultimately, the department's reliance on temporary housing for these hard-to-place youth creates a roadblock to achieve the department's goal of ensuring safe, stable, and permanent placements for children in custody.

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65. Casey Family Programs is a foundation focused on safely reducing the need for foster care in the United States and is a contractor of the department.

Use of Temporary Housing Across the State

The department's centralized tracking spreadsheet for regional transitional houses and office building placements **from March 3, 2025, to September 5, 2025**, shows that **children stayed in temporary settings every night statewide**.[66] See **Figure 54** in **Appendix 8** for the number of overnight stays by region. The subsections below summarize the **scope and duration** of these placements and their **impact on staff**.

Transitional Houses

Transitional houses include spaces where the department has agreements to temporarily house youth, such as apartments or churches and organizations (for example, Isaiah Houses) that provide short-term shelter while children await placement. See **Finding 4** in the **Placements Part 2** section.

From March 2025 to September 2025, **1,134 children** stayed in a transitional house for at least 1 night, which is approximately **13%** of all children and youth in the department's custody during this period. On average, youth stayed 9 to 12 nights depending on the region, and 11 youth remained in a transitional house for more than 2 months awaiting a more permanent placement.

Other Spaces – State Office Buildings

When a child needs a temporary placement but cannot stay in a transitional house, due to limited space or the need for separation from other youth, the department uses state office buildings as a last resort. Persistent placement shortages have forced staff to convert administrative offices into temporary sleeping spaces, sometimes for a single night, and in some cases, for many nights. **Between March and September 2025**, **172 total children spent at least 1 night in an office building.** In one instance, a child in the Northeast Region stayed **104 nights** in an office building while awaiting placement.

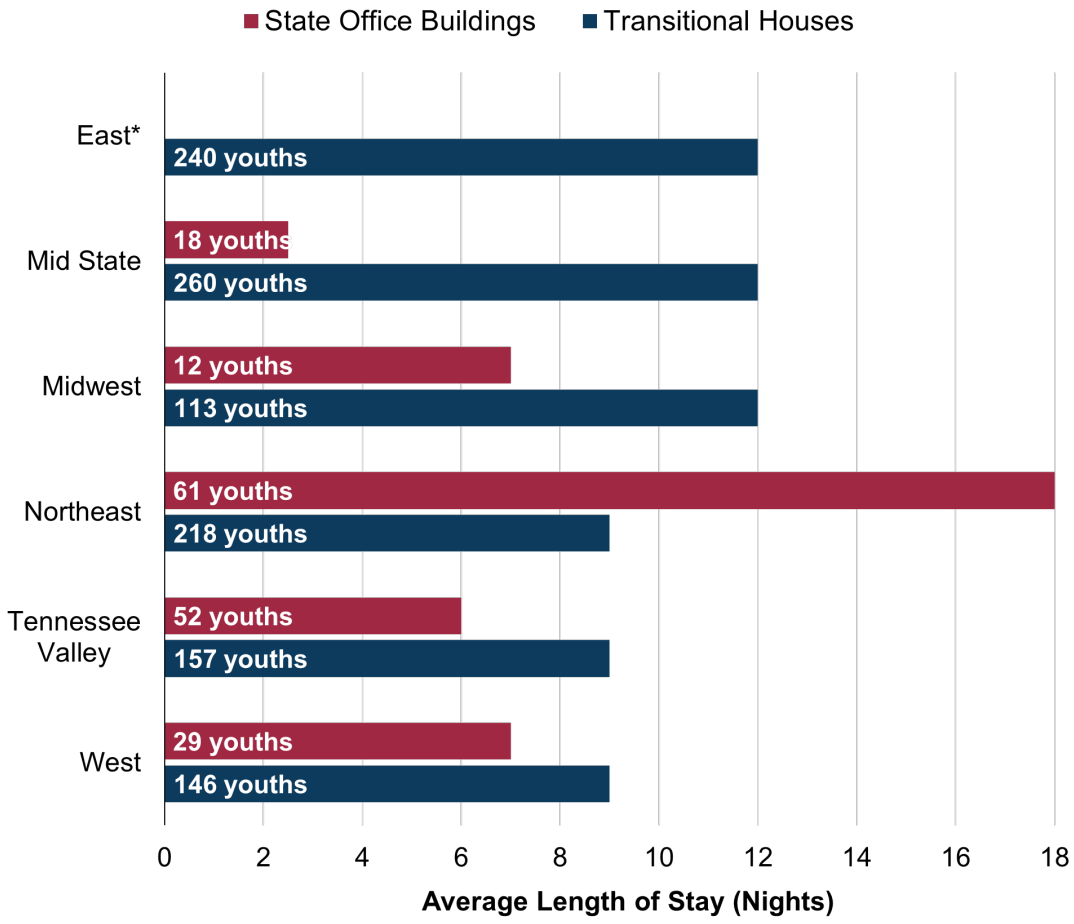
Except for the East Region, which reported no youth housed in office buildings during this period, an average of 2 to 6 children stayed in office settings statewide on any given night. The Northeast and Tennessee Valley Regions relied on office spaces most frequently. In the Northeast Region, between July 11 and July 24, **10 to 12 youth** stayed overnight in office buildings each night, split evenly between the Sevier and Washington County offices. See **Figure 22**.

During the 6-month period, the department housed **1,173 children and youth** in temporary placements. **Stays ranged from 1 day to 160 days**, **with an average of 12 days**, showing that some children and youth remained in short-term settings far longer

66. Each region had data for slightly different time periods at the time of our review.

than intended. Specifically, in the Northeast Region, children and youth stayed an average of **18 days** in an office building. See **Figure 22** for the average length of stay.

Figure 22: Total Number of Youths Staying in Temporary Housing and Average Length of Stay from March 2025 to September 2025



* East did not use state office buildings as temporary housing during the audit period.
Source: Auditor created based on analysis of management's tracking spreadsheets.

Impact on Staff "Sitting" in Temporary Housing

The time and resources needed to fill sitting shifts vary by the number of children in temporary settings in each region on any given day. According to the department's "Protocol for Accessing and Working in a Transitional House," "Each shift for [department] staff in a transitional house will be six (6) hours in length." According to the employee survey response and our review of a region's monthly sitting calendar, multiple staff stated it was necessary to work up to six sitting shifts per month, in addition to fulfilling their regular job responsibilities. The department's continued reliance on temporary housing places significant strain on staff capacity and morale. To provide around-the-clock

supervision in transitional homes and office buildings, staff must work additional sitting shifts, often during evenings, overnights, and weekends, on top of their regular caseloads and investigative duties. This added sitting responsibility reduces time available for core work such as case management, family engagement, and permanency planning.

The unpredictable and demanding nature of sitting shifts contributes to staff fatigue, burnout, and turnover, particularly among regional staff. Supervisors frequently have to reassign staff from essential functions to fill supervision gaps, creating operational inefficiencies and morale challenges. Regions with high numbers of youth in temporary settings face the most severe staffing pressures; they rely on overtime, contracted sitters, and security to help supervise children and youth.

These conditions strain both human and financial resources. Increased overtime costs, staffing reassignments, and contract expenditures reduce the department's capacity to invest in long-term placement solutions. Ultimately, the heavy operational burden of temporary housing detracts from the case manager's ability to focus on the well-being and permanency goals for children in custody.

Employee Survey Responses

Staff responses provided valuable insight into how these operational demands affect morale, workload balance, and the department's overall ability to provide continuous supervision for children in custody. See **Figure 23** for a sample of employee survey responses from an anonymous survey.

Figure 23: Sample of Employee Survey Responses

Source: A sample of comments from our survey of department employees.

Addressing the Department's Ongoing Placement Challenges

The challenges identified by management represent significant obstacles for both the department and the state to overcome. State leadership must continue to weigh funding priorities and policy decisions that serve the best interests of Tennessee's children and youth. While these challenges cannot be solved overnight, addressing them requires a coordinated effort among all stakeholders—including the department, foster parents, service providers, community organizations, and policymakers—to expand placement capacity and ensure that every child in custody receives safe, stable, and supportive care.

To begin addressing these challenges, the department intends to open additional intake facilities and assessment centers,[67] as outlined in its fiscal year 2024–2027 strategic plan, to *"Improve placement and the permanency experience for children,"* including those with higher placement needs. In the next sunset audit, we will evaluate the department's progress in implementing these initiatives and assess whether they improve placement capacity and outcomes for children in custody.

Management's Comment

Management concurs. The challenge of housing youth for periods of time in transitional settings or state office buildings requires significant planning, staff resources, and leadership attention. Despite these challenges, DCS has responded with every tool available within its fiscal, staffing, legal, and regulatory constraints. The use of these settings is a last resort, driven by a national crisis in placement availability and the increasing complexity of behavioral and mental health needs among children in custody.

We have taken deliberate steps to mitigate the need for, and operational burden of, temporary housing to include short-term strategies and long-term strategic actions. To that end, the department has:

- **Secured privatized specially trained residential case managers** to support transition settings with high numbers of youth, infusing these settings with individuals specially trained to provide temporary group care and to reduce the reliance on DCS staff.
- **Implementing a real estate plan** to address service gaps, fundamentally change the experience of children entering DCS custody, and eliminate the reliance on DCS front-line professionals to provide short-term transitional care.
- **Partnering with other state agencies including TennCare, advisory councils, external consultants, and private providers** to strategically fill gaps in the placement network, coordinate services, create new programming, expand successful partnerships, and recruit new vendors to provide for the changing needs of children in custody.
- **Engaging private providers** in a redesign of the placement service system to meet the needs of the children in custody today, refocus the goals of the

67. Management stated that these assessment centers and intake facilities are new concepts designed to clinically assess the needs of youths so that management has better information for long-term placements, rehabilitative activities, and other treatment strategies.

Department's performance based contracting system (PBC), and infuse evidence-based practices (EBPs) into the provider network.

- **Operationalize our Prevention to Permanency Vision –** a long-term strategy focused on building a future where DCS, sister agencies, individuals with lived experience, and community partners work together to keep children safe and families together as we agree that addressing these challenges requires a coordinated effort.

Placements Part 2: Department Responsibilities for Transitional Housing

The Department of Children's Services (the department) has direct responsibilities for children and youth who enter the state's custody and who are placed in temporary settings while staff seek long-term and individualized treatment placements. When staff use temporary settings to house children and youth for extended periods of time because no immediate placement option exists, the department must maintain effective oversight and critical documentation to ensure these temporary arrangements are safe and well-supervised.

Our goal was to determine whether the department corrected the prior audit findings and implemented internal controls to ensure that temporary placements, such as transitional homes, met required safety and supervision standards. In addition, we expanded our work to include the department's monitoring process for transitional houses. See **Finding 4.**

Background

The Department of Children's Services (the department) utilizes a team of regional transitional house coordinators to manage department staff sitting schedules, act as a liaison to schedule contracted sitters and security services as needed, and ensure that children in these settings have adequate food and amenities for the duration of their stay. These coordinators also work with regional case managers to ensure that these children have transportation to and from school, doctors' appointments, and other needed services.

Regional and Central Office Oversight of Transitional Housing

The regional staff handles day-to-day management, including walkthroughs and documentation.

In 2024, the department's Office of Continuous Quality Improvement conducted annual, informal spot checks of transitional homes to review whether there were smoke detectors, fire extinguishers, and other amenities such as bedding, bathroom facilities, and food. The office plans to conduct these spot checks annually.

The department's Network Development maintains a centralized spreadsheet for regional transitional coordinators to track the temporary setting where each child or youth is staying each day, in addition to tracking the child and youth placements in the Tennessee Family and Child Tracking System (TFACTS). Management uses the spreadsheet and TFACTS as the two methods to track utilization data, such as the number of children and youth in temporary placements and their length of stay. See **Finding 5** in the **Tennessee Family and Child Tracking System** section to learn more about TFACTS' lack of functionality.

Child and Youth Supervision

The department's "Protocol for Accessing and Working in a Transitional House" requires staff to maintain a youth-to-staff ratio of no more than three children and youth per department staff member and to document their supervisory presence through sign-in and sign-out logs. The protocol also requires a staff member to remain on-site whenever children and youth are present and prohibits contracted sitters and security personnel from supervising children without department staff present.

Incident Reporting

The department's Policy 1.4, "Incident Reporting," and the "Protocol for Accessing and Working in a Transitional House" require staff to document all incidents involving youth in custody, such as safety concerns, behavioral incidents, or property damage, in TFACTS, including details on location, time, and individuals involved.

Results of the Prior Audit

In the department's 2022 performance audit, we reported that Tennessee faced a crisis-level shortage of long-term placement options for foster care homes to meet the needs of children and youth in custody. Because of limited foster care home capacity, we found that children and youth frequently stayed overnight in state office buildings or transitional houses while awaiting permanent placement.

Between April and July 2022, every region had youth spend at least 1 night in temporary settings, with some remaining for extended periods, up to 38 nights in a transitional home

and 24 nights in a state office building. Management required case managers to supervise these children and youth overnight, adding significant strain to an already high workload.

We concluded that the shortage of placements and data limitations impaired the department's ability to plan for and meet the needs of children and youth entering custody. Department management concurred with our prior audit findings.

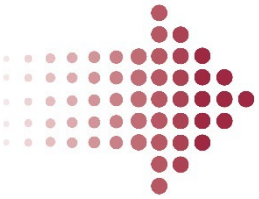
In management's six-month follow-up, the department reported that they were in the process of implementing, or had implemented, several steps from the recommendations in the 2022 performance audit, including the following:

- **Expanded Placement Options**: The department opened 3 enhanced primary assessment homes with 72 total beds and expanded its partnership with the Department of Disability and Aging, and enhanced partnerships to create additional beds with Youth Opportunity Investments, Aspen, Tennessee Strong Homes, and CSI Memphis.
- **Recruitment Progress**: The Every Child TN portal launched as an interactive recruitment and engagement tool to connect potential foster families and community partners.
- **Policy Implementation**: A transitional housing protocol was finalized, setting standards for safety, amenities, and staff ratios in transitional houses.
- **Quality Assurance Measures**: The Office of Continuous Quality Improvement started conducting spot checks of transitional houses, and management developed a reporting process to review and respond to identified issues.
- **Ongoing Collaboration**: The department continued its partnership with Casey Family Programs to analyze placement stability and identify opportunities to strengthen provider capacity and community partnerships.

While the department has worked to increase the network of foster care placements and implemented new policies, contracts, and oversight measures since the 2022 audit, increasing numbers of children and youth with complex behavioral and mental health needs continue to strain available placements and staffing resources.

Current Audit

We focused our review on the department's corrective actions and their progress in implementing internal controls for transitional placements to ensure the required safety and supervision standards were met. We also expanded our work to include the department's monitoring process for transitional placements. See **Finding 4**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.



Repeat Condition and New Conditions

Finding 4: Despite recent improvements, the department has not fully met its oversight responsibilities for hard-to-place children and youth remaining in transitional housing

Following our 2022 audit, the Department of Children's Services (the department) took steps to strengthen oversight of transitional houses. In 2024, it implemented the "Protocol for Accessing and Working in a Transitional House" and directed the Office of Continuous Quality Improvement to conduct a statewide review. The resulting *2024 Transitional House Report* documented one round of site visits per region to check environmental safety elements such as smoke detectors, fire extinguishers, bedding, and hygiene supplies.

Weak Oversight of Transitional Housing

Regional staff focus on day-to-day operations in transitional housing, addressing issues as they arise, but do not systematically monitor incident patterns or ensure long-term compliance. Department management is responsible for maintaining a centralized oversight function to monitor transitional homes for compliance with applicable laws and policies. Following our prior audit, management assigned the statewide review responsibility to the Office of Continuous Quality Improvement (OCQI). We reviewed OCQI's 2024 annual report, issued after its "spot checks" of transitional housing, and found that the report identified no safety concerns at the time of review. However, OCQI does not conduct continuous monitoring to assess long-term compliance or verify that corrective actions are implemented.

Network Development staff track utilization data, such as the number of children and youth in temporary placements and their length of stay, but do not evaluate safety conditions, supervision practices, or compliance with policy. As a result, the department lacks a complete and ongoing view of conditions and compliance within transitional housing settings.

This fragmented oversight structure limits management's visibility into the actual conditions of transitional housing. It prevents the department from identifying recurring problems and ensuring that facilities remain safe and compliant. Without consistent monitoring and accountability, the department risks allowing unsafe or noncompliant practices to persist.

During our site visits conducted between **February 2025** and **April 2025**, we observed the same concerns reported in the prior audit involving the staffing resources needed to supervise the children and youth, and the length of nights a child or youth stayed in temporary settings. We also identified new concerns related to overcrowding; missing or incomplete supervision records; and inconsistent incident reporting, including insufficient staff training on incident reporting.

Overcrowding and Safety Concerns

Our review of transitional housing found **inconsistent operational standards across regions.** Some homes maintained the required safety equipment and stocked hygiene supplies, while others lacked these basic items or were temporarily closed due to unsuitable living conditions. These inconsistencies indicate that the department has not established or enforced uniform safety expectations statewide.

During our visit to the Davidson County Transitional House in February 2025, we observed mattresses on the floor as sleeping spaces, holes in the walls, and graffiti throughout.

In contrast, during our March 2025 visit to the Shelby County Transitional Apartments, we found newly refurbished units that were clean, organized, and equipped with bunk beds and mattresses awaiting occupancy. After the apartments were reoccupied, however, in May 2025, often by more children and youth than the space could safely accommodate, the conditions began to deteriorate. According to the department's centralized tracking sheet, between July 9 and July 24, 2025, the West Region housed between 14 and 21 youth in temporary settings. On the night when 21 youth stayed in a temporary setting, **15 youth were housed in these apartments with only 9 available beds**. These conditions increase the risk of more serious incidents or injuries among children, youth, and staff, as limited space and high occupancy can make it more difficult for staff to provide adequate supervision, respond quickly to behavioral crises, and maintain a safe environment for everyone present.

Missing or Incomplete Supervision Records

Our review of transitional houses found inconsistent documentation practices across regions. We reviewed supervision logs from February 2025 at three transitional homes and found they were often incomplete or missing critical information. These logs record which staff or sitters supervised children and youth and serve as the only record of who was on duty during incidents or emergencies. For two of the transitional houses, we found that the logs were missing names or signatures, making it impossible to verify who was present. For the remaining transitional house, we did not find any issues.

Regional managers explained that frequent staff rotations and the use of contract sitters, assigned across multiple counties, caused many of these gaps. Contracted staff often did not understand the department's documentation standards, especially when filling in on short notice. In one region, staff stored logs in multiple binders without a consistent filing method, making management review difficult.

Although these may appear as administrative errors, incomplete supervision records directly affect safety and accountability. Without accurate logs, management cannot confirm that youth received continuous supervision, assess response times during incidents, or determine who was responsible for children and youth under the department's care. In the event of an investigation, missing documentation would prevent investigators from drawing conclusions about potential neglect, safety issues, or abuse.

Inconsistent Incident Reporting

The department's Policy 1.4, "Incident Reporting," requires staff to document all incidents involving youth in custody, such as safety concerns, behavioral incidents, or property damage, in TFACTS, including details on location, time, and individuals involved.

Our review found that the incident reporting practices were inconsistent across regions. Staff frequently omitted the "resource name"[68] field when entering reports, making it difficult to determine whether the event occurred in transitional houses. To identify locations, we had to manually cross-check incident records against placement information in TFACTS[69] and the centralized tracking spreadsheet. Additionally, on our visit to the Davidson County Transitional House, we found police reports that described incidents for which staff had failed to enter data into TFACTS. These included youth altercations, property damage, and one runaway. Staff stated that some Child Protective Services and Juvenile Justice staff assigned to transitional homes did not understand the reporting process and would receive additional training once the new information system is implemented.

When staff fail to record incidents or omit the location-specific information, the department cannot accurately identify safety trends or assess whether transitional houses are meeting the behavioral and security needs of the children and youth they serve. Incomplete reporting also limits management's ability to evaluate risk, allocate resources, and intervene before problems escalate. (See **Finding 8** in the **Oversight of Facilities** section for a related finding on incident reporting in contracted facilities.)

Overall Effect

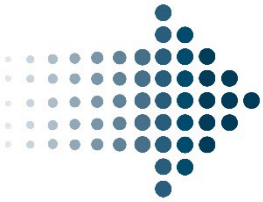
Without ongoing monitoring and consistent documentation,[70] management cannot ensure that transitional housing environments are safe, stable, or appropriately supervised. The

68. The resource name refers to the name of the home or location where the child is placed.
69. In November 2025, the department provided an example from July 2025 of where it began tracking the number of overall incidents reported each week in transitional houses and office buildings. In the next sunset audit, we will review management's new process for tracking incidents in transitional houses and office buildings.
70. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) requires management to establish and maintain effective internal control systems that ensure programs operate efficiently, risks are managed, and objectives are achieved. Under these standards, management must identify, analyze, and respond to risks that could hinder operations (Principle 7) and design and implement control activities through documented policies and procedures to mitigate those risks (Principles 10 and 12). The Green Book further emphasizes that management must perform regular monitoring activities to assess the quality of performance and ensure that identified deficiencies are promptly evaluated and corrected (Principles 16 and 17). In addition, management should communicate essential information internally so that employees understand their responsibilities and carry out required control activities consistently (Principle 14).

lack of oversight leaves management unaware of conditions within these spaces and limits its ability to identify and correct safety or compliance issues in a timely manner.

Incomplete supervision logs and inconsistent incident reporting further weaken accountability and hinder investigations when safety incidents or allegations of misconduct occur. As a result, children may be placed or remain in settings that present increased safety risks, making it difficult for the department to consistently safeguard their welfare and respond to emerging concerns.

See **Observation 6** in the **Strategic Plan and Risk Assessment** section for additional information on risks related to temporary settings that management did not identify in their risk assessment.



Recommendation: The Commissioner should ensure that the department strengthens its oversight and monitoring of transitional housing by establishing a centralized review process that ensures consistent compliance with safety, supervision, and documentation requirements across all regions. Management should require regional staff to complete and regularly review supervision logs, safety checklists, and incident reports, and establish a process for the Office of Continuous Quality Improvement to verify compliance. The department should also provide training to ensure that staff and contracted sitters understand and follow documentation and safety requirements in all transitional settings.

Management's Comment

Management concurs. Transitional settings are used as a last resort, driven by a national shortage of appropriate placements and increasing acuity among children in the care of the department. DCS is implementing structured day-to-day operations to improve safety, services, and stability for youth who remain in these settings.

Privatized residential case managers have been deployed to high-volume transition sites; transition home Program Coordinators oversee daily operations; and behavioral health specialists provide on-site support for higher-acuity youth.

Tennessee Family and Child Tracking System

The Tennessee Family and Child Tracking System (TFACTS), the Department of Children's Services' primary information system, is essential to child welfare operations. TFACTS provides case management by tracking children in custody, initiates the payment process to parents and providers, and maintains children's sensitive medical and personal data. Our first goal was to assess management's progress in addressing functionality issues within TFACTS while management continues to work toward implementing its replacement. Our second goal was to evaluate whether management safeguarded sensitive data. See **Finding 5** and **Observation 2**.

Background

The Department of Children's Services (the department) relies on information systems to support its mission and its critical day-to-day operations. The department's significant information system is the Tennessee Family and Child Tracking System (TFACTS), the statewide child welfare management system implemented in 2010. TFACTS serves as the central location for information about the children and families that the department serves. It supports Child Protective Services, Foster Care, Juvenile Justice, and Adoption programs, and contains records for children in state custody, as well as children at risk of entering state custody. Department staff use TFACTS to document investigations, hotline calls, child placements, and health screenings, while external providers record information about children placed in their care. Department staff also use TFACTS to initiate payments to foster parents, adoptive parents, and private providers.

TFACTS' Replacement – the CCWIS Modernization Project

Because of long-standing issues with TFACTS, management has decided to replace the system with a new system, which will be built on an existing framework that the federal government calls the Comprehensive Child Welfare Information System (CCWIS). Management recognized that TFACTS could not provide the functionality needed to support effective and efficient care for children in custody or at risk of custody. By moving forward with the new system, which the department has not yet named, management aims to equip employees with the automated tools and resources necessary to achieve its goals and improve overall child welfare operations.

The department initiated the project to replace TFACTS in March 2023 by contracting with Ernst & Young (E&Y) to gather and define system requirements for the new system. E&Y worked directly with department management and incorporated feedback from

employees to ensure the requirements reflected both operational needs and solutions to the long-standing challenges the department has with TFACTS. By September 2023, E&Y completed this requirements phase.

In August 2023, the department expanded project support by contracting with KPMG for project management and quality assurance support. KPMG also provided additional assistance with preliminary data cleansing efforts[71] to improve data quality in TFACTS and ensure accurate, consistent information that can be transferred to the new system.

In June 2024, the department and the Department of Finance and Administration's Division of Strategic Technology Solutions (STS) partnered with Deloitte to design, develop, and implement the new system. The department secured Deloitte's services through Tennessee's participation in the National Association of State Procurement Officials cooperative purchasing program. Under the contract, Deloitte is responsible for system development and must also provide a nine-month warranty after implementation to ensure the new system meets the agreed-upon requirements and to address potential defects at no additional cost.

While Deloitte is primarily responsible for building the system, it will also assist the department with the self-assessments required by the federal Administration of Children and Families to certify the system as CCWIS-compliant.[72] Department management and STS will provide project oversight, contribute system requirements during the design phase, conduct system testing, and participate extensively in user acceptance testing.

The department originally set April 2026 as the target go-live date for the new system. To extend testing of the new system and to provide user interface training, the department adjusted the timeline to October 2026. Given the new system's significance to the department's operations, the department will present quarterly status updates to the state's Information Systems Council[73] throughout the project's lifecycle.

At the time of our audit, management's CCWIS Modernization Project to replace TFACTS was underway. The department secured authorization for up to $62 million in federal American Rescue Plan Act funding, which it will receive through reimbursement of eligible expenses incurred through December 31, 2026. The department designated $43.4 million to Deloitte for design, development, and implementation, and set aside another $9.8

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71. According to department management, KPMG's data cleansing support included collaboration with the department and Strategic Technology Solutions to identify problem areas within TFACTS and to then develop solutions to fix those problem areas so that only quality data is moved from TFACTS into the new CCWIS. Part of the data cleansing process involved identifying and correcting duplicate profiles within TFACTS.

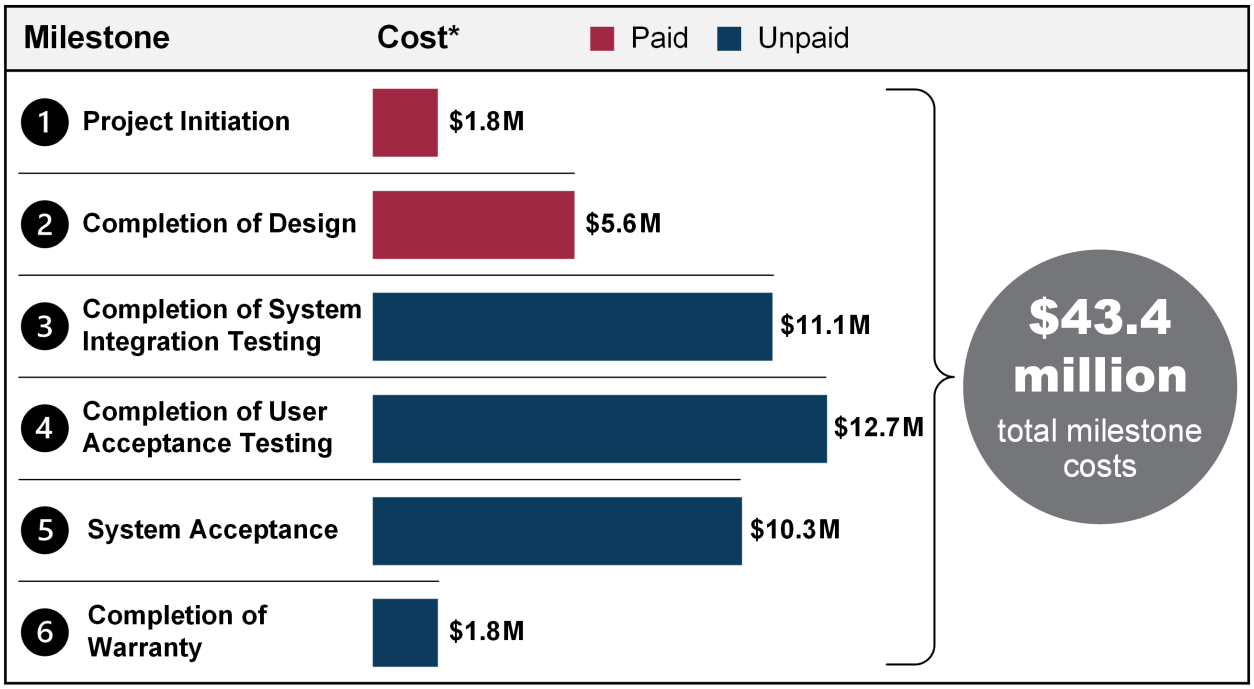
72. The Administration for Children and Families in the U.S. Department of Health and Human Services determines CCWIS-compliant status of state systems.

73. The Information Systems Council is charged with overseeing information technology for the State of Tennessee and developing policies for managing the state's information technology overall.

million for licensing and software. In addition to these federal funds, the department committed $11.2 million in state appropriations for contracts with KPMG to provide project management and data cleansing services. As of November 17, 2025, the department had incurred $12.9 million in reimbursable federal expenses and had paid $8.2 million of the $11.2 million state appropriation to KPMG.

To ensure accountability, the department's contract with Deloitte links payments to the successful completion of specific milestones. The contract permits the department to withhold payments if Deloitte fails to meet expectations. **Figure 24** shows the milestone payment schedule, and **Figure 25** compares budgeted versus actual costs as of October 2025.

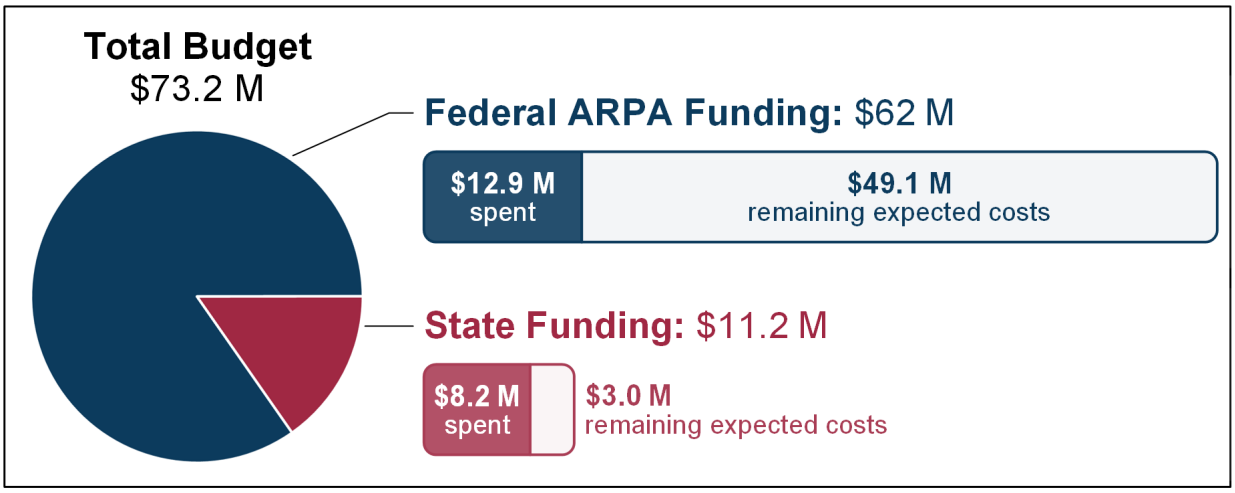
Figure 24: New System Modernization Project Milestone Costs, 2024 to 2026



* Milestone costs are shown in millions, rounded to one decimal place. The (unrounded) total milestone cost is $43,359,442.68. Project milestones do not correspond directly to project phases as described in the section below.

Source: New system project milestone schedule obtained from department management.

Figure 25: New System Modernization Project Budget, 2024 to 2026



Source: New system modernization project budget and payments through October 2025, obtained from department management.

TFACTS Upgrade

The original software vendor for TFACTS stopped supporting this software in 2008, meaning it no longer provided updates or new functionality. As a result, the department struggled to update and modify TFACTS and faced challenges in finding staff with the expertise to work with the obsolete code. To stabilize TFACTS while pursuing a replacement system, the department partnered with STS and CMA to upgrade the outdated software used to build TFACTS.

According to management, the June 2024 upgrade improved the overall security and stability of TFACTS and gave the department greater flexibility to maintain TFACTS until the department implements the CCWIS. Management reported fewer problems with system performance issues after the upgrade. The department reported spending $7.5 million on this software upgrade, funded by a mix of state and federal dollars.[74]

Information Technology Support and Oversight Structure

To operate and maintain TFACTS, the department relies on STS to provide technological infrastructure and day-to-day IT support. STS has direct responsibility for TFACTS, including managing user accounts, maintaining the application's software code, and coordinating with the department to implement functionality changes.

Since TFACTS is integral to the department's operations, the department and STS are responsible for protecting sensitive information and ensuring that the application meets

74. According to management, the TFACTS upgrade to remove the outdated software code included approximately $2 million of state funding and $5.5 of federal funding.

the needs of staff and providers while facilitating all child welfare operations. The state's *Enterprise Information Security Policy* requires the department and STS to maintain controls that safeguard information systems. These controls include general controls—such as access management, change management, and system backups that protect overall system integrity—and application controls embedded in TFACTS that validate data entry, apply business rules correctly, and generate accurate reports. Together, strong information systems controls and system usability are essential to protecting sensitive data and ensuring department leaders, case managers, providers, and other users can efficiently carry out their responsibilities and make informed decisions based on correct and reliable information for Tennessee's most vulnerable children.

Results of the Prior Audit

In the 2022 performance audit report, we reported that the department continued to experience numerous functionality issues with TFACTS even after implementing a major enhancement to the financial component of TFACTS in 2021. These functionality issues included

- non-payments or delayed payments to foster parents and private providers,
- insufficient ad-hoc reporting for department staff and for the department's decision-makers,
- inefficient manual workarounds that resulted from system functionality limitations, and
- system latency concerns contributing to inefficiencies in case management.

The prior audit report recommended that management evaluate the costs and benefits of continuing to update TFACTS until it meets the department's needs or replace TFACTS with a new system.

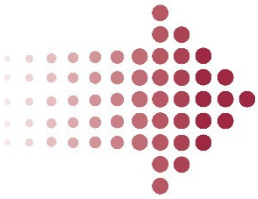
As noted above, department leadership initiated a technology upgrade to stabilize TFACTS and improve security. The department also began a separate project to replace TFACTS with a modernized system that fulfills the department's needs.

In addition, the 2022 performance audit report identified that department management and STS did not provide adequate internal controls in one area, increasing the risk of unauthorized access to sensitive data. In response to this prior audit finding, department management reported to our office that, starting in December 2022, the department collaborated with STS to implement enhanced internal controls in this area to detect and prevent future deficiencies. The nature of this condition is considered confidential, or for limited official use, according to Section 10-7-504(i), *Tennessee Code Annotated*. Therefore, we will not list specific details in this report.

Current Audit

We focused our review on two key areas. For the first area, we assessed management's corrective actions to upgrade TFACTS and reviewed the status of the department's current efforts to replace TFACTS with the new system. We examined the department's plans, timelines, and project budget estimates for the new system. See **Finding 5**.

For the second area, we evaluated whether department management established appropriate internal controls over TFACTS to safeguard sensitive information and to follow up on management's corrective actions to resolve the prior audit finding related to information system controls. See **Observation 2**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.



Repeat Conditions and New Conditions

Finding 5: Management cannot continue to rely on TFACTS as it currently exists, and as such, management must provide constant and consistent oversight of the new system development to avoid repeating TFACTS' history of unmet user needs that impacted critical child welfare operations

Beginning in 2012, our office issued multiple audit reports, including those released in 2014, 2016, 2020, and 2022, that documented recurring weaknesses in TFACTS. These reports identified long-standing functionality issues with TFACTS, including slow speeds, unexpected logouts, and cumbersome processes that hindered casework efficiency.

Follow-up on Prior Audit Finding and Identification of New Conditions

In the current performance audit, we found fewer reported issues with provider payments and system latency. Despite this progress, however, we identified four critical areas where the TFACTS functionality problems have persisted. Two of these areas were also noted in the prior audit. These areas include

- **insufficient ad-hoc reporting** for both users and management to facilitate day-to-day decision-making (**Repeat Condition**);
- **inefficient manual workarounds** that management and staff had to use because the system cannot provide all critical information or timely information case managers need to make informed decisions for the children in their care (**Repeat Condition**);
- **duplicate caregiver and child profiles** that waste staff time, cause errors, and make case records unreliable (**New Condition**); and

- **ineffective processes for limiting access** to children's sensitive and confidential information (**New Condition**).

TFACTS' insufficient ad-hoc **reporting** capabilities caused staff to create some reports manually to fulfill their responsibilities in case management and childcare. As a result, management creates reports outside of TFACTS to track children in the state's care, including reports on the timeliness of child placement and changes in child placement. See **Finding 4** in the **Placements Part 2** section for additional information.

In addition to the insufficient reporting described above, Department of Children's Services (department) management provided other examples of **manual workarounds** they were forced to create due to TFACTS's lack of functionality. These include updating provider waiting lists, monitoring referrals, and documenting provider network development utilization.[75] In some cases, management uses other external software to collect and manage their cases, such as collecting and managing requests for child placements and requesting a Child and Family team meeting[76] decision.

Furthermore, within the context of manual workarounds, the automated Structured Decision-Making Tool in TFACTS does not categorize Child Abuse Hotline reports according to the department's processes and policies. Management stated that ensuring this reporting functionality works as intended is a priority for the new replacement system. See **Observation 1** in the **Child Safety Part 3** section for additional information.

TFACTS did not prevent users from entering **duplicate caregiver and child profiles** for the Relative Caregiver Program. Duplicate profiles waste staff time, increase the risk of decision-making errors, and make case records unreliable. Department management acknowledges these data quality concerns and has contracted with external software vendors to perform data cleansing within TFACTS in preparation for the upcoming CCWIS replacement system.

TFACTS does not have robust capabilities for enforcing **controls over sensitive and confidential documents** that department staff upload into TFACTS. In addition, the department did not sufficiently train staff in the best practices for uploading sensitive and confidential documents into TFACTS. Under 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 department management with detailed

75. According to the department, the Office of Network Development has different teams that review and support intake; placement options (for example, foster home or residential); and provider network development for children.

76. According to the department, a Child and Family Team Meeting is a collaborative planning session with the family, child, and professionals to create a support plan focused on the child's needs and family goals.

information regarding the specific conditions we identified, as well as the related criteria, causes, and our specific recommendations for improvement.

The department has begun working to replace TFACTS with the new system. Until it becomes operational, however, TFACTS remains the department's primary case management system, and its persistent shortcomings continue to jeopardize management's ability to oversee child welfare operations effectively.

New System Project Challenges and Risks

Throughout the new system modernization project, the department has encountered challenges and delays. As department management reported at the March 5 and May 28, 2025, Information Systems Council (ISC) meetings, the department delayed the design phase due to the complexity of system interfaces and the customization required for financial functionality that integrates with the state's centralized accounting system. Management originally established a goal of completing the design phase by December 2024 but moved the target to July 31, 2025, and reported to the ISC on September 10, 2025, that the design phase was completed by the revised target date.

According to management, they are also closely monitoring dates to meet the federal deadline to request reimbursement for American Rescue Plan Act funds by December 31, 2026, and emphasized the importance of staying on track with the project timeline. They also highlighted the risk of insufficient testing and scheduled nearly a year of iterative testing to address that risk. According to management, the department and Deloitte started the first phase of testing, system integration testing, in August 2024. In September 2025, the department started planning user access testing, which will begin April 2026 and will simulate real-world scenarios from start to finish.

While testing functionality is crucial, the department must also ensure that the new system generates and maintains high-quality data. Management acknowledged the historical challenges associated with TFACTS and prioritized data cleansing and conversion throughout the project. To support this effort, the department contracted with vendors and STS staff to perform data cleansing and conversion.[77] The department's goal is to migrate approximately 7 to 10 years of historical data from TFACTS into the new system. Furthermore, the department plans to embed data quality checks into the new system to improve overall data quality, including the detection of potential duplicate records.

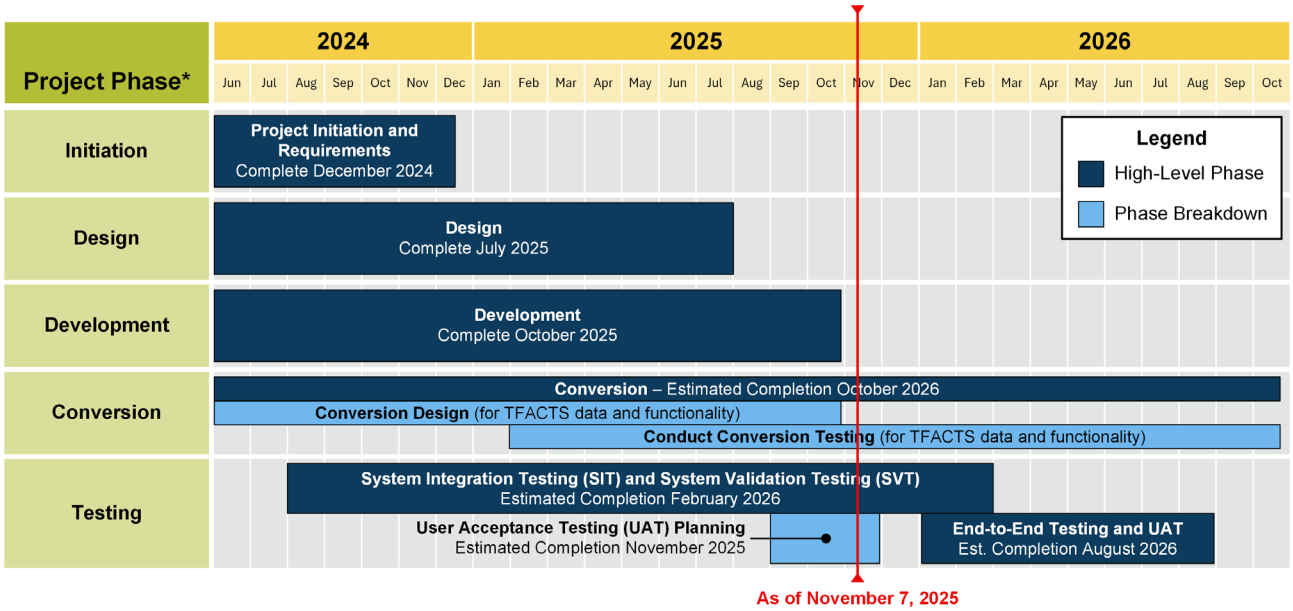
Current Status and Timeline

The department and Deloitte completed the **Initiation, Design,** and **Development** project phases and corresponding payment milestones by November 2025. Data conversion

77. Between August 2023 and July 31, 2025, KPMG provided data cleansing support to the department. Beginning in August 2025, the department has engaged Deloitte to handle ongoing data cleansing efforts.

from TFACTS into the new system started at project initiation and will continue throughout the project lifecycle. Management moved the new system's go-live target from April 2026 to October 2026 because of design delays. The department continues to provide quarterly updates to the state's Information Systems Council. See **Figure 26** for the new system modernization project's phases, timeline, and current status.

Figure 26: New System Modernization Project Timeline



* Project phases do not directly correspond to payment milestones; development and conversion phases do not have payment milestones.

Source: New system timeline provided by department management.

See **Observation 6** in the **Strategic Plan and Risk Assessment** section for additional information on risks related to the implementation of the new information system that management did not identify in their risk assessment.

Recommendation: The department should ensure that its case management systems (TFACTS and the planned new system) meet user needs, provide reliable information, protect sensitive data, and function efficiently to support child welfare operations. Specifically, the department must implement the new system on schedule, within budget, and with the functionality needed to meet user needs. The new system must have the capability and functionality to help

management effectively and efficiently care for children in the department's custody or at risk of custody and to provide the best automated resources and tools for department employees to do their jobs effectively.

To achieve this, the department should continue monitoring project risks, data quality, and vendor performance; ensure that the system's built-in functionality replaces manual workarounds; and provide staff with the training and support needed for accurate and consistent system use. The department should also continue reporting progress to state leaders and communicating with stakeholders to ensure the system ultimately supports the department's mission of protecting children and serving families.

Management's Comment

Management concurs. TFACTS is a legacy system originally built on software that has been discontinued since 2008, which has limited the department's ability to enhance the system for many years.

DCS is retiring TFACTS and implementing a new Comprehensive Child Welfare Information System, C-FIRST!, with a planned go-live in October 2026.

There is ongoing oversight regarding the development of C-FIRST!, including structured design reviews, a Subject Matter Expert (SME) Advisory Committee, and routine risk/schedule reviews.

Observation 2: Beyond the issues noted for TFACTS, department management and Strategic Technology Solutions did not provide adequate internal controls in one specific area

Department of Children's Services (department) 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 or modification of sensitive data. Ineffective implementation and

operation of internal controls increase the likelihood of errors, data loss, and unauthorized access to department information.

Under Standard 9.61 of the U.S. Government Accountability Office's *Government Auditing Standards,* we omitted details from this observation because they are confidential under the provisions of Section 10-7-504(i), *Tennessee Code Annotated*. We provided department 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.

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

Management's Comment

Acknowledge – No management comment required.

Child Health Screenings

Regular medical and dental care, including prevention, diagnosis, and treatment, is essential to restoring and maintaining children's overall health. Early identification of needs through scheduled checkups supports both immediate well-being and long-term development and provides case managers and nurses with the opportunity to spot issues before they become urgent. Our goal was to determine whether management ensured that child health screenings were completed within the required timeframes and that results were entered into the Tennessee Family and Child Tracking System quickly and accurately. See **Finding 6**.

Background

The Department of Children's Services (the department) holds primary responsibility for safeguarding the health and well-being of children in state custody. To carry out this responsibility, the department's Office of Child Health establishes guidance for other department divisions and monitors healthcare services statewide. Case managers and caregivers arrange care for children in custody, and regional health teams, including

nurse consultants, health advocacy staff, and service appeals tracking coordinators, ensure that child health screening results are recorded in the Tennessee Family and Child Tracking System (TFACTS). Because children in custody are enrolled in TennCare Select, the department must also coordinate closely with TennCare[78] and its dental benefits manager to make sure services are available when needed.

Initial and Annual Comprehensive Medical and Dental Screenings

To comply with federal regulations, Department Policy 20.7, "Early Periodic Screening Diagnosis and Treatment Standards (EPSDT),"[79] directs staff to ensure that every child in state custody receives an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical screening to identify health needs. Children must receive an initial medical screening within 30 days of entering custody and an annual medical screening thereafter, following the schedule established by the American Academy of Pediatrics. Each EPSDT medical screening includes seven components:

1. health and developmental history,
2. physical examination,
3. immunizations,
4. laboratory tests,
5. health education,
6. vision screening, and
7. hearing screening.

Department Policy 20.12, "Dental Services," requires children in state custody who are 12 months or older to receive a dental examination within 30 days of entering custody. After the initial exam, children must receive a dental examination every 6 months. If a child has already had a dental exam in the 6 months before entering custody, the 30-day requirement does not apply. A child or youth's dental screening includes the following components:

- medical history;
- oral hygiene and periodontal health exam;
- diagnosis of oral health needs;

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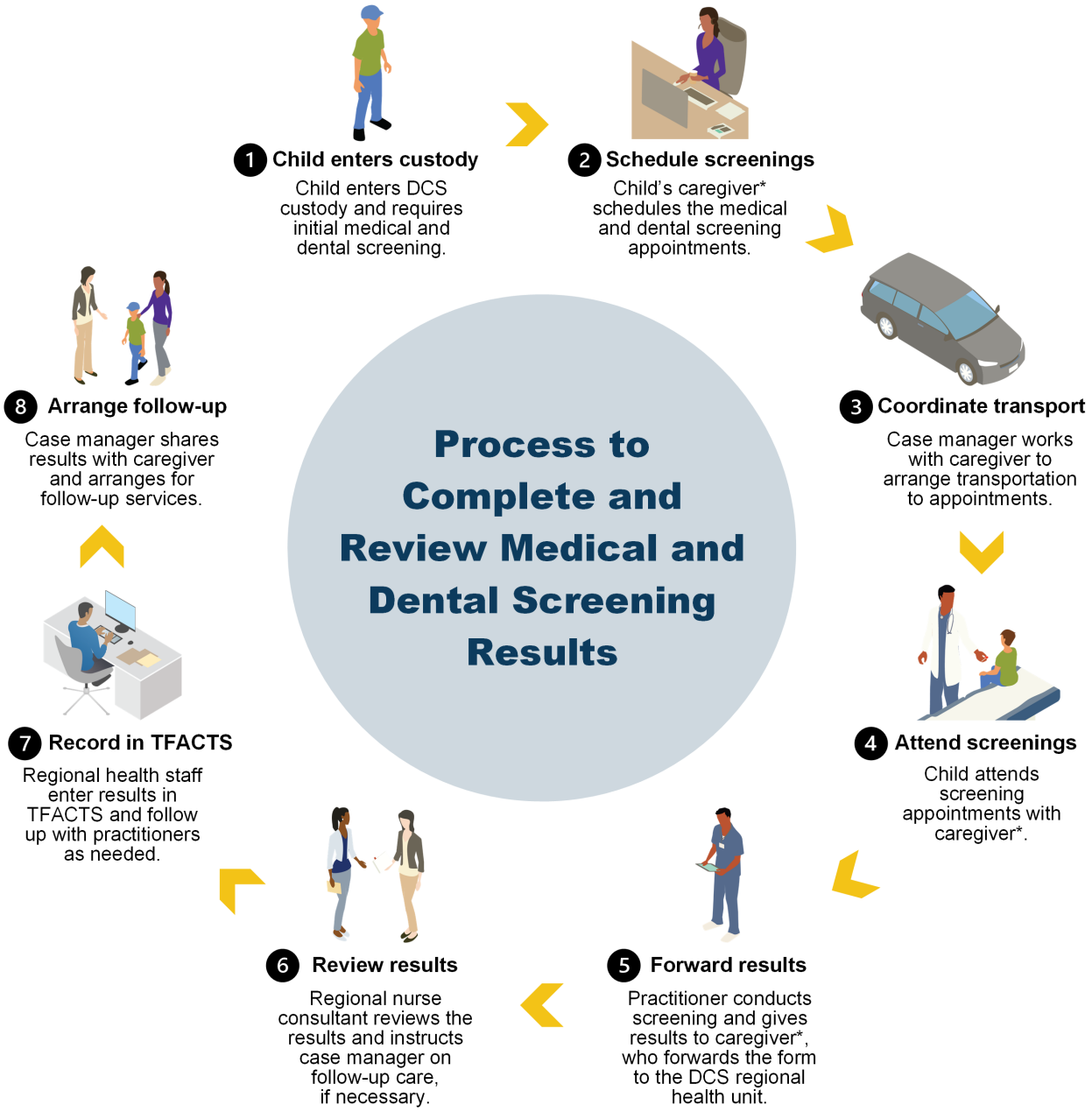
78. Title 42, Chapter IV, Subchapter C, Part 441, Subpart B of the *Code of Federal Regulations* outlines the requirements of each state's Medicaid agency for completing the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of individuals under age 21.
79. The department approved updates to Policy 20.7, "Health Services for Children/Youth in a Custody," in February 2025 that removed the seven components of the "EPSDT" screening and instead refer to it as a "comprehensive medical screening." These changes do not affect our results, which are presented below.

- plan of treatment;
- dental cleaning; and
- diagnostics aids (for example, X-rays, photographs, laboratory tests, and study casts) as needed.

Health Screening Process

The department relies on paper forms to complete and review medical and dental screening results because TFACTS cannot capture this information directly. When a child attends a screening, the adult who accompanies the child must take the correct paper form, ask the practitioner to fill it out, and return the form to the child's case manager. The case manager then forwards the form to the regional nurse, who reviews the information to determine the need for follow-up services. The service appeals tracking (SAT) coordinator then enters the results into TFACTS by hand. See **Figure 27** for a summary of the department's process to complete and review medical and dental screening results.

Figure 27: Process to Complete and Review Medical and Dental Screening Results



* The child's case manager could function as the child's caregiver.
Source: The auditor prepared this figure based on discussions and walkthroughs with management.

Upcoming and Overdue Screenings Report

After the SAT coordinator enters a child's screening data into TFACTS, the system automatically transfers the information into the department's reporting repository, Oracle

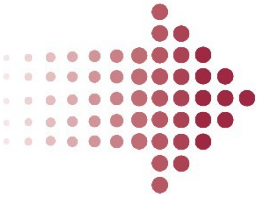
Business Intelligence Enterprise Edition.[80] Family service workers use the repository to obtain screening reports to monitor compliance. By filtering the data for their assigned cases, family service workers can identify which children have upcoming examinations and which have overdue screenings. The department relies on this process to ensure that screenings remain up-to-date until an automated solution can be implemented.

Results of the Prior Audit

In the department's 2022 performance audit report, we found that management did not ensure timely medical and dental screenings for children in custody. The department's continued reliance on paper forms and manual processes created delays in completing, reviewing, and following up on screenings. At that time, we concluded that these weaknesses limited the department's ability to verify whether children received required care on time and to take prompt action when follow-up services were needed. Management's corrective action to address the conditions noted in the finding was to implement an automated solution; however, management later decided not to proceed with adding this automation until the implementation of the new Comprehensive Child Welfare Information System, which will replace TFACTS. See **Finding 5**.

Current Audit

We focused our review on the upcoming and overdue screening reports to determine their accuracy and the reasons for screening delays. Our review resulted in **Finding 6**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.



Repeat Finding

Finding 6: The department continues to experience delays in obtaining medical and dental screenings for children in their care, which increases the risk that children may not receive prompt care for their health needs

As a result of the prior performance audit, management planned to pursue corrective action by initiating efforts to automate their manual health screening processes. Management decided later, however, to revise its original corrective action plan and postponed its plan to automate its processes until it can replace the current system, the Tennessee Family and Child Tracking System (TFACTS), with the new Comprehensive Child Welfare Information System. By postponing, management's continued reliance on

80. The department uses the Oracle Business Intelligence Suite Enterprise Edition system to gather, store, and provide access to TFACTS data.

manual processes leaves the Department of Children's Services (the department) exposed to the same risks identified in the prior audit, limiting its ability to ensure that children in custody receive timely and appropriate healthcare services.

Data Reliability and Oversight Concerns

Because staff must still handle paper forms and manually enter results into TFACTS, screening information remains vulnerable to error and delay. Specifically, information may be

- **lost** before staff upload it into TFACTS;
- **incorrectly keyed into TFACTS**, which reduces the data accuracy and limits the department's ability to monitor compliance; and
- **delayed in reaching the regional nurse consultant**, whose review is critical for determining whether follow-up services are needed.

Our review examined how staff record and track medical and dental screenings based on paper forms completed by healthcare providers. These forms must pass through several steps before the screening results appear in TFACTS. After each screening appointment, the provider fills out a paper form, and the adult accompanying the child must return it to the case manager. Regional nurses then review the documentation to determine whether the child needs follow-up care, and service appeals tracking (SAT) coordinators enter the results into TFACTS.

Department policy[81] requires SAT coordinators to enter screening results into TFACTS within three business days of receiving documentation; however, the department has not set a written timeframe for how quickly documentation must be submitted to the regional health unit. As a result, there may be a delay in entry into TFACTS, which impacts scheduling follow-up services for children.

Contributing Factors that Caused Deficiencies

Additional factors contribute to delays in child health screenings:

- providers frequently delay sending forms, which delays the nurse's review to schedule necessary follow-up appointments; and
- the data from TFACTS used to create the Overdue Screening Report does not accurately reflect whether screenings occurred on time because the reports depend on when staff upload documentation, not just on when the screening occurred.

81. Policy 20.7, "Early Periodic Screening Diagnosis and Treatment Standards (EPSDT)."

Collectively, these manual processes and system issues reduce the accuracy and reliability of the data in TFACTS. These weaknesses limit management's and staff's ability to use upcoming and overdue reports as effective oversight tools and to provide services to meet children's health needs.[82]

Overdue Screening Results

Review of Management's Reports

We reviewed overdue screening reports for calendar year 2024[83] and found consistent noncompliance with required timelines based on the data reported.[84]

Medical Screenings

In the months we reviewed, between 10% and 13% of children had medical screenings that were more than 30 days overdue. Specifically, during January 2024, there were 1,111 children and youth who were waiting at least a month longer than required to receive their medical screening. See **Figure 28** for the population of children with overdue medical screenings in 2024.

82. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book), Principle 14.05, states that "upward communication is necessary for the effective oversight of internal control."
83. We analyzed reports for January through December 2024, with the exception of March and May due to reports not being retained by staff.
84. The Supplement to Policy 20.7, "Protocol for Early Periodic Screening, Diagnosis and Treatment Standards," states "the Initial EPSD&T screening must be completed within thirty (30) days of the child/youth entering custody… and the annual EPSDT screening for children/youth age three (3) years and older must occur within 365 days from the previous screening."

Figure 28: Population of Children with Overdue Medical Screenings in 2024

Month	Total Custodial Youth	Screenings More Than 30 Days Overdue	% of Population
January	**8,717**	**1,111**	**13%**
February	8,709	1,013	12%
April	8,713	877	10%
June	8,747	840	10%
July	8,762	895	10%
August	8,826	875	10%
September	8,839	889	10%
October	8,830	929	11%
November	8,775	962	11%
December	8,669	973	11%
Average	**8,759**	**937**	**11%**

Source: Auditor testwork.

Dental Screenings

In the months we reviewed, between 13% and 19% of children had dental screenings that were more than 30 days overdue. Specifically, during January 2024, there were 1,657 children and youth who were waiting at least a month longer than required to receive their dental screening. See **Figure 29** for the population of children with overdue dental screenings in 2024.

Figure 29: Population of Children with Overdue Dental Screenings in 2024

Month	Total Custodial Youth	Screenings More Than 30 Days Overdue	% of Population
January	**8,717**	**1,657**	**19%**
February	8,709	1,518	17%
April	8,713	1,402	16%
June	8,747	1,440	16%
July	8,762	1,563	18%
August	8,826	1,359	15%
September	8,839	1,166	13%
October	8,830	1,303	15%
November	8,775	1,390	16%
December	8,669	1,359	16%
Average	**8,759**	**1,416**	**16%**

Source: Auditor testwork.

Testwork Results for Overdue Medical and Dental Screenings

We also analyzed the population of screenings reported as more than 30 days overdue during 2024 and used that data to select our test samples. From the total population of children in the department's custody at any point during 2024, there were 10,966 medical screenings and 16,164 dental screenings more than 30 days overdue. From this population, we selected a sample for detailed review, with each sample item representing 1 child who had at least 1 overdue screening. To identify the causes of these delays, we examined the child's case file in TFACTS, focusing on when documentation was received, reviewed, and entered. We found the following:

- **Medical screenings:** We reviewed 30 cases. Staff had not uploaded forms for 12 of 30 children (40%). For the remaining 18 children (60%), **staff uploaded forms on average 106 days after the appointment**.
- **Dental screenings:** We reviewed 27 cases. Staff had not uploaded forms for 10 of 27 children (37%). For the remaining 17 children (63%), **staff uploaded forms on average 37 days after the appointment**.

Because staff did not upload many forms on time—or at all—the department cannot consistently verify whether children received timely medical and dental care or ensure that staff arranged necessary follow-up services.

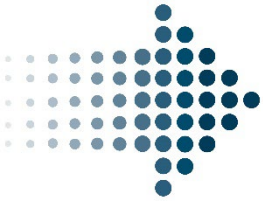
Management's Explanations for Overdue Screenings

Management identified several reasons why screenings were overdue. In some cases, staff could not explain the delay. In others, staff faced challenges obtaining records when children were placed out of state. Foster homes and contract agencies sometimes scheduled appointments late, and healthcare providers occasionally postponed screenings because of limited availability or holiday closures. A few delays resulted from extraordinary circumstances, such as a child preparing for surgery or a safety concern that required law enforcement to transfer the child.

Management also noted that some screenings appeared overdue even when providers completed them on time. For example, screenings completed before a child entered custody showed in the system as late. In other cases, even though screenings were completed, the medical providers had not sent the paperwork; thus, the system could not be updated to reflect the results. Therefore, many screenings appeared overdue because staff received the paper forms weeks or months after the deadline. In the most serious cases, however, staff had no documentation at all, leaving the department unable to verify whether screenings occurred.

Overall, the reasons management provided show that overdue screenings result from a combination of operational inefficiencies, external delays, and documentation challenges.

While some issues are beyond the department's direct control, many stem from weaknesses in tracking, communication, and timeliness of data entry.



Recommendation: Management should strengthen its oversight of medical and dental screenings by implementing clearer timelines, stronger accountability measures, and improved data collection processes. Specifically, management should evaluate the current process for tracking medical and dental screenings to identify where delays happen or information is missing and develop appropriate internal controls. After identifying gaps, management should ensure that the data is reliable and that screenings are completed as required. Finally, management should reduce reliance on paper forms and manual tasks by moving to electronic submission and system-driven reminders, improving both timeliness and consistency.

Management's Comment

Management concurs. The department is addressing delays in medical and dental screenings by examining root causes of workflow, network capacity, and logistics. The Health Unit is completing business-process mapping to inform policy updates which will set clear expectations for case managers, nurses, and health support staff.

In partnership with TennCare, DCS is targeting shortage areas and evaluating access to screenings through Health Departments and mobile dental providers. When the DCS Real Estate Plan is fully implemented, medical and dental facilities will be located in all 9 locations and available to all children and youth entering custody. This will enhance DCS's ability to access and document services timely.

Turnover, Vacancies, Overtime, and Caseload Management

The Department of Children's Services (the department) relies on case managers and investigators as the core of its child welfare operations. These staff members investigate reports of abuse or neglect, arrange and monitor foster care placements, and supervise youth involved with the juvenile justice system. Each child or family served by the department is recorded as a case in the Tennessee Family and Child Tracking System (TFACTS), and supervisors assign those cases to individual case managers or investigators. The number of active cases assigned determines a case manager's or investigator's caseload.

High turnover[85] and vacancies[86] reduce the number of available case managers and investigators, increasing caseloads, disrupting services, and affecting compliance with statutory requirements. Specialized units such as the Special Investigations Unit and Child Protective Services are more sensitive to these impacts due to smaller team sizes and specialized workloads. Our first goal was to determine whether management reduced case manager turnover, vacancy rates, and overtime statewide. Our second goal was to determine whether management ensured that case managers' caseloads did not exceed the state's statutory caseload average of 20 caseloads. Our third goal was to expand our work on turnover, vacancies, and caseloads to determine whether management's actions ensured caseloads were manageable within investigative units. See **Observation 3**.

Background

Department of Children's Services (department) field staff, such as case managers and investigators, are instrumental in carrying out the department's vision to keep children first. Turnover in these positions remains a focus for department leadership. Across Tennessee's 95 counties, thousands of field staff manage caseloads, which includes performing essential child protection work and conducting investigations. Whenever turnover occurs, management must reassign cases and duties until management can hire new employees, increasing workloads and stress among the existing workforce. It can

85. Turnover measures how often employees leave an organization and how often management brings in replacements.

86. A vacancy is a funded (budgeted or authorized) position intended for permanent or fixed-term staff that is currently unfilled due to resignation, termination, hiring delays, transfers, or other causes. The position remains listed in the department's authorized staffing count even while it is unfilled.

take several months for new staff to complete the specialized training required for these roles, which can further impact job satisfaction and staff retention.

Persistent turnover adds pressure on management to maintain adequate staffing levels and service delivery so the department can continue to act in the best interest of Tennessee's children and youth.

Monitoring Turnover and Vacancies

Monitoring turnover and vacancy trends is a key activity that helps management ensure adequate staffing levels, maintain service continuity, and support the department's mission. The department's Human Resources staff monitors turnover and vacancies monthly using staffing data from the state's accounting system, Edison. Human Resources staff also track regional hiring progress to provide leadership with the timely information needed to identify areas with higher turnover, prolonged vacancies, or slower hiring timelines.

Each departure of field staff requires management to advertise the position, screen candidates, and train new employees. These activities increase state costs and place additional strain on remaining staff until management fills vacant positions.

Caseload Requirements

Each child served by the department, whether in custody or at risk of coming into custody, is represented by a case in the Tennessee Family and Child Tracking System (TFACTS), and supervisors assign those cases to individual caseload-carrying field staff, which includes case managers and investigators. The count of a case manager's active cases defines their caseload.

Caseload-carrying field staff perform the day-to-day work that enables the department to serve children and families. Investigators respond to reports of abuse or neglect. Case managers coordinate and track foster care placements and work with youth involved with the juvenile justice system.

The number of open cases decreased from 28,004 in January 2022 to 24,831 in May 2025, a decrease of 11%.

Source: Data obtained from the department's TFACTS system.

Case managers and investigators[87] account for **56%**[88] of the department's total budgeted positions of **3,930**,[89]

87. See **Figures 57** and **58** in **Appendix 10** for a description of case manager and investigator responsibilities.
88. Case managers made up 71% of the department's budgeted positions during fiscal year 2022. Management reclassified case manager positions that were not carrying cases to other positions. The department completed these reclassifications in 2024, resulting in a reduction of 550 case manager positions. We did not include Clerk and Account Clerk positions as they do not always carry cases.
89. Total budgeted position count as of June 30, 2025.

and they typically work in 1 of 3 offices: Child Programs,[90] Child Safety, or Juvenile Justice.

To ensure that the workload remains manageable, statute sets limits on the number of cases that caseload-carrying staff should have. Section 37-5-132(a) (1)(2), *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.

Department Policy 31.7, "Caseload Assignment for DCS Employees," defines caseload limits based on the experience of case managers and other caseload-carrying staff. These limits state that supervisors should not assign newly hired case managers as many cases as experienced case managers. Specifically, during training, supervisors should not assign new case managers more than 5 cases for their first 6 months and no more than 10 cases for the remainder of their first year. If the new employee has experience in case management from prior employment, management can grant a waiver, allowing a full caseload of 20.

National organizations recommend more conservative standards than Tennessee's statutory requirements. The Council on Accreditation,[91] which accredits the department, advises that case managers should carry between 10 and 15 cases, depending on the intensity of services required. These standards emphasize the number of cases assigned to each individual worker. In contrast, Tennessee statute measures caseloads by regional averages. As a result, some workers may carry far more than 15 cases, while others carry fewer, as long as the average complies with the law.

Monitoring Caseload Compliance

The department tracks caseloads using a statewide reporting tool[92] that extracts data from TFACTS and organizes it into a reportable format. Staff in the Office of Data Governance and Analytics then generate reports from those extracts that show the

90. As of March 2025, the department's reorganization moved Child Programs under Regional Operations, except for foster care support.
91. The department is accredited by the Council on Accreditation (COA) to demonstrate commitment to quality assurance, professionalism, and continuous improvement. COA standards inform department policies and processes, including service delivery, administration, and client rights.
92. The Oracle Business Intelligence Suite Enterprise Edition system. The department uses this platform to gather, store, and provide access to TFACTS data.

average number of cases per case manager, broken down by region and program area. These reports allow administrators to compare staffing levels across the state and monitor whether each region complies with statutory requirements. According to management, they use the reports to identify areas with rising caseloads, evaluate trends, and direct resources where they are most needed, to support compliance with Section 37-5-132, *Tennessee Code Annotated*.

Results of the Prior Audit

In the department's 2022 performance audit, we reported that the department faced a staffing crisis. Turnover and vacancies among case managers had risen to unprecedented levels, and the department did not maintain compliance with statutory caseload requirements under Section 37-5-132, *Tennessee Code Annotated*. In fiscal year 2022, the statewide turnover rate for case managers was 56%, with Davidson County's rate reaching 127%. At the same time, nearly 22% of case manager positions across the state remained vacant. These shortages left remaining staff overworked and contributed to caseload averages well above the statutory limit of 20 cases in many regions.

Management concurred with the finding and outlined several corrective measures focused on compensation, workload reduction, and targeted staffing support. The department proposed

- increasing starting salaries for case managers to $43,992 per year,
- creating a new hire policy that caps first-year caseloads at no more than 10 cases at a time,
- requesting a budget increase for fiscal year 2024 for $30.8 million for increasing provider rates to improve capacity for the placement of children,
- increasing rates for sitter services to $45/hour to attract more sitters to reduce the number of case managers who are sitting with youth after hours and on weekends,
- creating and posting Case Manager Assistant positions to assist with administrative tasks, and
- implementing a new onboarding training curriculum for new hires.

At the 6-month follow-up, management reported that they increased case manager starting salaries to $50,600, which was 15% higher than originally anticipated. They also reported that they implemented the new onboarding training curriculum for new hires. The department implemented a new policy, capping first-year case manager caseloads at 10, which went into effect on March 1, 2023. Finally, they identified that they were able to implement the remaining corrective action steps of increasing provider rates, increasing sitter rates, and creating and advertising Case Manager Assistant positions.

In the 2022 performance audit report, we also noted that case managers in the Davidson Region carried average caseloads of 41.6 and 41.5 cases in January and May 2022, respectively. Individual case managers carried even heavier workloads, with some responsible for more than 100 cases at one time. Case managers identified long hours, extensive overtime, and personal safety concerns during overnight supervision and home visits as reasons for leaving their positions. Case managers also stated that low pay and limited opportunities for salary increases worsened the problem.

Management concurred with the finding and outlined several corrective measures focused on reducing turnover, improving workforce capacity, and stabilizing caseloads across the state. These measures included increasing compensation, strengthening workload controls for new staff, expanding placement and support resources, and enhancing case management processes. Specifically, the department's corrective action plan included

- submitting a two-year budget request totaling $11.4 million to fund privatized case management services in regions with persistent staffing shortages;
- creating a Special Response Team[93] of six experienced case managers in the Office of Child Safety to assist with case management tasks and reduce caseloads in hard-hit areas;
- initiating second-shift teams in Davidson, Rutherford, and Montgomery Counties to provide after-hours coverage in high-volume regions;
- hiring a consultant to review case management workflow and identify opportunities for improved efficiency; and
- implementing a new hire policy that caps first-year caseloads at no more than 10 cases at a time.

At the 6-month follow-up, management reported that it had completed most of the planned corrective actions intended to stabilize staffing and reduce caseload pressures. The department received approval for a two-year, $11.4 million budget to fund privatized case management services beginning in July 2023. It created a Special Response Team of 6 experienced case managers in January 2023, which worked 927 cases across multiple regions by mid-year. The department also deployed second-shift teams in Davidson, Rutherford, and Montgomery Counties in February 2023 to provide after-hours coverage, assisting in 545 cases through the end of the review period. A new hire policy capping first-year caseloads at 10 cases became effective March 1, 2023, and management indicated support for legislative caseload caps planned for 2024. In addition, the

93. According to the department's fiscal year 2022–2023 annual report, the Special Response Team is a team that the department mobilized to assist counties that are experiencing the highest caseloads and vacancies. This team responds to Child Protective Services cases and conducts investigative tasks.

department conducted 6 surge events that resulted in the closure of more than 600 cases, and the department identified a consultant to review case management workflow, with work scheduled to begin by September 30, 2023. For more information, see the 2025 Department Reorganization information in the **Background** of this report.

Current Audit

We focused our review on the department's progress in addressing turnover, vacancies, overtime, and caseloads to determine whether management improved turnover and vacancy rates, reduced overtime hours for the case managers, and met caseload requirements. We also expanded our work to review turnover, vacancies, and caseloads for specialized units within the department. Our review resulted in **Observation 3**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.

Observation 3: Management has reduced vacancy and turnover rates since 2023; however, establishing clear benchmarks for turnover, vacancy, and overtime among case managers and investigative staff would enhance management's ability to identify and respond early to staffing challenges and increasing caseloads

Maintaining adequate staffing levels is essential for the Department of Children's Services (the department) to achieve its mission of protecting children and supporting families. High vacancy rates can reduce the department's capacity to manage caseloads effectively, delay service delivery, and increase workload for remaining staff. Sustained vacancies can also undermine morale and contribute to further turnover, creating a cycle that strains both staff and program outcomes. Addressing vacancy rates is therefore not only a workforce management issue but a critical component of operational effectiveness and child safety.

Improvement in Case Manager Turnover, Vacancy, and Overtime Rates

In our previous audit, we reported that high turnover and vacancy rates limited the department's ability to manage caseloads effectively. Since that time, management implemented several corrective actions that reduced both turnover and vacancy rates to improved levels in fiscal year 2024. In fiscal year 2024, management lowered turnover to

18%, which is consistent with the national average[94] for state and local governments, and reduced vacancies to 9%.

Management also cited Casey Family Programs'[95] August 2023 brief, which estimated national turnover among child welfare case managers at approximately 30% prior to the COVID-19 pandemic. The brief notes that variation in turnover rates across jurisdictions reflects differences in how agencies calculate turnover, making consistent comparison and interpretation difficult. Casey Family Programs emphasized that without accurate measurement, agencies cannot effectively address or track turnover trends over time.

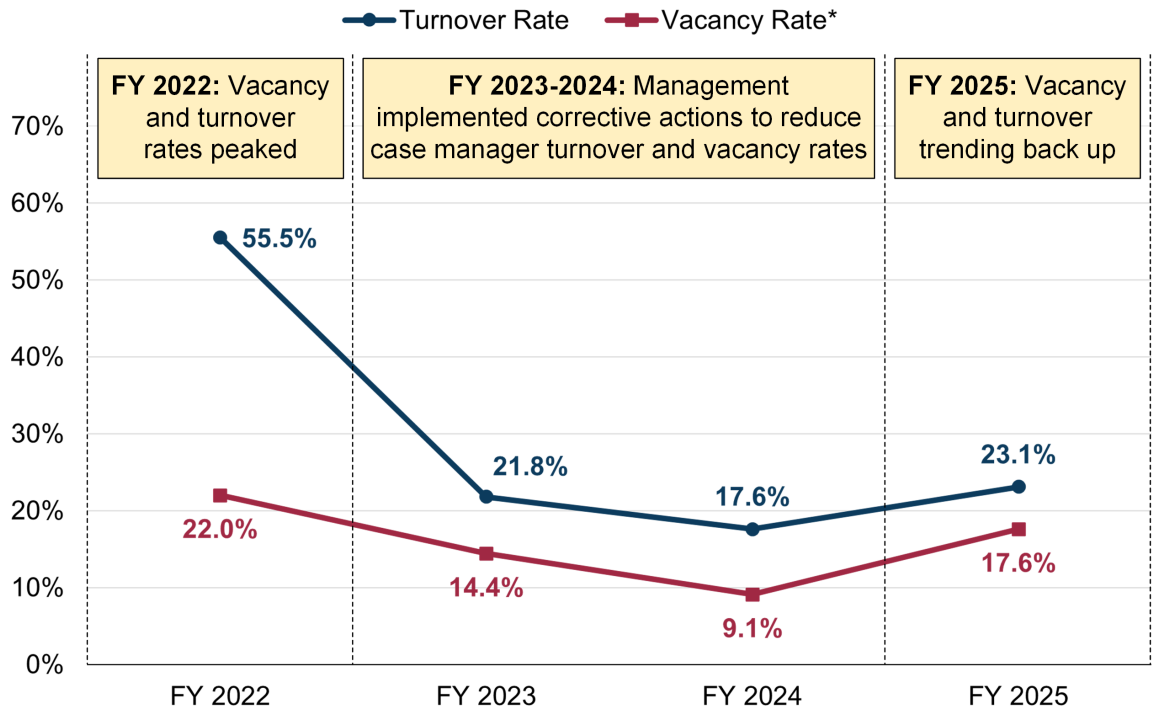
Although the department's turnover, vacancy, and overtime rates for fiscal year 2024 represent improvement compared to external averages, management has not established formal internal benchmarks to define manageable turnover or vacancy rates for the department or any of its individual units. The absence of such benchmarks limits management's ability to measure progress objectively, assess workforce risk, and evaluate the effectiveness of corrective actions over time. According to the U.S. Government Accountability Office, *Standards for Internal Control in the Federal Government* (Green Book), Principle 10.04, management of human capital requires agencies to recruit, develop, and retain competent personnel to achieve organizational objectives, which includes maintaining sufficient staffing levels and monitoring workforce data to identify and address emerging turnover risks.

Upward Trend of Case Manager Turnover, Vacancies, and Overtime

The inherently stressful nature of case management work continues to present challenges for workforce stability. Our current review found that the department did not sustain these improvements in fiscal year 2025, as both turnover and vacancy metrics began trending upward again. See **Figure 30**. Additionally, overtime trends demonstrated a growing strain on staff capacity. During this time, **86% of case managers worked overtime,** compared to 58% the previous year. Although median[96] overtime hours decreased to 12.1 per month, a larger percentage of staff worked overtime, showing that more employees carried added responsibilities, even if individual totals were lower. (See **Appendix 9** for detailed data on turnover, vacancies, and overtime hours.)

94. According to the U.S. Bureau of Labor Statistics, the average turnover for state and local governments, excluding education, for calendar years 2023 and 2024 was 18%.
95. Casey Family Programs is a foundation focused on safely reducing the need for foster care in the United States. See the brief here: https://www.casey.org/turnover-costs-and-retention-strategies/.
96. The middle value when all data points are arranged from lowest to highest.

Figure 30: Case Manager Turnover and Vacancy Rates by Fiscal Year (FY), 2022 to 2025



* Vacancy rates are measured as of July of each fiscal year.
Source: Auditor analysis of vacancy and turnover data for the department's case manager job series from Edison.

Impact of Investigators' Turnover and Vacancies on Caseloads

Caseload-carrying staff[97] in the **Special Investigations Unit** and **Child Protective Services** face unique challenges that affect their capacity to meet operational demands. We expanded our review to include turnover, vacancies, and caseloads in these units[98] and assessed the impact on their operations.

Special Investigations Unit

The **Special Investigations Unit** (SIU) investigates child abuse and neglect in situations involving custodial youths or by authority figures like teachers, coaches, or daycare workers. In the first half of 2025, turnover and vacancies spiked within the unit.

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97. For our analysis, we included the case manager series 1-4 and the investigator series 1-3 to calculate turnover and vacancy rates for Child Protective Services. Since there were so few positions within the Special Investigations Unit, we included all positions in our analysis of turnover and vacancies.
98. For the entirety of our review period, we used department-identified codes to separate Special Investigations Unit positions from Child Protective Services positions, allowing us to analyze each population separately.

Because SIU averages only 48 filled positions statewide, staffing losses have had a magnified impact on its operations. In 2025, SIU experienced a **turnover rate of 21.5%**. Additionally, SIU had a **vacancy rate of 31.3%**, resulting from both employee turnover and the creation of new positions[99] that had not yet been filled at the time of our review. This left the unit with fewer personnel to carry out specialized investigations. According to management, in September 2025, SIU had not yet filled approximately half its case manager positions. Turnover within the unit and vacant positions contributed to an increase in caseload averages among remaining staff. This redistribution of work contributed to rising caseloads across the unit in the first 5 months of 2025, reaching an average of **28 cases per investigator** by May. Management also reported that staffing losses required supervisors to carry active caseloads, leaving them with less time to perform routine oversight and quality assurance functions. These conditions contribute to an increased risk of delayed or incomplete investigations.

Child Protective Services

Child Protective Services (CPS), which investigates allegations of child abuse and neglect of non-custodial youth by someone responsible for their care (such as a parent, guardian, or family member), had turnover and vacancy rates generally consistent with statewide averages in fiscal year 2024, but these rates began to trend upward in fiscal year 2025. In 2025, CPS had a **turnover rate of 23.3%** and a **vacancy rate of 20.3%**.[100] Some CPS regions' caseloads were impacted more than others. The Davidson Region continued to report higher caseloads than other regions, consistent with turnover and vacancy conditions noted in the previous audit.

In March 2025,[101] the department combined the Davidson Region with 13 other counties[102] to form the new Mid State Region, which, according to management, continues to see elevated turnover and vacancy rates due to challenges within Davidson County. Prior to the reorganization, caseloads in the previous Davidson, East Tennessee, Mid Cumberland, and South-Central Regions averaged between 20 and 35 cases per case manager. After the reorganization, caseloads for the new regions remained under 20, except for the Mid State Region, which exceeded the statutory requirement. These averages have risen steadily since March 2025, indicating that staffing shortages are driving heavier workloads in this region and increasing operational risk. See **Figures 31** and **32**.

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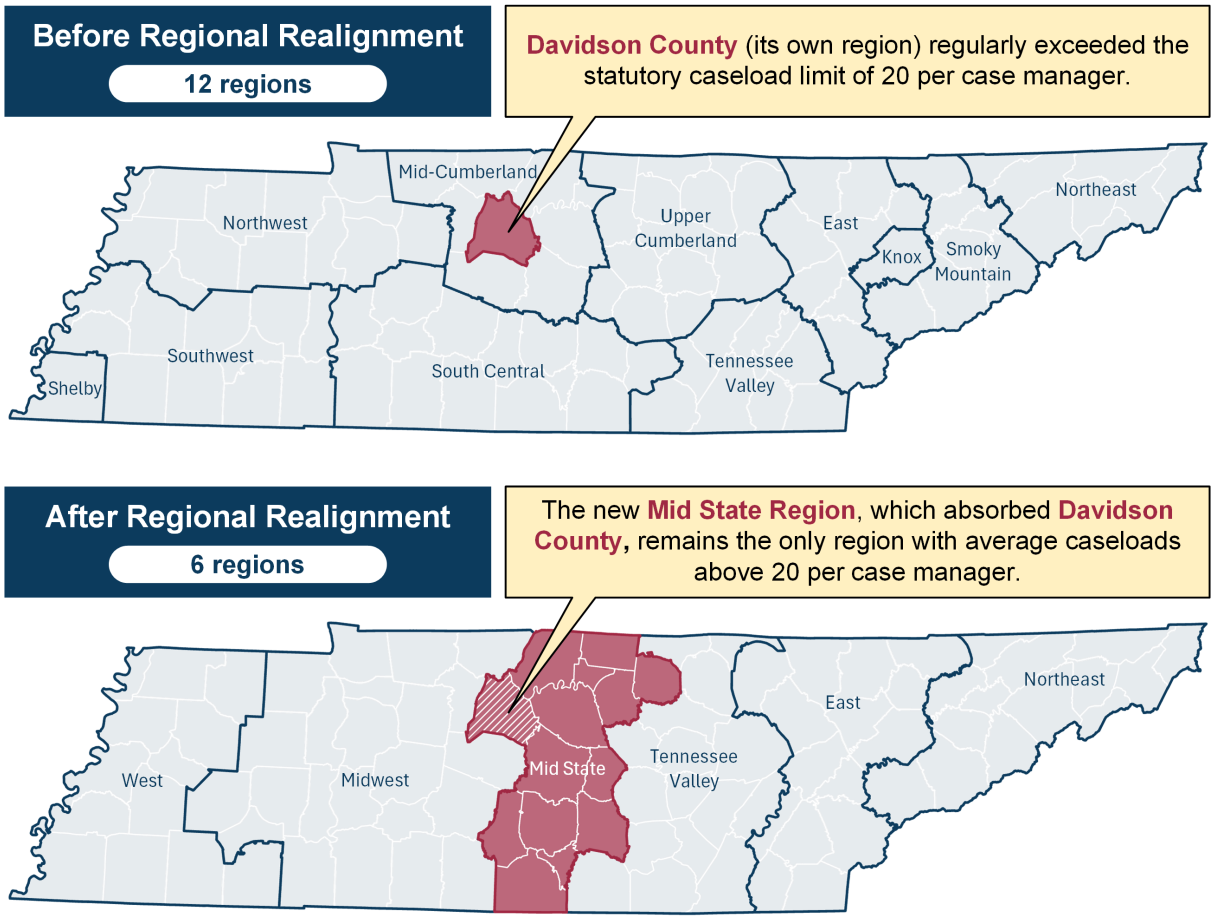
99. The department added 12 positions within SIU between July 1, 2024, and June 30, 2025.
100. We did not calculate the regional-level CPS turnover and vacancy rate for fiscal year 2025 due to management's change in Edison, which removed region-specific codes as part of the department's reorganization.
101. See the 2025 Department Reorganization in the **Background** for information on the department's reorganization.
102. In March 2025, the department combined Sumner, Macon, Trousdale, Jackson, Smith, Wilson, Rutherford, Cannon, Coffee, Bedford, Marshall, Moore, and Lincoln counties with Davidson to form the new Mid State Region.

Figure 31: Child Protective Services' Caseload Averages by Region

Region	Regional Caseload Averages as of Date*				
	3/3/2025	3/17/2025	4/1/2025	4/15/2025	5/1/2025
East Region	15.2	16.6	15.0	18.4	16.9
Mid State Region	**23.8**	**24.9**	**24.6**	**28.5**	**28.2**
Midwest Region	21.8	21.7	17.7	19.8	18.7
Northeast Region	14.1	16.3	14.0	17.0	15.3
TN Valley Region	15.5	17.7	16.5	19.8	18.4
West Region	15.4	17.6	16.7	18.9	16.9
Statewide	17.7	19.3	17.6	20.5	19.2

* The department calculates caseload averages at biweekly intervals.
Source: Data from the department's Office of Data Governance and Analytics.

Figure 32: March 2025 Region Realignment



Source: Auditor created based on the department's region reorganization.

According to department management, persistent vacancies in the Mid State Region, particularly in Davidson, Coffee, Bedford, and Rutherford Counties, have contributed to these higher caseloads, which could impact the timeliness and thoroughness of child abuse and neglect investigations.

Turnover in Focus

We identified several factors that contributed to the increase in turnover during fiscal year 2025. Department staff responding to our employee survey identified concerns with the ongoing overnight[103] supervision requirements and safety risks in those settings, and challenges associated with the March 2025 reorganization.[104]

Employee comments described day-to-day conditions that elevate turnover risk. Respondents most often cited overnight "sitting" assignments and extended shifts as the primary source of strain. They reported safety concerns in transitional settings, fatigue from consecutive work and sitting shifts, and reduced time for core casework. Many explained that management added sitting assignments to their caseloads while limiting overtime, which they viewed as creating unsustainable schedules, missed deadlines, and diminished work-life balance. Others described longer transport requirements and irregular hours following the 2025 reorganization. Overall, themes of **safety, workload, overtime restrictions, and reorganization-related disruption** dominated the open-ended responses.

Some respondents, however, noted signs of progress. They highlighted pay adjustments, reduced caseloads in certain offices, and supportive immediate supervisors. Several expressed optimism that new initiatives, such as clearer role specialization and ongoing facility and real estate planning, could ease workload pressures over time. Many also recommended creating dedicated staff positions for transitional housing supervision so that case managers can focus on core casework responsibilities, describing this as a practical step to stabilize workloads and improve retention.

Management Explanations and Future Planned Actions

Management acknowledged that these factors contributed to higher turnover in fiscal year 2025 and outlined several steps to address them. They have goals to

- increase the number of case manager hiring classes,
- reduce reliance on caseload-carrying staff having to sit in transitional settings, and

103. This means "sitting" with children and youth in transitional settings. See the **Placements Part 1** section for information on this supervision requirement.
104. See the 2025 Department Reorganization in the **Background** for information on the department's reorganization.

- launch targeted training and leadership development for supervisors.

In addition, Department of Human Resources leadership is developing plans for new policies for bonuses and incentives in high-turnover areas. The department will review these policies and submit a proposal to the Department of Human Resources that must be approved by the Department of Human Resources, the Department of Finance and Administration, and the Governor's Office. According to the Deputy Commissioner of Regional Operations, the department intends these efforts to reduce the pressures staff identified, improve organizational culture, and strengthen staff retention across the department.

Overall Effect of Turnover and Vacancies on Caseloads

While management monitors turnover and vacancies and uses industry averages as a general benchmark, the department has not established internal thresholds that define manageable risk levels. Without unit-specific benchmarks, particularly for specialized or high-workload units, the department cannot fully assess when staffing losses pose a risk to operations.

Turnover and vacancies directly affect caseloads, which in turn influence the department's ability to maintain timely, effective services. When positions remain unfilled, caseloads for remaining staff increase, extending investigation and case-management timelines, and reducing staff availability to respond to new referrals. In regions with higher turnover and vacancies, remaining staff often carry heavier workloads, demonstrating how staff shortages at the local level can strain operations even when statewide averages remain compliant.

While management has made progress in reducing turnover, vacancies, and caseloads since the prior audit, opportunities for further improvement remain in certain regions and divisions. Management has acknowledged that turnover, vacancies, and caseload pressures contribute to several other issues discussed in this report (see **Findings 1**, **2**, and **3**). Continued progress will depend on establishing clear performance benchmarks, regularly monitoring unit-level data, and implementing targeted interventions in areas where caseload pressures remain the highest.

As identified in the department's **Mission Challenge** and **Finding 4**, certain children and youth present greater placement challenges. The limited availability of specialized placement options, combined with an increasing number of youth with complex needs, has resulted in case managers relying on transitional settings more frequently. To effectively address this issue, the department must continue fostering trust and open communication with staff who have expressed growing concerns. Supporting and investing in staff well-being is essential to maintain manageable turnover and vacancy levels, stabilize the workforce, and achieve better outcomes for the children and youth the department serves.

The Commissioner and Deputy Commissioners of the Offices of Continuous Quality Improvement, Regional Operations, and Statewide Services should continue efforts to address turnover and vacancies and develop department-specific risk tolerance levels for both measures. Establishing defined thresholds would help management identify emerging workforce pressures early, monitor how staffing shortages contribute to higher caseloads, and reduce strain on remaining staff so that investigations and child safety responses occur promptly and consistently. Strengthening these internal controls will enhance the department's ability to maintain workforce stability and fulfill its mission to protect children and support families.

Management's Comment

Management concurs.

Relative Caregiver Program

Relatives who care for children when parents are unable to do so serve as a critical safety net, preventing many children from entering state custody. To strengthen support for these families, the Tennessee General Assembly established the Relative Caregiver Program. In 2023, recognizing the financial challenges these caregivers face, the General Assembly expanded the program to include monthly stipends equal to half the foster care board rate.

Our first goal was to review management processes to determine whether the Department of Children's Services ensured that it made stipend payments only to eligible relative caregivers. Our second goal was to determine whether stipend payments were timely and accurate. Our third goal was to determine whether management developed a centralized process to track and prioritize caregiver waitlists for the program and stipend. See **Finding 7**, **Observation 4**, and the **Matter for Consideration**.

Background

History of the Relative Caregiver Program

The Tennessee General Assembly created the Relative Caregiver Program in 2000 to help families care for children whose parents could not and prevent those children from

entering state custody.[105] The program was designed to provide a range of support services to families, including emergency financial assistance, support groups, parenting education, and connections to community resources like counseling and respite care.

Tennessee lawmakers passed legislation that authorized monthly stipends for eligible relative caregivers, which became effective on January 1, 2023.[106] The stipends equal half the foster care board rate and provide ongoing financial assistance to help caregivers meet the costs of raising children outside of state custody.

In 2024,[107] the General Assembly also expanded stipend eligibility for the program by removing income limits and expanded the court-ordered relative caregivers who can participate. These changes recognized the growing role that relatives play in keeping children safe and stable while reducing the number of children entering state custody.

Through these expansions, the General Assembly and the Department of Children's Services (the department) have strengthened Tennessee's support network for families, helping more children remain in familiar, nurturing homes.

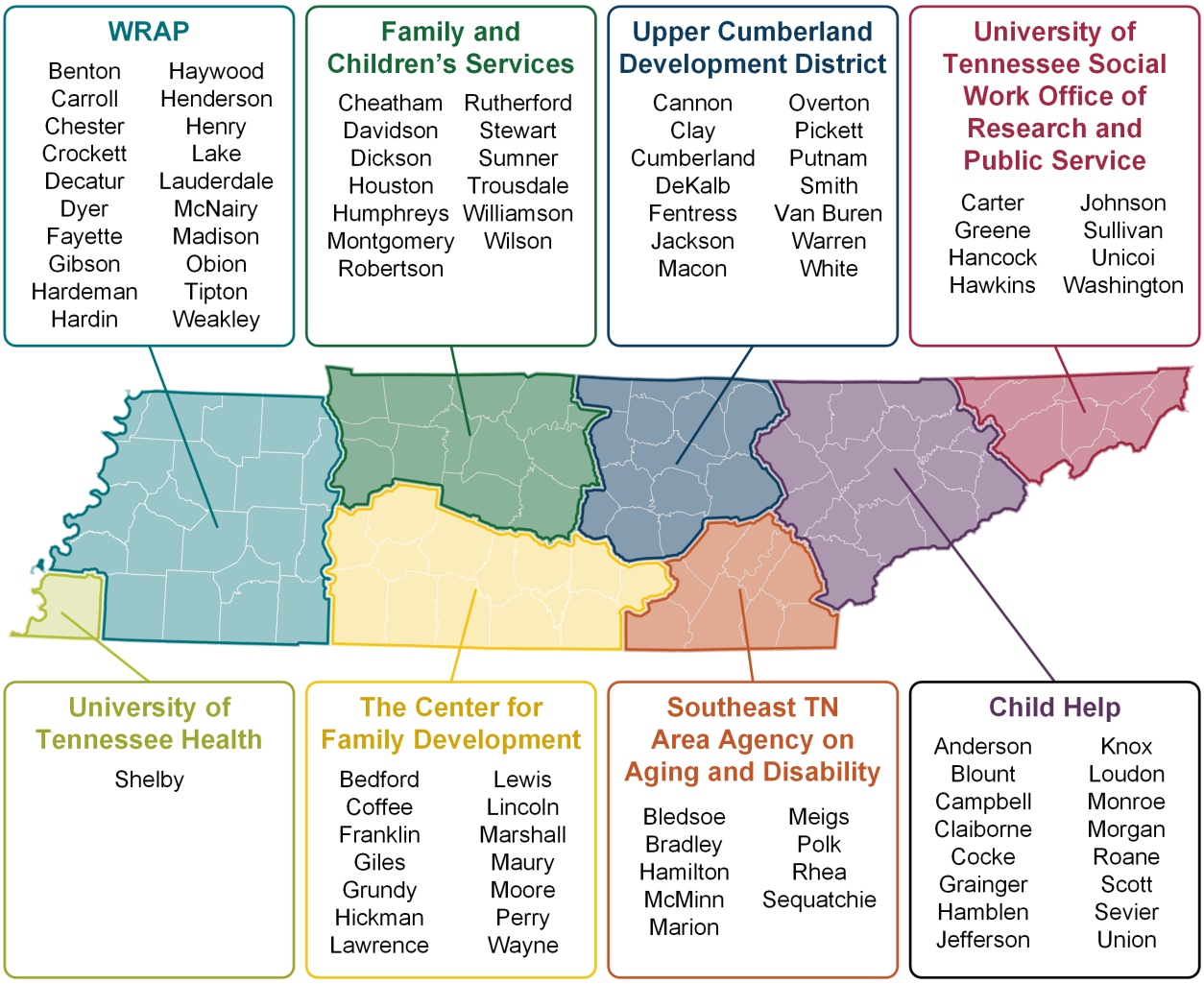
Program Administration and Funding

The department administers the Relative Caregiver Program through contracts with eight community-based providers across the state. These providers deliver a range of supportive services, including short-term case management, caregiver support groups, parenting and educational workshops, and referrals to resources such as TennCare, the Supplemental Nutrition Assistance Program (SNAP), and other community assistance programs. Providers may also offer limited financial assistance[108] to help caregivers address immediate needs that support family stability.

Figure 33 shows the current Relative Caregiver Program providers statewide.

105. Public Chapter 989 of the 101st General Assembly created the Relative Caregiver Program.
106. Section 37-2-422, *Tennessee Code Annotated*.
107. Public Chapter 574 of the Tennessee 113th General Assembly took effect on July 1, 2024.
108. These are typically one-time payments for things like clothing, food, or utilities to help families and are different from the monthly stipend payments.

Figure 33: Relative Caregiver Provider Agencies and Service Areas



Source: Relative Caregiver Program regional map obtained from department management.

According to the department's Assistant Commissioner of Finance and Budget, the Relative Caregiver Program operates with an **annual budget of approximately $32 million**. Of this amount, the department allocates about $19 million for monthly stipend payments to eligible caregivers and $13 million for contracts with community-based providers.

In 2024, the department paid $18,561,595 in stipend payments directly to relative caregivers for the care of 2,825 children.

Source: The department's Relative Caregiver Stipend Program Annual Report 2024.

The program receives its funding entirely through state appropriations. The 2023 expansion, which introduced monthly stipends, required additional state funding to cover direct caregiver payments. The department manages the distribution of these stipend payments, while contracted providers verify eligibility and submit approved cases for payment processing. Through this funding and administrative

structure, the department maintains accountability for overall program oversight and fiscal management, while leveraging local provider networks to deliver services more efficiently and responsively to families across Tennessee.

Program and Stipend Eligibility Requirements

Relative Caregiver Program

Department Rule 0250-07-14-.03(1), *Rules of the Tennessee Department of Children's Services*, Social Services Division, Relative Caregiver Program, sets the following eligibility guidelines for participation in the Relative Caregiver Program:

- the child must reside in the home of the relative caregiver through court order, power of attorney, or informal agreement with the parents;
- the relative caregiver must be willing to take part in a needs assessment;
- the caregiver must agree to accept needed support services through the program;
- the caregiver must be able to provide a safe home and be committed to providing the home as long as necessary and appropriate;
- a parent of the child may not reside in the home of the relative caregiver;
- the relative caregiver must be within the first, second, or third degree of relationship to the parent or stepparent of the child through blood, marriage, or adoption; and
- the relative caregiver family must not be receiving any type of department kinship payment or subsidy.

Stipend Program

In 2023, the Relative Caregiver Program expanded to include monthly stipends for families who met statutory requirements. If a relative caregiver wants to participate in the Stipend Program as well, they must meet all six statutory requirements outlined in Section 37-2-422, *Tennessee Code Annotated:*

(1) The child is not in state custody;

(2) The relative caregiver is twenty-one (21) years of age or older;

(3) The relative caregiver has been awarded custody of the child by an order of the court;

(4) A parent of the child does not reside in the relative caregiver's home;

(5) The relative caregiver agrees to cooperate with any child support proceedings initiated by the department of human services, including providing information relative to the establishment of paternity, if known; and

(6) The relative caregiver and the child meet all other requirements as prescribed by rules promulgated by the department.

The original statute required relative caregivers to have household incomes below a specified threshold to qualify for the stipend. Effective July 1, 2024, the General Assembly removed the income requirement to expand access to financial support for families who care for children outside of state custody. The stipends equal half the foster care board rate.

The department and its contracted providers must verify each eligibility requirement through official documentation, home assessments, and case record reviews before approving a caregiver for stipend eligibility. If a child enters state custody or a caregiver no longer meets eligibility criteria, the department must suspend or terminate the stipend.

Our audit focused on the department's process for determining **stipend eligibility** for relative caregivers.

Stipend Eligibility Determination Process

According to the department's *Relative Caregiver Program Manual,* referrals to the Relative Caregiver Program and the Stipend Program may come from multiple sources.[109] Families may also self-refer to the program. The Stipend Program is only for those caregivers who meet additional eligibility requirements. Relative caregivers can still participate in the program, though, even if they are deemed ineligible to receive the stipend.

When a relative caregiver expresses interest in the stipend, the provider must determine whether the caregiver meets eligibility requirements. To do so, provider staff collect demographic information about the caregiver, children, and other household members. Staff also obtain documentation[110] to verify the ages, relationships, and custody arrangements of all parties involved.

Providers use the department's Tennessee Family and Child Tracking System (TFACTS) to verify that the child is not in state custody. After this verification, providers also conduct an in-home visit and family assessment to evaluate the household's safety and stability.

For stipend recipients, providers then download the Stipend Agreement[111] Form within TFACTS, which the caregiver signs as the final step in the stipend eligibility determination

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109. These include the Department of Children's Services, the Department of Human Services, hospitals, community mental health services, schools, juvenile or family courts, churches, private agencies, and other child and family-serving agencies.
110. According to the *Relative Caregiver Program Manual,* this may include such records as the Department of Human Services' Eligibility Benefit Management System, birth certificates, hospital birth records, family Bibles, trust documents, wills and property deeds, income tax records listing the child as a relative, juvenile court or family court records, and school records.
111. This agreement contains terms that the caregivers sign to show their acknowledgment to participate in the program and abide by the program's rules.

process. The form includes an attestation section where the caregiver certifies that they meet all six statutory requirements to receive stipend payments.

Before issuing payments, providers must ensure that each eligible caregiver completes a W-9[112] form and a direct deposit form. The Internal Revenue Service classifies these stipend payments as taxable income, which is why the department requires caregivers to complete a W-9. To process payments, the department's Supplier Maintenance Team[113] uses these documents to add a profile for each eligible caregiver in Edison, the state's accounting and payment system.

Stipend Redetermination

In addition to conducting initial stipend eligibility determinations, program providers must perform annual and quarterly redeterminations to ensure caregivers continue to meet program requirements. Section 37-2-422(d), *Tennessee Code Annotated*, ties stipend payments to the caregiver and the child's ongoing eligibility. To comply with this requirement, the department directs providers to complete both annual[114] and quarterly[115] redeterminations for families receiving the relative caregiver stipend.

These periodic reviews confirm that relative caregivers meet the same conditions that made them eligible when they first entered the program. Providers must also document any changes that could affect eligibility, such as custody modifications, household composition, or changes in the child's living situation.

While providers are responsible for performing redeterminations, the department is required by rule[116] to oversee and monitor the process. Department policy and rule require the department to ensure that eligibility reviews occur on time and in accordance with statute, rules, and program policy. This oversight helps prevent improper payments and ensures that stipend funds support only families who remain eligible under the law.

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112. The "Request for Taxpayer Identification Number and Certification" is used to collect a person's name, address, and taxpayer identification number.
113. This refers to the unit within the Department of Finance and Administration that sets up individuals and businesses as vendors in Edison. The department's system, TFACTS, must interface with Edison to pay relative caregivers.
114. Rule 0250-07-14-.03(2)(b), *Rules of the Tennessee Department of Children's Services,* states, "The RCP Provider will redetermine eligibility for the Relative Caregiver Stipend annually."
115. Department Policy 14.30(D), "Relative Caregiver Program," states, "The Department or RCP Provider will redetermine eligibility for the Relative Caregiver Stipend every three (3) Months. If the relative caregiver does not cooperate in the redetermination process to ensure continuing eligibility, the Department or RCP Provider may terminate the stipend and close the RCP case."
116. Rule 2050-07-14-.03 (3) (b) of the *Rules of the Tennessee Department of Children's Services,* Social Services Division, Relative Caregiver Program states that the department "will monitor Relative Caregiver Program determinations of eligibility."

For the annual review process, providers must submit eligibility documentation to the department each year, even when a caregiver's circumstances have not changed. If a provider fails to complete the redetermination or does not submit the required documentation, according to departmental policy, the department halts stipend payments and closes the case to prevent further disbursements until eligibility is reverified.

Monthly Review and Approval of Stipend Payments

Each month, Relative Caregiver Program provider staff must review and approve stipend payments in TFACTS. This review involves verifying the payment rate, service dates, and continued compliance with the six statutory stipend eligibility requirements. Providers ensure that all information in TFACTS accurately reflects the caregiver's current eligibility status before submitting the payment for processing.

After the provider's review, the department's fiscal staff conducts a review to confirm that each payment was for the right caregiver and child and that no duplicate payments were made. Once the fiscal review is complete, the department authorizes stipend payments, which are typically issued on the 15th day of the current month for services provided during the previous month.

Waitlists

According to the *Rules of the Tennessee Department of Children's Services*, Social Services Division, Chapter 0250-07-14:

> Eligible relative caregivers who do not receive the Stipend payment due to insufficient appropriations will be waitlisted and enrolled in the Stipend Program on a first-come, first-served basis once there is availability in the Stipend Program or additional funds are appropriated subject to the relative caregiver's continued eligibility.

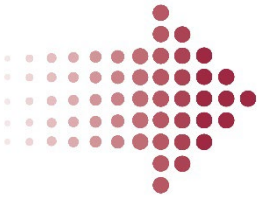
In practice, each program provider maintains its own waiting list that includes both families waiting to enter the Relative Caregiver Program and families waiting for stipend eligibility determinations.

Current Audit

We focused our review on the initial stipend eligibility determination process managed by Relative Caregiver Program providers. Specifically, we assessed how providers verify eligibility requirements and document approvals for relative caregivers seeking stipend payments. We also examined the department's methodology for calculating stipend rates and evaluated whether stipend payments were issued accurately and in accordance with program policy and statutory requirements.

Additionally, we reviewed whether the department developed and implemented a centralized process to track, manage, and prioritize caregiver waitlists for the Relative Caregiver Program and the stipend, ensuring consistent oversight and equitable access

statewide. Our review resulted in **Finding 7**, **Observation 4,** and the **Matter for Consideration**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.



Finding 7: The department's lack of oversight of provider eligibility determinations resulted in stipend payments that did not comply with program requirements

Lack of Oversight of Eligibility Determinations

The Department of Children's Services (the department) is required to maintain effective accountability for overall program oversight and fiscal management for the Relative Caregiver Program. Although the Relative Caregiver Program has operated since 2002, the introduction of **caregiver stipends** represented a significant fiscal and operational expansion. Despite this change, the department did not update its monitoring systems to confirm that eligibility determinations made by providers comply with applicable statutes, rules, policies, and contracts.[117] Management acknowledged this oversight risk in the department's 2024 risk assessment.

We reviewed 26 caregiver files from all 8 contracted providers where staff determined eligibility between July 1, 2024, and April 30, 2025. During our review of the Relative Caregiver Program, we identified internal control weaknesses in the stipend eligibility determination process. Specifically, we found inconsistent practices and documentation among providers and stipend overpayments to caregivers.

117. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book), Section 10.02, requires management to design control activities that help meet objectives and reduce risks.

Stipend Eligibility Determination

Inconsistent Documentation of Eligibility Requirements

We found that providers used inconsistent methods and documentation to verify key statutory[118] stipend eligibility requirements for caregiver stipends. Providers varied significantly in how they documented two specific requirements:[119]

- **Child Support Agreements:** Providers used different approaches to document caregiver cooperation. Some providers recorded notes in case files, some accepted Child Support letters instead of signed forms, and some checked boxes on the department's Stipend Agreement Form or created their own forms for caregivers to sign.
- **Confirmation of No Parent in the Home:** Providers used different approaches to confirm this requirement, such as home visits, documented conversations, and caregiver attestations documented within the Stipend Agreement Form.

Management explained that providers documented eligibility differently because the department did not issue clear guidance or standardize documentation requirements for verifying each eligibility criterion.

When the department does not define clear, uniform documentation standards, providers may fail to keep sufficient evidence showing that they properly determined caregiver eligibility. This increases the risk of ineligible payments and noncompliance with program requirements.

The Department Did Not Enforce Quarterly Eligibility Reviews

During our review of provider eligibility determinations, we found that the department did not require providers to complete quarterly redeterminations of eligibility as required by the department's Policy 14.30, "Relative Caregiver Program." The policy requires providers to verify each family's eligibility every three months. These reviews ensure that only caregivers who continue to meet statutory requirements will receive stipends and that stipend payments align with verified eligibility periods.

We found no evidence in TFACTS that providers completed quarterly redeterminations. Management stated that the department stopped requiring these reviews because a

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118. Section 37-2-422(c), *Tennessee Code Annotated*, outlines the stipend eligibility requirements for relative caregivers.

119. Section 37-2-422, *Tennessee Code Annotated,* states that two of the conditions that must be met to receive the stipend for the Relative Caregiver Program are (4) "a parent of the child does not reside in the relative caregiver's home," and (5) "the relative caregiver agrees to cooperate with any child support proceedings initiated by the Department of Human Services, including providing information relative to the establishment of paternity, if known."

technical issue in TFACTS prevented providers from documenting quarterly eligibility updates.

When the department does not enforce quarterly redeterminations, it cannot ensure that stipend payments go only to caregivers who are eligible for them. This increases the risk that ineligible caregivers may continue to receive payments without the department's knowledge, resulting in potential improper expenditures and noncompliance with departmental policy and state rules.

Stipend Overpayments

Stipend Payments Were Made Prior to Signed Agreements

The Stipend Agreement Form serves as the final step in the eligibility determination process for stipend recipients. The caregiver must sign this form to certify that they meet all six statutory requirements to receive stipend payments. The department requires a separate agreement for each child in the caregiver's home.

We reviewed the forms for 26 relative caregivers involving 52 children. We found that **the department issued payments before caregivers signed their agreements for 34 of 52 children** (**65%**) **in our sample, resulting in $20,182 in overpayments**.

Because the department did not monitor provider compliance or issue clear guidance, providers paid caregivers before completing final eligibility determinations for the stipend. Management acknowledged that providers should obtain a signed stipend agreement before authorizing payments and stated that they will update guidance to clarify that the signed agreement marks the official start of eligibility. By allowing stipend payments before verifying eligibility, the department may have reduced available Stipend Program funds and increased the risk of improper payments.

Noncompliant Stipend Rate Calculation

Caregivers receive monthly payments based on a daily rate for each child in their care. Section 37-2-422, *Tennessee Code Annotated,* states that the relative caregiver stipend must equal **50% of the full foster care board rate** for the care of each child. Additionally, the *Rules of the Tennessee Department of Children's Services,* Social Services Division, Chapter 0250-07-14, defines the "*foster care board rate*" as "the regular board payment rate determined by [the department] for the payment to foster parents providing residential care to a child in state custody."

We reviewed stipend payments for fiscal year 2025. During our review, we found that the department paid the correct rate for children ages 12 to 18 but overpaid caregivers of children ages 0 to 11 by paying $16.88 per child per day instead of $15.78. In our sample of 26 relative caregivers (covering 52 children, **including 32 children ages 0 to 11**), **these overpayments totaled $4,513**.

The department's foster care board rates are listed in **Figure 34**, which establishes the base from which relative caregiver stipend amounts of **50%** should be calculated.

Figure 34: Foster Care Board Rates for Fiscal Year (FY) 2025

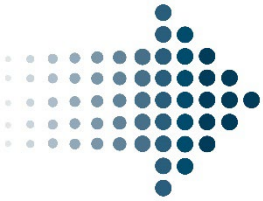
	FY 25		
	Full Rate	50% Rate	Paid Rate
Regular Board Rate (Ages 0-11)	$31.55	$15.78	**$16.88***
Regular Board Rate (Ages 12-18)	$36.17	$18.09	$18.09

* In fiscal year 2024, management averaged together the special circumstance rate for ages 0 to 11 ($32.95), special circumstance rate for ages 12 to 18 ($37.78), regular board rate for ages 0 to 11 ($29.96), and regular board rate for ages 12 to 18 ($34.35) and divided the total in half to come up with the **$16.88** rate they paid both age groups. In fiscal year 2025, the department paid the correct rate for the 12 to 18 age group but chose to maintain the higher rate for children in the 0 to 11 age group, rather than adjusting the rate downward.

Source: Auditor calculation based on rates provided by management.

Management explained that TFACTS originally could not process different stipend rates by age group, so the department paid all caregivers **50% of the average** foster care board rate until system changes could accommodate age-based payments. When the department later corrected the system, it chose not to reduce the rate for children ages 0 11 to the correct statutory amount because doing so would have decreased monthly payments to families. By continuing to pay the higher rate, the department overpaid caregivers of younger children and did not comply with state law. Although the higher rate is beneficial to children and families, these payment rates did not comply with statute. This practice may have reduced the funds available for other eligible participants and increased the risk of inequitable payments and program noncompliance.

See **Observation 6** in the **Strategic Plan and Risk Assessment** section for additional information on risks related to the Relative Caregiver Program that management did not identify in their risk assessment.



Recommendation: Management should strengthen oversight of the Relative Caregiver Program by implementing periodic quality assurance reviews of provider case files to confirm eligibility determinations, redeterminations, and stipend authorizations comply with statutory and policy requirements. These reviews should be documented and used to provide feedback or corrective action to providers as needed. Management should also establish uniform documentation

standards and develop standardized training materials and conduct regular training sessions for provider staff.

Management should clarify procedures to ensure that stipend payments begin only after stipend eligibility is fully approved and the payment start date corresponds with the caregiver's signed stipend agreement. Additionally, the department should comply fully with Section 37-2-422, *Tennessee Code Annotated*, by ensuring that all relative caregivers receive stipend payments equal to 50% of the foster care board rate or seek a change in legislation. Adhering to this statutory requirement will ensure fairness among participants and alignment with legislative intent.

Management's Comment

Management concurs. DCS will implement additional eligibility oversight, staff training, and payment validations to ensure payments equal 50% of the approved foster care rate as required by Section 37-2-422, TCA.

Observation 4: Management should develop standardized waitlist procedures and strengthen provider data collection for waitlists

The Relative Caregiver Program plays a critical role in helping the Department of Children's Services (the department) achieve its goal of keeping children safe with their families and out of state custody. The program's success depends on consistent oversight, clear eligibility processes, and accurate tracking of families waiting to receive services or stipend payments.

Background

According to department Rule 0250-07-14-.03(11), *Rules of the Tennessee Department of Children's Services*, Social Services Division,

> The Department will make payments to eligible relative caregivers enrolled in the Stipend Program equal to the amount specified in T.C.A. § 37-2-422 for the care

> of the child, subject to the appropriation of sufficient funds to make such payments. Should insufficient funds be appropriated for the Stipend Program to provide Stipend payments to all eligible relative caregivers, then the Department will provide funds to eligible, enrolled relative caregivers on a first-come, first-served basis. Eligible relative caregivers who do not receive the Stipend payment due to insufficient appropriations will be waitlisted and enrolled in the Stipend Program on a first-come, first-served basis once there is availability in the Stipend Program or additional funds are appropriated, subject to the relative caregiver's continued eligibility.

At the time of our review, the department had not reached the maximum approved budget for caregiver stipend payments. The department and providers had waitlists for caregivers awaiting program entry or stipend eligibility determinations, but stipend funding had not yet limited them.

Wait Lists

We found that providers tracked families waiting to enter the program and families waiting for stipend eligibility determinations, but the department's centralized tracking spreadsheet lacked essential information. The tracker did not include the following:

- distinctions between families waiting for program entry and those waiting for stipend eligibility,
- applicant and family demographic data,
- dates when applicants were added to or removed from the list,
- reasons for removal, or
- average wait times for services or stipend determinations.

As a result, the department could not accurately determine the number of families waiting for services or the length of time they had been on the waitlist.

Management had not established clear, written policies[120] for how providers should manage waitlists for the Relative Caregiver Program or the stipend eligibility process. As a result, there is an increased risk that providers use inconsistent procedures to add and remove applicants and to prioritize families (such as first-come, first-served or based on need).

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120. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) establishes that management should design and implement control activities to achieve program objectives and respond to risks (Principle 10), use quality information to support decision-making (Principle 13), communicate expectations and requirements to personnel (Principle 14), and perform monitoring activities to evaluate compliance and performance (Principle 16).

Management stated that awareness of the Relative Caregiver Program increased after February 2025, leading to a rise in referrals. Until then, the department saw little need for formal waitlist procedures or data collection.

Without standardized policies and consistent data collection, the department cannot monitor program demand, evaluate equity in access, or ensure fair and timely enrollment for eligible families. Weaknesses in waitlist tracking also limit the department's ability to make informed budget and staffing decisions or to assess regional differences in service delivery.

Management should develop clear, written policies and procedures requiring providers to manage and maintain waitlists for both Relative Caregiver Program enrollment and stipend eligibility determinations. These procedures should include consistent criteria for adding, removing, and prioritizing applicants.

The department should also enhance its centralized waitlist tracker to include key data fields such as

- applicant and family demographics,
- dates added to and removed from the list,
- reasons for removal, and
- separate indicators for program and stipend waitlists.

Collecting and maintaining this information will help management monitor wait times, identify service gaps, and ensure equitable access across regions and provider networks.

Management's Comment

Management concurs.

Matter for Consideration: Department management should continue to work with federal and state partners to change or seek an exception on the tax classification of stipend payments to relative caregivers

The Department of Children's Services (the department) administers the Relative Caregiver Stipend Program to support relatives who care for children outside of their

biological parents' custody. The program provides monthly financial assistance to qualifying caregivers to help offset the costs of caring for these children and to prevent unnecessary entry into the foster care system. The department contracts with eight local providers statewide to administer the program and deliver services directly to families.

During our fieldwork, staff at all eight Relative Caregiver Program providers informed us that, because the Internal Revenue Service classifies stipend payments as taxable income, some caregivers have experienced a loss or reduction of other public benefits, including

- Tennessee Housing Development Agency housing assistance,
- Supplemental Nutrition Assistance Program (SNAP) benefits,
- TennCare, and
- Social Security benefits.

In addition to the loss or reduction of benefits, the providers reported families experiencing a reduction in tax refunds or an increase in tax liability because of the stipend payments. Several providers also noted that they have increased their direct assistance payments[121] to help families offset the financial impact of these changes. Department staff stated that the department communicates with providers to ensure that caregivers understand how the stipend may impact other benefits. Provider staff reported that some caregivers choose not to receive stipend payments so that they do not lose SNAP or other benefits. The department should also continue to work with state and federal partners to seek clarity on whether relative caregiver stipends can be excluded from income requirements.

Management's Comment

Management concurs in part. While DCS does not determine federal or state tax policy, the department will continue to work with federal and state partners to seek formal clarification on Relative Caregiver stipends. DCS will align program guidelines accordingly.

Auditor's Comment

We evaluated management's comment and determined that no changes were needed to our conclusion.

121. Direct assistance payments are non-recurring payments that can be made for special needs, such as clothing, furniture, food, or housing, to enable families to provide safe, stable homes for their related children.

Oversight of Facilities

Residential facilities play a central role in providing safe and structured environments for youth in state custody or detention. The Department of Children's Services (the department) is responsible for ensuring that youth in its custody are properly supervised, that youth receive appropriate medical care, and that all incidents are reported as required. To achieve this, the department operates a youth development center, licenses juvenile detention centers, and monitors contract provider facilities.

Our goal was to determine whether management's monitoring process of facilities where youth accused or adjudicated of a delinquent offense are housed, and how these facilities complied with requirements related to medication administration, staffing ratios, and incident reporting, in accordance with applicable laws, regulations, contract requirements, and departmental policies and procedures. See **Finding 8** and **Matter for Legislative Consideration 1**.

Background

Under the authority of Title 37, *Tennessee Code Annotated*,[122] the Department of Children's Services (the department) is responsible for the **care, custody, and placement** of children who have been ordered into the department's custody and adjudicated dependent, neglected, or delinquent. The department fulfills this mandate by operating and overseeing a network of licensed and contracted facilities that house children and youth in its custody. When the department cannot place youth in a foster home, it places them in a facility that meets their individual treatment, behavioral, and supervision needs.

122. Section 37-5-106(a)(8), *Tennessee Code Annotated*, states the department may "enter into contracts with the departments of human services, mental health and substance abuse services, disability and aging, education and health, with agencies of such departments, or any other department or agency of state government, with private individuals and corporations, and with associations, organizations or any other entities, governmental or otherwise, for services that the department of children's services may deem necessary to carry out the purposes of this title. Such services may include, but are not limited to, health, psychological, social, education, transportation, program evaluation, placement, detention, prevention, assessment and case management."

Many of the youth placed in these facilities present complex behavioral, emotional, or mental health challenges, often stemming from histories of abuse, neglect, trauma, or delinquent behavior. Because of these needs, the department must ensure placements can provide enhanced supervision, behavioral interventions, and therapeutic support. These youth are considered high-risk due to their potential for aggressive behavior, self-harm, or disruption, and therefore require environments with specialized staffing, structure, and safety protocols.

As of October 9, 2025, there were 8,260 children and youth in department custody. Of these, 651 are delinquent youth placed in a residential facility.

Source: Data obtained from the department's TFACTS system.

The department operates its own hardware-secure **youth development center**[123] for juvenile delinquents, which serves youth from diverse backgrounds. Because the department operates only one facility, it cannot meet all the needs for all children in state custody. As such, the department must rely on **contracts with third-party providers** to secure sufficient bed availability to house children and youth when departmental placements are unavailable or when a specialized level of care is needed.

Other licensed but **non-contracted juvenile detention facilities** may also house youth in the department's custody when space is available, but without a contract, the department is not guaranteed a bed to place a youth whenever they choose.

Oversight Responsibilities

The department oversees all contracted and licensed facilities. The facilities must comply with applicable laws, regulations, contract requirements, and departmental policies and procedures, and are monitored by the following divisions:

- The **Provider Monitoring and Evaluation Division** monitors compliance at all **116 contracted facilities**, *excluding licensed juvenile detention centers (JDCs)* that hold contracts with the department.
- The **Office of Child Welfare Licensing** verifies compliance at all **16 local government-owned JDCs** in Tennessee. Of these centers, **13** are operated by local governments, sheriff's offices, or juvenile courts, while the remaining **3** are operated by private provider agencies. Seven of the 16 JDCs also maintain contracts with the department to provide additional placement capacity for youth in custody.

123. Section 37-5-201(a), *Tennessee Code Annotated,* states, "For the detention, treatment, rehabilitation and education of children found to be delinquent, there shall be youth development centers. Such centers shall be under the supervision and control of the commissioner of children's services."

The department promulgates rules and regulations[124] for JDCs[125] and temporary holding resources,[126] which govern the operations of these facilities. These rules establish minimum standards related to administration, staffing, supervision of youth, programming and educational services, infrastructure, security, medical services, and the use of seclusion and restraints.

For a list of the facilities we visited for our audit, see **Figure 35**.

Figure 35: Facilities Visited for Audit

Facilities	Licensed by the Department	Contracted
Davidson County Assessment Centers*		●
Davidson County Juvenile Detention Center	●	
Duck River Youth Center		●
Knox County Juvenile Detention Center	●	●
Mountain View Youth Academy		●
Shelby County Juvenile Detention Center	●	
Standing Tall Music City*		●

* According to management, this facility is licensed by the Department of Mental Health and Substance Abuse Services.
Source: Auditor site visits.

When conducting our visits to these facilities, we focused on three main areas of compliance: medication administration, staffing ratios, and incident reporting.

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124. *Rules of Tennessee Department of Children's Services,* Chapter 0250-04-08, "Minimum Standards for Juvenile Detention Centers and Temporary Holding Resources."
125. Section 37-5-501, *Tennessee Code Annotated,* defines juvenile detention centers as "a place or facility operated by any entity or person, governmental or otherwise, for the confinement in a hardware secure facility of a child or children who meet the criteria of § 37-1-114(c) or other applicable laws and who: (A) are in need of legal temporary placement; (B) are awaiting adjudication of a pending petition; or (C) are awaiting disposition or placement."
126. Section 37-5-501, *Tennessee Code Annotated,* defines temporary holding resources as "a place or facility housing primarily no more than eight (8) children operated by any entity or person, governmental or otherwise, providing a short-term (less than seventy-two (72) hours, exclusive of non-judicial days) placement alternative for a child or children in a primarily staff-secure facility, as defined by the department, while the child or children await adjudication of a pending petition or disposition following adjudication, or pending return to a dispositional placement. This facility shall have a maximum of two (2) hardware secure rooms. At least one-half (½) of the rooms in the facility shall be non-hardware secure."

Medication Administration

The department's rules require strict control over the administration of medications[127] to youth housed in the juvenile detention centers. Staff responsible for administering medications must complete appropriate training,[128] and facilities must maintain a running count of all prescription and controlled medications to ensure accurate documentation and accountability.

Additionally, the rules require facility staff to promptly contact a qualified mental health professional following any mental health event[129] involving a youth. The qualified professional must assess the youth within 24 hours to ensure timely evaluation and appropriate care.

Staffing Ratios

The Prison Rape Elimination Act (PREA) establishes national standards for facilities that primarily house juvenile delinquents. These standards define expectations for staffing ratios, the reporting and investigation of sexual abuse and sexual harassment, and the protection of youth from such incidents.

Under PREA, facilities must maintain a minimum staffing ratio of 1 staff member for every 8 youth during waking hours (1:8) and 1 staff member for every 16 youth during sleeping hours (1:16). The department's rules[130] align with these federal standards, requiring the same staffing ratios to ensure adequate supervision and the safety of youth in custody.

For contracted providers who provide residential treatment, the department's *Residential Treatment Contract Provider Manual* sets standards for contracted treatment facilities.

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127. Rule 0250-04-08-.06 (9) states, "All medication shall be double-locked within the medical area of the facility or other area approved by DCS Licensing. A medication receipt, log, and administration system shall be established. A running count of all prescribed medications shall be documented on an approved Medication Administration Record (MAR) including controlled medications and prescribed medications."
128. Rule 0250-04-08-.06 (8) states, "There shall be strict control of medications to be issued to youth. All medications shall be prescribed by a physician or nurse practitioner at the time of use. A trained staff member shall be responsible to see that medication is administered as prescribed."
129. Rule 0250-04-08-.06 (12) states, "Staff shall immediately place youth identified as needing further evaluation for suicide risk or other acute mental health conditions on constant observation until they can be formally assessed by a qualified mental health professional. . . . Staff shall promptly contact a qualified mental health professional in order to develop an emergency intervention plan for such youth. The qualified mental health professional shall conduct an assessment of the youth within twenty-four (24) hours. Only a qualified mental health professional may remove a youth from constant observation."
130. Rule 0250-04-08-.07 (8) states, "There shall be at least one (1) direct care staff for every eight (8) youth during waking hours and at least one (1) direct care staff for every sixteen (16) youth during sleeping hours or other staffing plan approved by the Department's licensing office."

These standards require 1 direct care staff[131] member to be present for every 8 youth **during waking and sleeping hours** (1:8).

Incident Reporting

Contracted facilities must comply with department policies, including Policy 1.4, "Incident Reporting," which outlines the types of incidents[132] that providers must document in the TFACTS Incident Reporting System. Policy 1.4 specifies that designated staff, such as family service workers, juvenile service workers, foster parent support staff, youth development center staff, and contract provider agency staff (including those at JDCs), are responsible for entering incidents into TFACTS. The policy further requires providers to enter all incidents within five business days of the occurrence or immediately upon notification of the incident. Facilities are not required to report incidents in TFACTS for youth residing in their care who are not in the custody of the department.

Departmental rules also require providers to make all incident reports available to licensing staff,[133] who review the documentation for completeness during both announced and unannounced visits. JDCs must internally document incidents involving all youth, regardless of custody status. When a JDC also serves as a contracted facility, it must enter incidents involving youth in department custody into the TFACTS Incident Reporting System, as required by department policy.

Monitoring Process for Facilities

Through monitoring activities, the department ensures that third-party facilities meet established safety, care, and operational standards for youth in its custody.

Provider Monitoring and Evaluation

The Provider Monitoring and Evaluation (PME) Division conducts both announced and unannounced visits annually for contracted facilities to assess compliance with

131. The *Contract Provider Manual* defines direct care staff by the trainings that are provided to those staff. This includes first aid, de-escalation, incident reporting, sexual harassment prevention, and trauma-informed behavior management techniques.
132. Types of incidents that must be reported include assault, contraband, emergency medical treatment, restraints or use of chemical defense spray, medication error, mental health crisis, escape, police involvement with youth, and seclusion.
133. Rule 0250-04-08-.03(19) states, "Any significant incident involving a youth shall be documented in a written incident report and retained in the youth's individual file. The incident report shall include date, time, location, and witnesses. Every incident report shall also clearly document the youth's involvement and behavior, and staff actions or reactions (e.g., verbal and physical interventions and follow-up actions) resulting from the incident. Incident reports completed by the facility to fulfill contractual requirements issued by the department shall be considered acceptable in meeting compliance with this provision. The incident shall be reviewed by the facility administrator or the facility administrator's designee prior to the conclusion of the shift and reported as designated by the department and the local jurisdiction. All incident reports shall be made available for review by licensing personnel."

departmental requirements. These reviews are designed to ensure that providers maintain safe environments, deliver appropriate care, and adhere to applicable laws, regulations, contract provisions, and departmental policies and procedures. PME staff use a standardized agency compliance review monitoring tool to evaluate facility operations, staffing levels, incident reporting practices, and overall program performance.

Office of Child Welfare Licensing

The Office of Child Welfare Licensing inspects JDCs and provides technical assistance to promote compliance. This office of the department has licensing consultants who perform one announced and one unannounced visit each year to these facilities. During the annual announced visit, the consultant uses a facility compliance review monitoring tool to evaluate standards of compliance. This inspection includes reviewing a random sample of 20 days of documentation to calculate staffing ratios from the prior year, as well as reviewing the current staffing levels on the date of the visit. These consultants also review incident reports and medical files during monitoring visits to ensure compliance with the JDC rules and regulations.

Monitoring Results – Reporting and Enforcement

Following the compliance evaluations conducted by both licensing and PME staff, the monitors prepare a formal report summarizing their findings. This report is provided to the facility's leadership for review and response. When licensing or PME staff identify deficiencies, the facility must submit a corrective action plan outlining the steps it will take to address the findings. Both monitoring groups review and approve these corrective actions and work collaboratively with facility leadership to ensure that all identified issues are resolved and that the facility achieves full compliance with applicable standards.

While the Office of Child Welfare Licensing monitors all 16 JDCs for compliance with the *Rules and Regulations for Juvenile Detention Centers and Temporary Holding Resources*, the department's statutory authority to enforce compliance differs depending on whether a JDC is publicly or privately administered.[134] According to Section 37-5-510, *Tennessee Code Annotated*, the department has broader enforcement authority over private JDCs than over those operated by local governments.

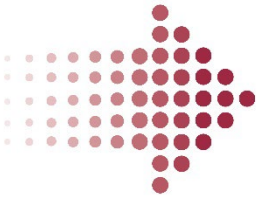
For **privately operated facilities**, the department may take several actions to compel compliance, including placing the JDC on probation and suspending or revoking its license; however, when a **publicly operated** JDC remains out of compliance, the department's options are limited. The department may coordinate with the Tennessee

134. Section 37-5-510, *Tennessee Code Annotated*, states, "(a) Any child care agency, as defined in § 37-5-501, that is under the direct management of an administrative department of the state, a county, or a municipality, or any combination of these three (3), shall not be subject to licensure, but shall meet the minimum standards for programs and care as required of such child care agencies."

Attorney General's Office to file a complaint[135] in Chancery Court, or it may withhold an approval letter[136] while working with the facility's leadership to correct deficiencies. Importantly, a lack of corrective action[137] by the facility or the department's decision to withhold approval does not prevent a publicly administered JDC from continuing operations.

Current Audit

We focused our review on the department's monitoring processes for juvenile detention facilities that the department licenses and for those facilities under contract with the department to determine whether monitoring procedures were addressing noncompliance with applicable standards for medical care, staffing ratios, and incident reporting. Our review resulted in **Finding 8** and **Matter for Legislative Consideration 1**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.



Finding 8: The department must strengthen its oversight of residential facilities and juvenile detention centers that house custodial youth to ensure safety, compliance, and accountability

In general, juvenile justice residential facilities house youth with significant behavioral and treatment needs. The Department of Children's Services (the department) reports that the youth placed in these settings often exhibit significant behavior challenges and require higher levels of supervision and therapeutic care.

The department must strengthen its oversight of residential facilities and juvenile detention centers (JDCs) that house custodial youth to ensure safety, compliance, and accountability (discussed in the following section). The department should continue its efforts to update its rules (see **Challenges With Updating JDC Rules** in this finding) and

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135. Section 37-5-510(e)(1), *Tennessee Code Annotated*, states, "If violations of the standards for child care agencies are found and are not corrected within a reasonable time, or, if serious violations are found that meet the requirements that would justify the suspension of a child care agency's license pursuant to §4-5-320, the department may file a complaint in the chancery court of the county in which the child care agency is located."

136. An approval letter is the way the department documents that a publicly administered JDC has met licensing standards, because an actual license is not issued.

137. Section 37-5-510(c), *Tennessee Code Annotated*, states, "It is the duty of the department to cooperate with the publicly administered agencies herein referred to, to implement recommended changes in program and policies."

pursue legislative remedies (see **Matter for Legislative Consideration 1**) to remove existing limitations that restrict management's ability to address facility noncompliance.

Given these elevated risks, we conducted site visits to juvenile justice residential facilities. The department should have effective monitoring to ensure facilities provide appropriate medical care, maintain sufficient staffing levels to supervise youth, and report incidents consistently and accurately as required.

During our site visits conducted between **February 2025** and **April 2025**, we identified instances of facility noncompliance in three critical areas: medical care, staffing ratios, and incident reporting. Within the facilities where we noted noncompliance, all four facilities had issues with staffing ratios, while one facility had issues in all three areas. See **Figure 36** for details.

Figure 36: Areas of Noncompliance by Facility

Facility Name	Noncompliance		
	Medication	Staffing Ratios	Incident Reporting
Knox County Juvenile Detention Center*	✕	✕	✕
Davidson County Juvenile Detention Center		✕	
Shelby County Juvenile Detention Center*		✕	
Mountain View Youth Academy[138]		✕	

* We could not calculate staffing ratios based on the documentation the facilities maintained, which is necessary for sufficient monitoring.
Source: Auditor testwork.

Medical Care and Medication Errors

Knox County Juvenile Detention Center

During our audit fieldwork, a source within the Knox County government contacted our office, sharing concerns they had received regarding potential medication administration errors at the Knox County JDC. In response, we performed an expanded review of medical files for youth housed at this facility. Our review identified medication errors and medical deficiencies affecting six youth.

The errors we noted included the following:

138. A contracted residential treatment center.

- missing doses of prescribed medications,
- staff failing to administer medications as prescribed or administering them incorrectly, and
- staff failing to provide timely treatment for injuries or mental health episodes.

Based on our work, we learned that the facility employed only one nurse, who was scheduled to work Monday through Friday during the day shift. When the nurse was not at the facility, security staff were responsible for administering medications to youth. The security staff assigned to this duty had completed the department-required medication administration training; however, the medication errors we identified occurred during times when the nurse was not present. The timeline of these discrepancies indicated that medical care at the facility was less reliable during periods without professional nursing coverage.

During our review, we also learned that breakdowns in communication between facility leadership and the nurse caused delays in medical treatment. In one case, a diabetic youth went without insulin for two weeks, and security staff later administered the insulin incorrectly during the night shift. In another case, the nurse recommended hospital care for a youth experiencing a mental health episode and poor vital signs, but facility leadership and staff failed to act.

In prior internal reports, both department licensing staff and Special Investigations Unit investigators identified systemic issues with the medication administration process at this facility. More recently, a monitoring review performed by the licensing consultants revealed similar concerns. At the time of our fieldwork, licensing staff were again working with the facility's management and leadership team to address these recurring issues and implement corrective actions.

Subsequent Action Taken

In June 2025, the Knox County Commission replaced the facility's full governing board. The facility's superintendent retired in August 2025. The newly appointed board brought in new leadership to address the operational and compliance concerns identified at the facility. The Knox County Health Department began assisting the facility by rotating nurse staff, supplying new medical equipment, and implementing updated health and medication administration policies.[139] Additionally, the Knox County Sheriff's Office is scheduled to assume operational control of the facility in 2026.

During our visit to this facility, we also noted noncompliance with staffing ratio requirements and incident reporting procedures, which are discussed later in this finding.

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139. The Knox County JDC had a medical policy; however, many of the facility's policies were outdated. The policies are in the process of being updated as of September 2025.

Staffing Ratio Noncompliance

Davidson County Juvenile Detention Center

We analyzed staffing rosters and youth census records for the period **April 1, 2025, to April 29, 2025**, to calculate staffing ratios for each dorm and shift at the Davidson County JDC. Our analysis identified multiple instances of noncompliance with staffing ratios. Most of the noncompliance resulted from instances in which a single staff member was responsible for supervising two separate dorms simultaneously. On several days, multiple dorms did not meet the minimum staffing requirements established by departmental rules[140] and Prison Rape Elimination Act standards.[141]

Figure 37 illustrates the number of dates and dorms during the review period in which we identified noncompliance with the required staffing ratios.

Figure 37: Davidson County JDC Staffing Ratio Noncompliance

Month	Number of Days of Staffing Ratio Noncompliance	
	Day Shift (7:00 a.m. – 8:00 p.m.)	**Night Shift** (7:00 p.m. – 8:00 a.m.)
April 2025	**11** out of 29 days* with **1 of 6 dorms** below the required staffing ratio per day of noncompliance	**24** out of 29 days* with an average of **4 of 6 dorms†** below the required staffing ratio per day of noncompliance

* We tested staffing ratio compliance for April 1, 2025, through April 29, 2025, a total of 29 days.
† Plus one instance when the facility's master control and intake unit were unstaffed.
Source: Auditor analysis of staffing rosters and youth census records provided by the facility.

140. *Rules of Tennessee Department of Children Services,* Chapter 0250-04-08, "Minimum Standards for Juvenile Detention Centers and Temporary Holding Resources."
141. Title 28, *Code of Federal Regulations,* Part 115, "Prison Rape Elimination Act National Standards."

Shelby County Juvenile Detention Center

During our visit to the Shelby County JDC, facility leadership provided documentation showing the number of staff on duty and the number of youths housed in the facility for the dates we requested; however, this documentation did not include sufficient detail to calculate staffing ratios for each dorm on any given date or shift. As a result, we could not determine whether the facility complied with the required staffing ratios.

Knox County Juvenile Detention Center

We identified the **same deficiency** at the Knox County JDC, where the available documentation also lacked the level of detail necessary to verify compliance with staffing ratio requirements. This lack of accurate and detailed documentation limits both facility management and the department's ability to ensure that adequate staffing levels are maintained at all times.

The absence of reliable staffing records reflects a broader weakness in facility documentation and oversight. As noted earlier in this finding, the Knox County JDC experienced medication administration errors and delays in medical treatment during times when staffing was limited or medical personnel were unavailable. Inadequate staffing and supervision increase the likelihood of similar medical care deficiencies and heighten the overall risk to youth safety and well-being.

Mountain View Youth Academy

Our analysis of staffing documentation for the Mountain View Youth Academy identified multiple instances of noncompliance with required staffing ratios. Facility records showed that staff were often assigned at levels below those required to ensure adequate supervision of youth. Specifically, we noted that the facility frequently assigned only one staff member to a dorm when the youth population required two.

In some cases, the assigned staff member was present for only a portion of the shift, with no documentation indicating who supervised the youth during the remainder of that shift. This lack of documentation raises concerns about the adequacy of supervision and compliance with departmental and federal standards.

Our review covered staff rosters and youth census records for the period **February 3 through March 31, 2025**. On multiple days during this period, several dorms did not meet the minimum staffing ratios required by the department.[142] **Figure 38** presents the

142. The *Residential Treatment Contract Provider Manual* states the staff-to-youth ratio is "1:8 (one direct-care, awake staff for every eight on-site youth) during the day and 1:8 (one direct-care, awake staff for every eight on-site youth) overnight staff."

number of dates and dorms within each month where we identified noncompliance across various shifts.

Figure 38: Mountain View Youth Academy Staffing Ratio Noncompliance

Month	Number of Days of Staffing Ratio Noncompliance		
	First Shift (6:00 a.m. – 2:00 p.m.)	**Second Shift** (2:00 p.m. – 10:00 p.m.)	**Third Shift** (10:00 p.m. – 6:00 a.m.)
February 2025	**16** out of 26 days* with **1 of 9 dorms** below the required staffing ratio per day of noncompliance	**8** out of 26 days* with **1 of 9 dorms** below the required staffing ratio per day of noncompliance	**26** out of 26 days* with an average of **3 of 9 dorms** below the required staffing ratio per day of noncompliance
March 2025	**3** out of 31 days with an average of **3 of 9 dorms** below the required staffing ratio per day of noncompliance	**22** out of 31 days with **1 of 9 dorms** below the required staffing ratio per day of noncompliance	**30** out of 31 days with an average of **3 of 9 dorms** below the required staffing ratio per day of noncompliance

* In February 2025, we tested staffing ratio compliance for 26 days, from February 3 through February 28.
Source: Auditor analysis of staffing rosters and youth census records provided by the facility.

Subsequent Action Taken

Because of the staffing deficiencies identified during our review and by the department's Provider Monitoring and Evaluation (PME) staff, **the department placed Mountain View on a Provider Performance Improvement Plan in May 2025**. The Provider Performance Improvement Plan requires the provider to implement corrective actions to address staffing shortages, improve documentation practices, and ensure ongoing compliance with departmental staffing ratio requirements. When a facility is on an improvement plan, the department conducts more intensive monitoring of the facility until concerns are fully addressed.

The Office of Child Welfare Licensing also used the information we presented to them to write a monitoring finding for the Davidson County JDC. This facility will require continued monitoring to determine whether it implements corrective actions and demonstrates measurable improvement.

Overall Incident Reporting Concerns

We learned that neither licensing staff nor PME staff review incidents in TFACTS prior to their visits to determine whether facilities are entering incidents as required or to identify potential areas of higher risk. In addition, neither group compares paper incident forms maintained at the facilities to the incidents entered into TFACTS to verify compliance with the department's incident reporting policies.

Because staff do not perform these reviews, the department cannot verify whether the facility entered all required incidents into TFACTS. This limits management's ability to identify unreported or recurring issues, assess trends, and take timely corrective action to address safety concerns affecting youth in custody.

Juvenile Detention Centers

Because JDC facilities serve **youth with significant behavioral and treatment issues**, the likelihood of incidents, such as assaults or physical restraints, occurring is elevated. Based on our review of TFACTS incident data, we found that **several JDCs had not reported any incidents in TFACTS during the 2024 and 2025 calendar years**,[143] even though they housed youth in the department's custody. The department contracts with three of these facilities—Knox County JDC, Madison County JDC, and Williamson County JDC—which are contractually required to enter all incidents involving department youth into the system.

Although we did not visit all the identified JDCs, the lack of incident reporting at multiple facilities presents a risk that other facilities may also be failing to report incidents as

143. We reviewed a report of all incidents reported during the period January 1, 2024, through September 5, 2025.

required. Specifically, at the Knox County JDC, we reviewed youth files and found paper copies of incident reports from January through April 2025 that were not entered in TFACTS. The department's Executive Director over Juvenile Justice Facilities stated that Knox County JDC was required to retroactively enter all incidents related to custodial youth from the period when reporting did not occur. This lack of reporting hinders the department from holding this contracted facility accountable.

The Knox County JDC superintendent stated that the department had never informed the facility of its obligation to enter incidents into TFACTS; however, department leadership reported that licensing staff had previously assisted the facility's assistant superintendent in obtaining system access and provided training after the departure of the employee formerly responsible for entering incidents.

When we reviewed TFACTS again in August 2025, we found that the Knox County JDC still had not entered any incidents from January through April 2025 but had begun entering new incidents starting in May 2025.

Subsequent Action Taken

After we presented our incident reporting concerns to department leadership in April 2025, the Executive Director reported that departmental staff began running a system report in TFACTS to identify juvenile justice facilities that were not entering incidents. Leadership confirmed that Madison and Williamson County JDCs[144] had not complied and stated that the department would ensure the appropriate staff at each facility were given system access and training. The Executive Director also stated that the department would continue generating this report regularly to verify that all juvenile justice facilities consistently report incidents in TFACTS when required.

While this is a step in the right direction, the department cannot effectively monitor facility operations where department custodial youth are placed, identify patterns of concern, or ensure timely corrective action when youth safety issues arise without complete and accurate incident reporting from facilities.

Challenges with Updating JDC Rules

We learned that departmental monitors were unable to calculate staffing ratios for some JDCs because the **current departmental rules** do not require these facilities to maintain documentation in a format that supports such calculations. When we discussed this issue with department management, the Office of Child Welfare Licensing reported that it is in the process of promulgating revisions to the rules for JDCs. The Director of Licensing stated that incorporating more detailed and stringent requirements regarding

144. These are two facilities that have a contract with the department.

documentation practices would enable stronger enforcement of compliance with staffing ratios for each dorm.

The department last updated the *Minimum Standards for Juvenile Detention Centers and Temporary Holding Resources* in June 2017. Since May 2022, it has worked to amend these rules, which include proposed updates to temporary physical restraints, seclusion, and staffing ratios. Department officials stated that they have experienced difficulty ensuring compliance under the current rules and that the proposed revisions aim to provide clearer and more enforceable guidance for JDC operations.

According to the department's legal counsel, a rulemaking hearing was held in May 2024, after which the department began incorporating feedback from the public and the Tennessee Attorney General's Office. As of June 2025, the department's legal counsel stated that the department has been revising the rules in conjunction with the Tennessee Attorney General's Office since May 2024.

Overall Effect

When management does not, or cannot, hold facilities accountable for noncompliance with applicable laws, regulations, standards, and contract provisions, youth placed in these settings may face increased risk of harm from inadequate supervision and insufficient medical care. These weaknesses heighten the likelihood of incidents occurring within the facility.

When providers fail to report incidents involving youth in the department's custody, management remains unaware of potentially dangerous situations and cannot intervene to protect those in care. Without consistent and accurate incident reporting, the department loses critical information needed to identify trends, assess facility performance, and implement targeted monitoring or corrective actions.

According to the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book), management should establish clear structures of authority, identify and respond to risks, and design control activities supported by reliable information and continuous monitoring (Principles 3, 7, 10, 12, 13, 16, and 17). The department's weaknesses in oversight, documentation, and enforcement indicate that it has not fully implemented effective internal control practices consistent with these principles. As a result, management's monitoring processes do not provide reasonable assurance that facilities comply with requirements related to medical care, staffing ratios, and incident reporting.

See **Observation 6** in the **Strategic Plan and Risk Assessment** section for additional information on risks related to incident reporting that management did not identify in their risk assessment.

Recommendation: Management should strengthen oversight of residential facilities and the juvenile detention centers where they place custodial youth by holding facilities accountable for noncompliance in areas such as medical care, inadequate staffing, and incident reporting.

Management should ensure that all facilities provide medical care to youth as required and should follow up on corrective actions implemented by facilities that have previously demonstrated noncompliance. Oversight staff should verify that facilities have adequate medical coverage and that medication administration is performed by properly trained personnel.

Management should enhance its monitoring of staffing ratios by requiring facilities to maintain detailed documentation that allows for verification of staffing levels in each dorm or unit. Departmental monitors should also conduct more comprehensive reviews of both historical staffing records and real-time staffing levels during each site visit to ensure compliance with minimum standards.

Management should strengthen oversight of incident reporting by (1) requiring PME and licensing staff to review TFACTS incident data before conducting monitoring visits, (2) establishing a process to routinely compare paper-based incident forms to TFACTS entries to verify accuracy and completeness, and (3) requiring that all JDCs housing department youth report incidents in TFACTS. Additionally, the department should continue its recent efforts to run regular system reports to identify noncompliant facilities and ensure that all facility staff responsible for incident reporting receive training and system access.

The department should continue collaborating with all parties in the JDC rulemaking process. The department should also ensure that the revised rules include specific standards for

maintaining staffing records in a consistent and verifiable format that supports compliance monitoring.

Until the new rules are formally adopted, the department should issue interim written guidance to all JDCs outlining minimum documentation expectations to enable monitors to verify staffing ratios and ensure adequate supervision of youth in custody.

Management's Comment

Management concurs in part. The Department holds these facilities accountable within the scope of the Department's current authority.

The Department, through various methods, has held each of the facilities accountable when necessary. In September 2024, the Commissioner issued a letter to contracted facilities reminding each of the requirements of ratios and our intent to hold them accountable to those rules. All areas of noted noncompliance have been addressed through the Department's current oversight processes.

The Department concurs that provider monitoring will review incident reports prior to all visits with facilities to ensure compliance with the submission policy.

Auditor's Comment

We evaluated management's comment and determined that no changes were needed to the finding.

Matter for Legislative Consideration 1: The General Assembly may wish to consider whether the department's statutory regulatory authority should be expanded or clarified to provide more direct enforcement mechanisms over the publicly administered juvenile detention centers

Under Section 37-5-510, *Tennessee Code Annotated*, the Department of Children's Services' (the department) statutory authority to enforce compliance at juvenile detention

centers (JDCs) differs depending on whether the facility is publicly or privately operated.[145]

When a **privately operated JDC** fails to comply with departmental rules or contract provisions, the department may take several actions to compel compliance, such as placing the facility on probation, suspending or revoking its license, or terminating its contract.

In contrast, when a **publicly administered JDC**—operated by a local government, sheriff's office, or juvenile court—remains out of compliance, the department's enforcement authority is limited. The department may withhold an approval letter and coordinate with the facility to implement corrective actions.[146] However, if the facility fails to take corrective measures, the department must work with the Tennessee Attorney General's Office to file a complaint[147] in Chancery Court, a process that can be lengthy and resource-intensive. In other words, withholding the letter of approval for a noncompliant facility does not prevent a publicly operated JDC from continuing operations.

Given these limitations, the General Assembly may wish to consider whether the department's statutory authority should be expanded or clarified to provide more direct enforcement mechanisms over publicly administered JDCs, ensuring consistent accountability and protection for youth across all facilities. See **Figure 39** for a list of publicly administered JDCs.

145. Section 37-5-510(a), *Tennessee Code Annotated*, states, "Any child care agency, as defined in § 37-5-501, that is under the direct management of an administrative department of the state, a county, or a municipality, or any combination of these three (3), shall not be subject to licensure, but shall meet the minimum standards for programs and care as required of such child care agencies."

146. Section 37-5-510(c), *Tennessee Code Annotated*, states, "It is the duty of the department to cooperate with the publicly administered agencies herein referred to, to implement recommended changes in program and policies."

147. Section 37-5-510(e)(1), *Tennessee Code Annotated*, states, "If violations of the standards for child care agencies are found and are not corrected within a reasonable time, or, if serious violations are found that meet the requirements that would justify the suspension of a child care agency's license pursuant to § 4-5-320, the department may file a complaint in the chancery court of the county in which the child care agency is located."

Figure 39: Publicly Administered JDCs

Facility Name	Operator
Bedford County JDC	Bedford County
Blount County JDC	Blount County Sheriff's Office
Bradley County JDC	Bradley County Juvenile Court
Hamilton County JDC	Hamilton County Juvenile Court
Madison County JDC	Madison County Juvenile Court
Putnam County JDC	Putnam County Sheriff's Office
Rhea County JDC	Rhea County Sheriff's Office
Knox County JDC (Richard Bean Juvenile Service Center)	Knox County Sheriff's Office*
Rutherford County JDC	Rutherford County
Scott County JDC	Scott County
Sevier County Juvenile Services Center	Sevier County Sheriff's Office
Shelby County Youth Justice and Education Center	Shelby County Department of Corrections
Williamson County JDC	Williamson County Juvenile Court

*The Knox County JDC will be operated by the Knox County Sheriff's Office beginning in 2026.
Source: Publicly administered JDCs list as of February 2025.

Management's Comment

Acknowledge – No management comment required.

Juvenile Probation and Aftercare Programs

Juvenile probation and aftercare programs hold youth accountable while supporting rehabilitation and community safety. Departmental policies require case managers in the Office of Juvenile Justice to conduct regular face-to-face visits with youth, families, schools, and service providers to monitor compliance and assess progress. These contacts are essential for ensuring safety, identifying needs, and keeping the courts informed. Our goal was to determine whether Juvenile Justice case managers completed the required face-to-face visits for juveniles under probation and aftercare programs. See **Observation 5**.

Background

The Office of Juvenile Justice operates within the Department of Children's Services (the department) as Tennessee's state juvenile justice agency.[148] The office provides services to youth adjudicated delinquent by the courts, as well as youth at risk of coming into the department's custody. The office's mission balances public safety with opportunities for rehabilitation, using prevention, intervention, treatment, and training to reduce future delinquent behavior. The Office of Juvenile Justice emphasizes placing youth in the **least restrictive setting possible**, preferring community-based and family-focused services whenever safety allows. The office also engages families in planning through Child and Family Team Meetings and Family Permanency Plans, which outline the juvenile's needs, strengths, and long-term goals.

Oversight Functions

The Office of Juvenile Justice also administers several statewide oversight functions that support both custodial and community-based programs.

- **Interstate Compact for Juveniles:** The Interstate Compact for Juveniles governs the movement and supervision of delinquent youth and status offenders across state lines. Through this unit, Tennessee coordinates with other states to ensure youth transfers, returns, and supervision comply with national standards and protect public safety.
- **Absconder Unit:** This unit monitors and responds to cases where youth under department supervision leave placement or probation without authorization. Staff

148. Section 37-5-101 (b)(1), *Tennessee Code Annotated,* states, "Within the department, there is created a division of juvenile justice to serve children who are adjudicated delinquent."

coordinate with law enforcement and local jurisdictions to locate and return youth, reducing risks to both the community and the youth themselves.

- **Electronic Monitoring:** The department employs electronic monitoring as an alternative to detention for certain youth on probation or aftercare. This function uses GPS ankle devices and reporting software to track compliance with curfews, school attendance, and court-ordered restrictions. Electronic monitoring supports community-based supervision and helps youth reenter the community while maintaining accountability.
- **Prison Rape Elimination Act (PREA) Compliance:** The department is responsible for ensuring that all juvenile justice facilities under its oversight comply with federal PREA standards.[149] This includes developing and enforcing policies that prevent, detect, and respond to incidents of sexual abuse and harassment. PREA oversight involves staff training, facility monitoring, and investigation of allegations to ensure safe conditions for youth in custody.

These functions provide statewide structure and accountability to Tennessee's juvenile justice system, reinforcing the department's responsibility to balance community safety with effective rehabilitation for youth.

Custodial and Non-Custodial Services

The department provides both custodial and non-custodial supervision for delinquent youth. **Non-custodial services** include probation, aftercare, and intensive supervision programs. These approaches divert youth from entering or returning to state custody while ensuring accountability and community safety. Case managers monitor youth progress with the conditions for probation or aftercare, coordinate with schools and service providers, and may use electronic monitoring as part of supervision.

When youth cannot remain safely in the community, the Office of Juvenile Justice oversees **custodial services** through a range of placement settings. These include community-based private provider facilities that offer therapeutic treatment, as well as hardware-secure facilities for youth who have committed serious or violent offenses. The John S. Wilder Youth Development Center is the state-operated, hardware-secure residential facility for delinquent male youth. The department also licenses and contracts with juvenile detention centers and residential facilities across Tennessee to provide short- and long-term placement options. In all placements, the Office of Juvenile Justice seeks to match youth needs with appropriate services while maintaining community safety.

149. Prison Rape Elimination Act, Juvenile Facility Standards, United States Department of Justice Final Rule, "Prison Rape Elimination Act National Standards," Title 28, *Code of Federal Regulations,* Part 115.

Our audit focused on non-custodial youth in probation and aftercare programs and the services they received, which are discussed in the next section.

Probation and Aftercare Services

When a court adjudicates[150] a youth as delinquent, it can order juvenile probation. After the department releases a youth from custody, case managers may be required to provide aftercare services. In both probation and aftercare, case managers regularly monitor youth to ensure they comply with court orders and to support their rehabilitation.

Under Department Policy 13.12, "Probation Requirements for Delinquent Youth," case managers must make at least one face-to-face contact with the youth each month, with additional contacts required for intensive probation. They must also contact the youth's parents or legal guardians, school, and service providers each month. For aftercare services, Department Policy 13.11, "Trial Home Visit and Aftercare Requirements for Delinquent Youth," states that case managers must meet similar contact requirements. Intensive aftercare requires three monthly visits with the youth and two contacts with parents or guardians.

Between August 1, 2024, and January 31, 2025, 936 youth began probation, and 360 youth began aftercare supervision.

Source: Data obtained from the department.

These standards ensure case managers stay engaged in all aspects of a youth's environment, including at home and school, and with service providers such as therapists or behavioral management programs.

Juvenile courts may also place youth on diversion, typically for first-time offenders, or on inactive supervision when circumstances such as out-of-state residence or adult incarceration apply. For both diversion and probation, case managers must update records in the Tennessee Family and Child Tracking System (TFACTS), administer the Child and Adolescent Needs and Strengths assessment[151] within seven days, and develop a Family Permanency Plan[152] that outlines requirements and services.

150. In a juvenile justice context, "adjudicates" means that the court has held a formal hearing and determined whether the youth committed the alleged offense.
151. When a youth enters custody, the department performs a Child and Adolescent Needs and Strengths assessment to help identify the specific risks and needs of each youth.
152. The method the department uses to document the strengths and needs of delinquent youth. The Family Permanency Plan documents the provision of treatment and/or services and the progress the youth is making toward permanency.

Monitoring Open Cases

According to the department's protocol for case tracking, Team Leads and Coordinators in the regions conduct fidelity reviews[153] to monitor open cases and determine whether case managers make all required contacts.[154] For each review, regional supervisors select 10 open cases each month and assess whether case managers carried out the responsibilities outlined in policy. Supervisors present the review results at bi-monthly regional meetings. Each region tracks compliance in an internal Excel spreadsheet. Unfortunately, TFACTS lacks functionality in several areas, including the integration of other documents into the system.

Case Closure

Staff close a case when a youth

- successfully meets probation or aftercare goals;
- meets the court order or statute permitting closure;
- moves out of state, and the Tennessee Court of Jurisdiction did not refer the youth for services through the Interstate Compact for Juveniles; or
- transfers to adult court.

Case managers must document closure in TFACTS within 72 hours and prepare a comprehensive summary of the youth's progress and services received. These steps hold staff accountable and demonstrate whether the youth met their supervision or probation requirements.

Results of the Prior Audit

In the 2022 performance audit, we reported that rising turnover and high caseloads limited case managers' ability to complete the monthly probation and aftercare contacts required by Policy 13.12, "Probation Requirements for Delinquent Youth," and Policy 13.11, "Trial Home Visit and Aftercare Requirements for Delinquent Youth." Case managers often missed required contacts with youth, families, schools, and service providers, which reduced the department's oversight of juveniles under supervision. We also noted that supervisors were not consistently utilizing the tracking spreadsheet to perform the fidelity review to ensure caseworkers made all required contacts.

In response, management revised multiple policies, including Policy 13.10, "Custody Requirements for Delinquent Youth"; Policy 13.11, "Trial Home Visit and Aftercare

153. The department's "Protocol for Internal Control Case Tracking – JJ."
154. Policies 13.11, "Trial Home Visit and Aftercare Requirements for Delinquent Youth," and 13.12, "Probation Requirements for Delinquent Youth," state that Team Leaders must review case documentation quarterly to ensure staff are meeting contract requirements.

Requirements for Delinquent Youth"; and Policy 13.12, "Probation Requirements for Delinquent Youth," to clarify supervision requirements. The department also began holding regular (usually twice per month) "data calls" with regional directors and field staff to review contact numbers and identify areas needing additional resources. Management also requested budget increases to support higher case manager salaries, additional training, and field support.

Current Audit

We examined management's process for ensuring case managers completed face-to-face visits for juveniles on probation or aftercare services to support their rehabilitation. Specifically, we assessed whether management ensured that all required contacts were made for open cases within the established timeframes and that those case files contained the required visit documentation and supervisory review. Our review resulted in **Observation 5.** See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.

Observation 5: Management should strengthen its internal controls to ensure compliance with required probation and aftercare services to achieve full corrective action

Management revised the Department of Children's Services (the department's) policies[155] for probation and aftercare to clarify visit requirements as part of the corrective action for the prior audit finding.[156] While these measures represent progress toward improved accountability and compliance, management has not yet achieved full corrective action to address the prior audit condition. As such, staff are not consistently documenting visits in TFACTS as required, and the monitoring process does not verify that these reviews occurred. Until management strengthens the process, management cannot rely on fidelity reviews to provide accurate, statewide oversight or to drive consistent service quality improvements across all regions.

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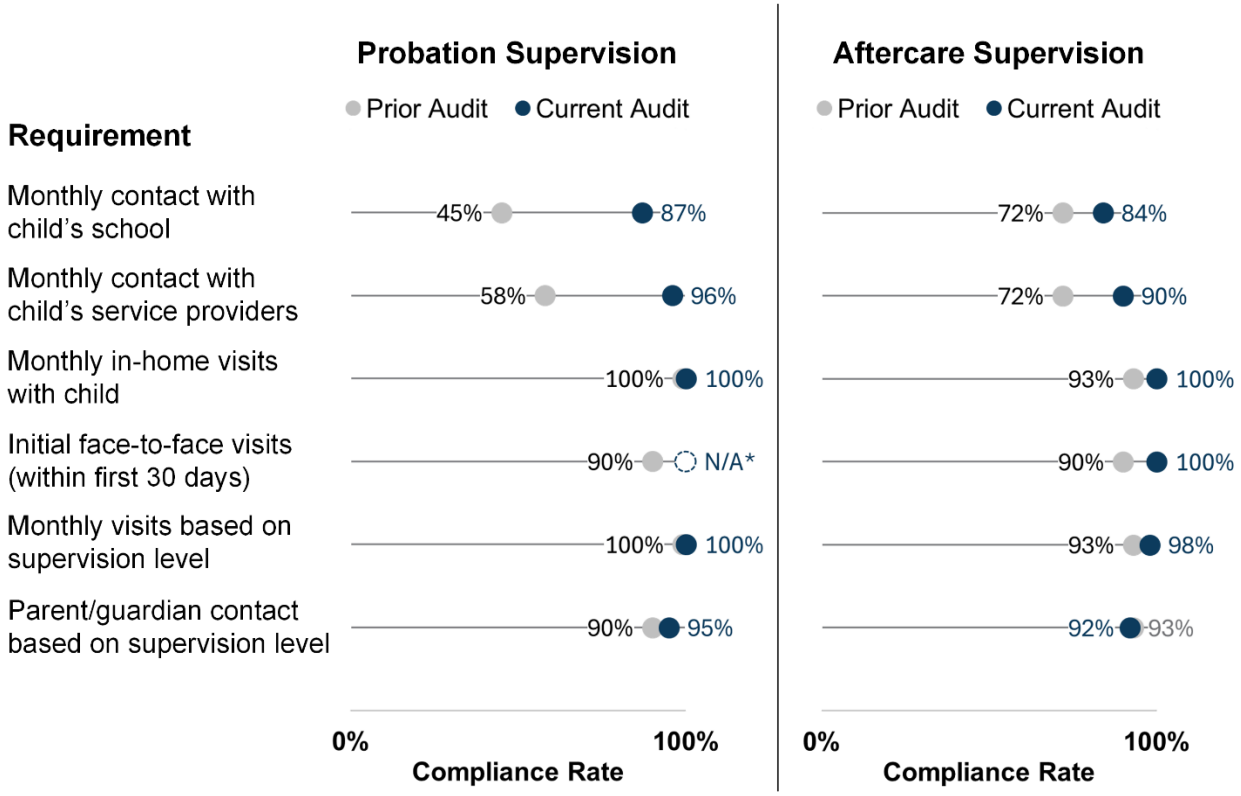
155. As part of its policy revisions, the department changed the school contact requirement in February 2025. This reduced the number of required contacts. Instead of once a month, under this change, case managers must contact a youth's school only when school issues cause the department to monitor the case. Our testwork for open cases was for the scope period of August 1, 2024, through January 31, 2025, prior to the change in policy.

156. See **Figure 59** in **Appendix 11** for a complete list of all criteria we reviewed to support the conditions of this observation.

Improvement Needed for In-person Visits to Schools, Service Providers, and Parent or Guardian Contacts

To test whether case managers conducted the required probation and aftercare services in compliance with the department's policies and procedures, we selected a nonstatistical, random sample of 60 open cases within our audit scope for each service. Probation and aftercare in-person visits showed improvement in almost all areas. See **Figure 40** for a comparison of prior and current audit results.

Figure 40: Probation and Aftercare Supervision, Comparison of Results from Prior Audit (2022) to Current Audit (2025)



* The department policy for initial face-to-face probation visits changed from the prior audit to the current audit, so we could not compare the 2022 results and the 2025 results.

Source: We created this table based on the results of our current and prior audit testwork.

These results indicate that although the department has reduced missed contacts across most categories, consistent documentation and completion of school, service provider, and family contacts remain areas where additional oversight and training are needed.

Documentation and Monitoring Weaknesses

Case managers must record all contacts in TFACTS;[157] however, we noted instances where case managers reported complete visits but failed to enter the visit into the system. Management attributed these lapses to staff turnover and confusion from when foster care case managers retained responsibility for a case that became an Office of Juvenile Justice case, which resulted in the case manager not knowing which department policy to use. When case managers do not document the required contacts, the department has reduced visibility into how youth on probation or aftercare are progressing.

We reviewed the fidelity process[158] supervisors use to monitor compliance with department policy and procedures. Each region maintains an Excel spreadsheet for supervisors to record their monthly fidelity reviews. Supervisors overwrite these spreadsheets each month rather than archiving them, leaving no historical records of review activity. As a result, management has not established an effective internal monitoring control.[159] Without historical review records, management cannot verify whether supervisors consistently conducted reviews, identify patterns of noncompliance, or confirm that staff corrected prior issues.

These gaps hinder management's ability to monitor compliance with department policies and to assess whether youth receive the intended level of support.

See **Observation 6** in the **Strategic Plan and Risk Assessment** section for additional information on risks related to juvenile justice that management did not identify in their risk assessment.

Management should strengthen oversight of probation and aftercare contacts by implementing a system that allows management to conduct real-time supervisory reviews rather than relying on spreadsheets (see the **Tennessee Family and Child Tracking System** section for more details). Until the new information system is implemented, management should save the regional supervisors' fidelity reviews. In addition, management should provide targeted training to ensure case managers understand both the requirements of Policy 13.12, "Probation Requirements for Delinquent Youth," and Policy 13.11, "Trial Home Visit and Aftercare Requirements for Delinquent Youth," as well as how to carry them out in practice. Improving supervisor review processes and case

157. Policies 13.11, "Trial Home Visit and Aftercare Requirements for Delinquent Youth," and 13.12, "Probation Requirements for Delinquent Youth," state that all contacts should be documented in the youth's electronic case file in TFACTS.
158. The department's "Protocol for Internal Control Case Tracking – JJ."
159. According to the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book), Principles 10 and 16, management should design control activities to achieve objectives and respond to risks, and management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.

manager training will help the department ensure that case managers consistently complete and properly document required contacts.

Management's Comment

Acknowledge – No management comment required.

Interstate Compact for Juveniles

The Tennessee Department of Children's Services (the department) has joined other states and U.S. territories to form the Interstate Compact for Juveniles, whose mission is to protect child welfare and public safety through the proper supervision of juveniles across state lines. To carry out the Interstate Compact for Juveniles' mission, the department houses the state's Interstate Compact for Juveniles office (the state's compact office), which shares juvenile case information among the members across states to ensure that the juveniles receive the required services and remain accountable even when they move beyond a state's borders. The compact also requires each state to maintain a state council to advise on compact issues in its respective state and to address changes from the compact's national governing body, the Interstate Commission for Juveniles.

Our first goal was to determine whether the state's compact office complied with the compact's case documentation requirements. Our second goal was to determine whether Tennessee met the compact's state council statutory membership requirements. Our review resulted in **Matter for Legislative Consideration 2**.

Background

History of the Interstate Compact for Juveniles

Before the Interstate Compact for Juveniles began in the 1950s, states faced challenges when dealing with juveniles who crossed state lines, either by running away, escaping custody, or moving while under probation/parole. Each state had its own laws, and there was no legal mechanism in place to ensure cooperation among the affected states. Without the compact, the states experienced gaps in juvenile supervision, accountability, and public safety across state lines. To address these issues, states created the original

Interstate Compact[160] for Juveniles, which was introduced in 1955, and by 1986, all 50 states and several U.S. territories had joined. The original compact in the 1950s was designed to

- provide a formal system for the **return of runaway juveniles** to their home states;
- establish **mutual obligations among states** for supervising and returning juveniles who abscond, escape, or relocate; and
- promote **public safety and victim protection** by preventing gaps in supervision.

Over time, states identified problems with the original compact. Communication between states was inconsistent, compliance was difficult to enforce, and states differed in how they defined and supervised juveniles. In response, the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention, along with the Council of State Governments, developed a revised compact, which

- created the national governing body, the **Interstate Commission for Juveniles**, with rulemaking authority;
- required every state to follow uniform rules; and
- strengthened state accountability, victim protection, and juvenile due process across state lines.

States began adopting the revised compact in 2003. In 2008, when Tennessee and Illinois joined, the compact reached the required 35-state threshold to take effect. Today, the compact governs all 50 states, the District of Columbia, and the U.S. Virgin Islands.

The UNITY Case Management System

In 2021, the compact launched the Uniform Nationwide Interstate Tracking for Juvenile (UNITY) system. According to the federal Interstate Compact for Juveniles' website, "About the Interstate Compact for Juveniles," this system helped create a secure, centralized platform for how states manage interstate juvenile cases.

At the same time, the compact adopted a strict privacy policy[161] to protect sensitive juvenile information stored in UNITY. Under this policy, states restrict access to authorized compact officials only. The compact prevents external entities, including auditors and reviewers, from accessing UNITY directly. The compact also forbids anyone from extracting or reusing UNITY documentation for audit purposes.

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160. An interstate compact is a legal agreement between two or more states to address shared issues, and once Congress consents, the compact carries the force of federal law.
161. The "ICJ Administrative Policy, UNITY Privacy Policy, 02-2021."

Tennessee's Compact Framework

Tennessee's compact framework is codified in Section 37-4-101, *Tennessee Code Annotated*, which authorizes the Governor to enter the compact and outlines its core purposes:

- ensuring proper supervision or return of juveniles on probation/parole who abscond, escape, or run away;
- returning runaway juveniles safely; and
- providing mechanisms for tracking, supervision, cooperative institutional placement, data collection, rulemaking, and training among member states.

Section 4-29-247, *Tennessee Code Annotated*, also requires the General Assembly to periodically reaffirm the state's membership or withdraw from the compact. In 2018, the legislature extended Tennessee's membership until June 2026. While Tennessee remains a compact member, it must comply with compact rules and policies.

This is the first performance audit of the Interstate Compact for Juveniles (the compact).

Organization and Requirements of the Compact

The National Interstate Commission for Juveniles

The Interstate Commission for Juveniles (the national commission) governs the compact and includes representatives from all member states and territories. Each state appoints its own representative, who enforces compact rules and represents the state at the national commission. The national commission carries out its work through an Executive Committee that manages daily operations, while other committees oversee compliance, finance, training, and other areas essential to compact administration.

State Council

The national compact requires each state to establish a state council. Section 37-4-101, Article IX, *Tennessee Code Annotated*, states that "each member state shall create a state council for interstate juvenile supervision." The state council meets at least once each year and must include at least one representative from the legislative, judicial, and executive branches, along with victims' advocates and the state's Compact Administrator or designee. As of June 2025, Tennessee's state council includes 14 members, who advise on state implementation and ensure broad representation in compact governance.

Tennessee's Interstate Compact for Juveniles

The Department of Children's Services (the department), through its Office of Juvenile Justice (the office), is the designated authority for managing Tennessee's responsibilities under the Interstate Compact for Juveniles. The office's staff has three key positions to

manage these responsibilities: the Compact Administrator; the Deputy Compact Administrator, who also serves as Tennessee's representative on the Interstate Commission for Juveniles; and the Program Coordinator. The Compact Administrator oversees the state's participation in the compact, coordinates with state and local agencies on the movement of juveniles across state lines, and represents the state at the National Interstate Commission for Juveniles.

Membership Fees

All member states and territories pay **annual dues** to support the national commission's operations and staffing. The commission uses a formula to calculate dues, which is updated every five years. Tennessee paid $22,000 annually from fiscal years 2021 through 2023. After the most recent recalculation in 2024, Tennessee's dues increased to **$29,700**.

Monitoring Performance with Compact Rules

The national commission conducts performance reviews of each member state to ensure compliance with compact rules. These performance reviews could result in a report, an email, or a phone call to share the results. States that fail to comply with the compact's requirements may face substantial financial sanctions of up to $10,000 to $75,000. According to the compact's Commissioner, Tennessee has not been sanctioned or fined in the nine years she has worked with the compact.

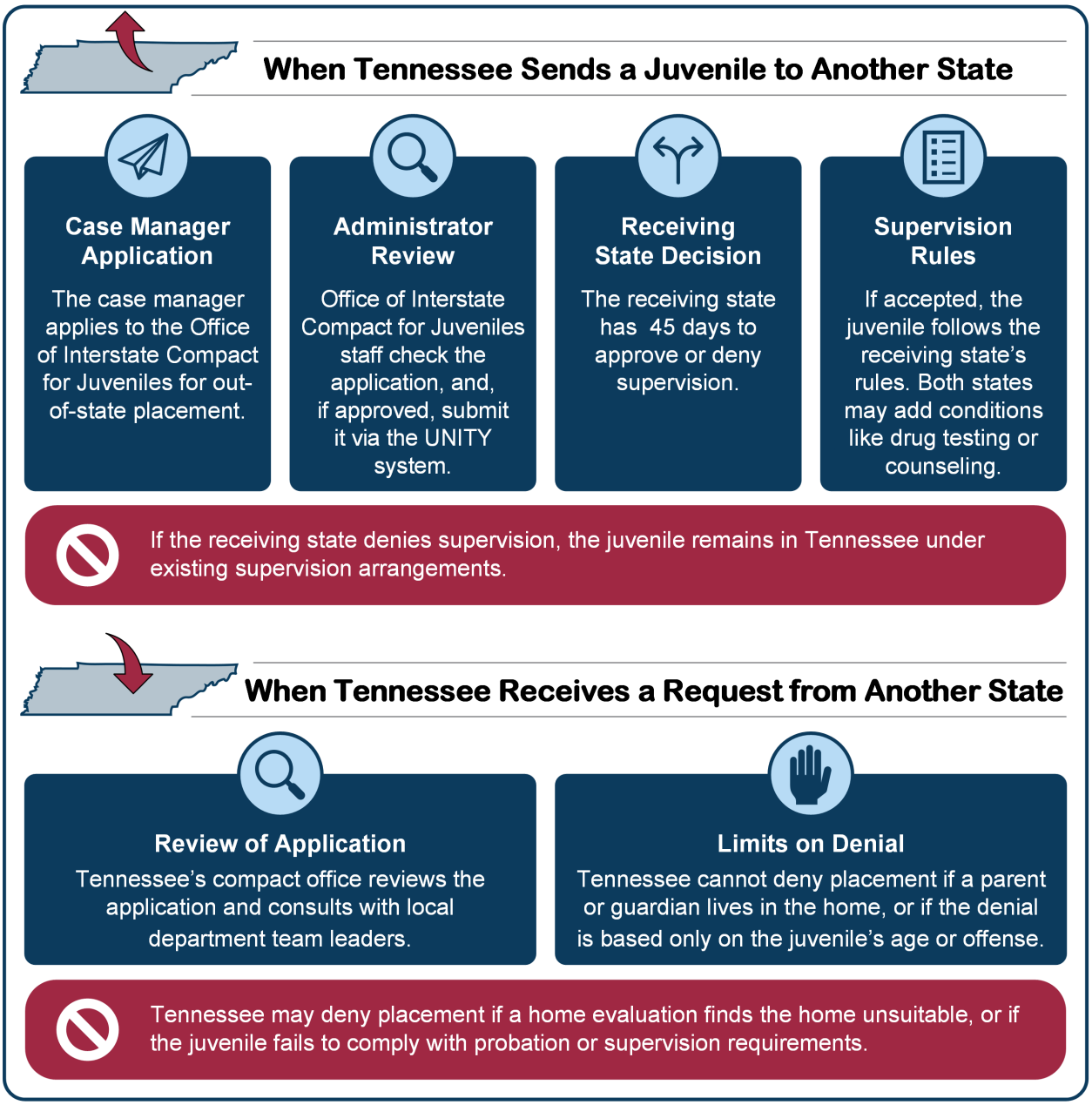
Tennessee's Compact Office

In 2024, Tennessee's office processed more than 200 juvenile cases under the compact. These cases involved juveniles under the department's care who required supervised transfers, returns as runaways or absconders, or other services coordinated across state lines.

Juvenile Placement and Supervision Process

To fulfill responsibilities under the compact, the department's Office of Juvenile Justice staff are responsible for processing the case files and coordinating the juveniles' transfers to other states or transfers of juveniles from other states to Tennessee. See **Figure 41** for the juvenile placement and supervision process.

Figure 41: Juvenile Placement and Supervision Process



Source: Auditor created using Department Policy 13.3, *Interstate Compact for Juveniles*.

Monitoring and Reporting Requirements

While juveniles are supervised under the compact, the office staff in a receiving state must prepare and submit quarterly progress reports regarding the juvenile to the sending state. These reports describe the juvenile's adjustment to placement, school or work performance, compliance with supervision rules, and any new legal charges. In Tennessee, Department Policy 13.3, "Interstate Compact for Juveniles," requires case

managers to document all casework in the Tennessee Family and Child Tracking System and on approved compact forms.

Current Audit

We focused our review on the state's compliance with the national compact requirements for uploading juvenile case documentation into the UNITY system and on membership requirements for the state council. See **Matter for Legislative Consideration 2**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.

> **Matter for Legislative Consideration 2:** The General Assembly may wish to evaluate the legislative options to enhance the state's oversight of the Interstate Compact for Juveniles to establish a privacy requirement that does not impede the state's oversight responsibilities to ensure transparency and accountability of the Interstate Compact

Oversight of the Compact

Under national compact rules, member states must use the national Uniform Nationwide Interstate Tracking for Juvenile (UNITY) system to share and store juvenile case information. The compact's privacy policy prohibits outside governmental agencies, including auditors, from accessing UNITY records of juveniles subject to the compact for review or assessment. Due to this privacy restriction, we were unable to independently verify the state's or the Department of Children's Services' (the department's) compliance with case documentation requirements.

Given the current limitations on transparency and accountability, the General Assembly may wish to evaluate legislative options to enhance oversight and balance privacy within the Interstate Compact for Juveniles (ICJ). The legislature could initiate its own actions to obtain sufficient oversight access or direct the department to collaborate with other member states to advocate for adjustments to the ICJ's privacy restrictions. The ultimate goal in either approach would be to gain access that allows the state to perform high-level monitoring and oversight, independently verifying that the ICJ operates in the best interest of both juveniles and the public, while also protecting sensitive juvenile information.

If national compact leaders do not modify the privacy policy to permit a member state's oversight and monitoring, the General Assembly may wish to consider the next best steps for Tennessee as a member state.

Appointment of Legislative Representation to the State Council

Section 37-4-101, *Tennessee Code Annotated*, Article IX, requires each member state's council to include at least one representative from the legislative, judicial, and executive branches of government, as well as victims' groups and the state's Compact Administrator or designee.

As of June 2025, Tennessee's state council had 14 members, but the legislative branch seat remained vacant. The General Assembly may wish to appoint a representative from the legislative branch and designate the chamber from which the appointment should come, bringing the state council into compliance with statutory requirements and ensuring legislative input in compact governance. After our review, this position was appointed in October 2025.

Management's Comment

TCA 37-4-101, et. seq. mandates the department's participation in the Interstate Compact for Juveniles. Our participation allows us to supervise delinquent youth/status offenders coming into Tennessee and youth who are relocating to other states to be supervised by the receiving state. It also allows for the return of runaway/escapee/absconders and accused delinquents to be returned to the state seeking them. All 50 U.S. states and 2 territories participate in the Interstate Compact for Juveniles.

During the Interstate Compact for Juveniles annual council meeting conducted on October 29, 2025, both Senator Walley and Representative Alexander were introduced as new members of the ICJ council.

The Department does not believe that withdrawal from the compact benefits children and youth in the state.

Strategic Plan and Risk Assessment

A critical step in fulfilling a department's mission and vision is to create and adhere to a robust strategic plan and risk assessment process. According to the Office of Customer Focused Government, a department's mission statement is its "purpose and reason for existence," and the vision statement "articulates the desired future state of a department in terms of its strategic direction." Management provides 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. Our first goal was to determine whether management revised its four-year strategic plan and annual Customer Focused Government plans to ensure goals and objectives are focused on mission-critical challenges that the Department of Children's Services encounters. Our second goal was to determine whether management ensured its risk assessment included an evaluation of risks within all major divisions and operations. See **Observation 6**.

Background

Strategic Plan

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,

> 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[162] plan each year, which supports an agency's overall four-year 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.

Risk Assessment Process

To help state agencies prepare their risk assessments in compliance with the Financial Integrity Act of 1983,[163] 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).[164] The Department of Children's Services (the department) also follows its Policy 1.7, "Risk Management,"

> The Department of Children's Services shall comply with the State of Tennessee policies and procedures, rules and laws to identify and reduce or eliminate risks to its property, interests, service recipients and employees, and to minimize and contain the costs and consequences in the event of harmful or damaging incidents arising from those risks.

To comply with the Financial Integrity Act of 1983 and its policy, the department's Internal Audit Director stated that for the fiscal year 2025 risk assessment, where leadership identified areas where the control is ineffective, the staff responsible created a Management Action Plan that documents the steps leadership plans to take and the timeline to correct the ineffective control. The department's Internal Audit Director coordinates updates to the risk assessment and communicates the status of management action plans to correct internal control deficiencies to department leadership on a quarterly basis.

Results of the Prior Audit

In the 2022 performance audit report, we found that management did not include goals and objectives in its strategic plan and annual Customer Focused Government plans to

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162. 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.

163. 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.

164. 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.

address mission-critical challenges that the department faces, such as staffing and placement. We also found that management's risk assessment did not include risks and controls for all major departments and operations. Management's corrective action to address the conditions noted in the finding was to revise their strategic plan, revise their risk assessment policy, expand their risk assessment to include all business units, and complete quarterly updates to the risk assessment. While management implemented these corrective actions, some risks and controls remain unaddressed in the department's risk assessment.

Current Audit

We focused our review on the department's revision to its mission, strategic plan, annual Customer Focused Government plans, and risk assessment. Our review resulted in **Observation 6**. See **Appendix 1** for our detailed audit objectives, conclusions, and methodologies.

Observation 6: Management's risk assessment process has significantly improved in recent years, but some risks and controls remain unaddressed

After the 2022 performance audit, the Department of Children's Services (the department) improved its risk assessment process. For instance, in 2022, the department had not evaluated several critical offices within the department, like human resources, continuous quality improvement, information technology and support, and mental health and education programs. The department evaluated these offices in fiscal year 2025. The department also identified several risk areas with controls that management found to be ineffective. The department was in the process of implementing management action plans to address these ineffective controls during our audit period.

Despite these improvements, the department has not fully identified or assessed the risks associated with some program areas. Without identifying these risks, management cannot design appropriate control activities to mitigate them. See **Figure 42.**

Figure 42: Program Risks

Report Section	Program	Unidentified Risk
Child Safety	**Special Investigations Unit and Child Protective Services**	Case extensions not properly justified or documented (see **Finding 1** and **Finding 2**)
		Inaccurate case substantiation decisions and monitoring of substantiation rates (see **Finding 1** and **Finding 2**)
		Lack of collaboration between Child Protective Investigative Team members (see **Finding 1** and **Finding 2**)
	Child Fatality and Near-Fatality Public Notifications	Delayed autopsy reports from medical examiners (see **Finding 3**)
	Child Abuse Hotline	Untimely screening of web reports (see **Observation 1**)
		Improper overrides of screening decisions (see **Observation 1**)
Placements	**Temporary Settings**	Children and youth staying in temporary settings such as transitional homes and state office buildings are not kept safe and do not receive needed services (see **Finding 4**)
Information Systems	**New System Implementation**	No risks or controls identified related to data cleansing and migration to the new Comprehensive Child Welfare Information System (see **Finding 5**)
Relative Caregiver Program	**Waitlists**	Families may experience delays getting services and receiving financial assistance (see **Observation 4**)
Oversight of Facilities	**Incident Reporting**	No risks or controls identified related to facilities not reporting incidents (see **Finding 8**)
Juvenile Justice	**Probation and Aftercare**	Case managers do not review to identify missed monthly school and parent contacts for delinquent youth (see **Observation 5**)
Interstate Compact for Juveniles	**Interstate Compact for Juveniles**	No risks or controls identified for the compact* (see **Matter for Legislative Consideration 2**)

* At the time of our review, the department had recognized that there was no program risk assessment for the compact, and management was planning on adding it to their fiscal year 2026 risk assessment.

Source: Auditor compiled based on the results of our review of the department's fiscal year 2025 risk assessment.

We also identified throughout our audit work other mitigating internal controls that management had identified as effective; however, these controls were not effective. See **Finding 1**, **Finding 2**, **Finding 3, Finding 4, Finding 5, Finding 6, Finding 7,** and **Finding 8.**

According to Green Book Section 1, "Fundamental Concepts of Internal Control," OV1.03,

> 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.

According to management, the risk assessment process continues to undergo quarterly revisions, and as a result, full remediation of the unidentified risks and the mitigating controls has not yet been achieved.

When management does not identify program risks and monitor the mitigating controls, it cannot ensure that operations function as intended or that critical services, including child safety investigations and caregiver supports, are delivered effectively and in a timely manner. Management should continue to follow up on each Management Action Plan and ineffective control. The risk assessment should identify risks within every program area and should include effective controls to mitigate the identified risks. Additionally, management should 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

Management concurs.

APPENDICES

Appendix 1: Objectives, Conclusions, and Methodologies

Prior Audit Follow-up

1. **Audit Objective:** In response to the prior audit finding, did management establish a process to investigate and document all Prison Rape Elimination Act (PREA) allegations in accordance with federal PREA standards and Department of Children's Services (department) policy?

   Conclusion: Based on our review, management established a process to ensure PREA allegations were investigated in accordance with federal PREA standards and department policy. Based on our testwork of PREA investigations, the federal PREA standards were met. See **Finding 1** in the **Child Safety Part 1** section for the impact on the Special Investigations Unit (SIU) investigative process involving PREA allegations.

2. **Audit Objective:** In response to the prior audit finding, did management establish a process to monitor all facilities that primarily house juvenile delinquents to ensure they are PREA compliant?

   Conclusion: Based on our review, management established a process to determine which facilities are required to follow federal PREA standards and monitored the facilities that primarily housed juvenile delinquents to ensure they are PREA compliant. Our review found that site visit forms, interview notes, supporting records, and the Statewide PREA Coordinator's approvals demonstrated that 19 facilities were visited and evaluated for PREA compliance during 2024.

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

   Conclusion: Based on our review, the Provider Quality Team staff followed up and conducted reviews on provider and Wilder Youth

Development Center employees to address concerns with violations with department standards, contract provisions, or state regulations.

Methodology to Address the Audit Objectives

To address audit objective 1, including gaining an understanding of the department's process to investigate and document PREA allegations in accordance with federal standards and department policy, and to assess the design and implementation of internal controls significant to this objective, we interviewed the Statewide PREA Coordinator, a Data Analytics Specialist, and a PREA Investigator. We reviewed

- Title 28, *Code of Federal Regulations*, Part 115, "National Standards to Prevent, Detect, and Respond to Prison Rape" (federal PREA standards);
- management's 30-day and 6-month corrective action plans developed in response to the prior audit finding;
- Department Policy, Chapter 14, *"*Child Protective Services*"*; and
- Department Policy 18.8, "Prison Rape Elimination Act (PREA)."

To test the operating effectiveness of the department's investigation controls, we obtained a list of 109 reported PREA allegations during calendar year 2024. From this population, we selected a random, nonstatistical sample of 25 reported allegations. Of this sample of 25 allegations, 6 were investigated before the transition to PREA investigators being incorporated into SIU. For those 6 allegations, we evaluated the investigation based on prior processes, and for the other 19 allegations, we evaluated investigations based on SIU investigative processes. For each allegation, we verified whether investigators completed the required steps under

- Policy 14.2, "Screening, Priority Response, and Assignment of Child Protective Services Cases";
- Policy 14.5, "Child Protective Services Multiple Response System";
- Policy 14.7, "Multi-Disciplinary Team: Child Protective Investigative Team (CPIT)";
- Policy 14.10, "Special Investigations Unit";
- Policy 14.11, "Child Protective Services Care File Organization, Documentation and Disposition"; and
- Policy 18.8, "Zero-Tolerance Standards and Guidelines for Sexual Abuse and Sexual Harassment Incidents and Prison Rape Elimination Act (PREA)."

We verified that investigators included timely face-to-face contact with alleged child victims, entered case documentation in the Tennessee Family and Child Tracking System, and met case closure deadlines.

To address audit objective 2, including gaining an understanding of the department's process to calculate and monitor facilities that primarily house juvenile delinquents for PREA compliance, and to assess the design and implementation of related internal controls, we interviewed a PREA Monitor and a department Data Analytics Specialist. We reviewed the

- CS-4242 PREA Site Visit Form,
- the "Protocol for the Statewide PREA Coordinator,"
- the Final Calculation for PREA Facilities in 2024,
- the PREA Facility Monitor Job Plan, and
- management's 30-day and 6-month corrective action plans developed in response to the prior audit finding.

To test the operating effectiveness of the department's monitoring controls, we obtained a list of all 19 facilities required to be monitored in calendar year 2024. We assessed the sufficiency and appropriateness of the data supporting this list and recalculated facility populations to verify that all applicable PREA facilities were included. We reviewed monitoring records created through the CS-4242 "PREA Site Visit" forms, interview notes, and supporting records, and confirmed that the Statewide PREA Coordinator reviewed and approved each site visit report in accordance with department policy.

To address audit objective 3, including gaining an understanding of the Provider Quality Team's (PQT) process and procedures for identifying provider employees involved in repeat SIU investigations and addressing concerns of child abuse allegations and to assess the design and implementation of significant internal controls, we reviewed the PQT protocol, PQT's tracking tools, Contract Provider Manual, SIU policies, Behavior Management Policies, the department's Memorandum of Understanding with DMHSAS, and all Provider Performance Improvement Plans that were active during the audit scope period. We interviewed PQT management, Network Development management, Licensing management, Legal, Provider Monitoring and Evaluation management, Child Abuse Hotline Staff, and SIU staff. To determine the operating effectiveness of this objective, we performed a reconciliation between SIU's records that contain all SIU provider investigations initiated and closed between January 1, 2023, and December 31, 2024, against PQT's SIU Tracking Tool containing all SIU provider investigations forwarded by SIU in 2023 and 2024. After verifying the accuracy and completeness of PQT's Tracking Tool, we selected a random, nonstatistical sample of 30 items and requested all follow-up action documentation to ensure that all child abuse allegation concerns regarding provider employees were properly addressed in accordance with the PQT protocol and SIU policies. For all provider concerns that were outside of PQT's scope, we communicated with the appropriate divisions within the department to determine if the concerns were properly addressed.

Current Audit

Child Safety Part 1: Special Investigations Unit and Child Protective Services Investigations

1. **Audit Objective**: In response to the prior audit finding, did the department move child abuse and neglect allegations through key points of the Special Investigations Unit's (SIU) investigative process as required by statute and department policies?

   Conclusion: Based on our review, management and staff still did not meet key timelines of the investigative process for SIU. We found that investigators did not meet priority response, notify the Child Protective Investigative Team (CPIT), conduct safety assessments, and classify or close cases in a timely manner. Our expanded review also found that investigators did not complete all monthly face-to-face visits with children. Supervisors also did not complete monthly supervisory reviews, ensure all classification decisions were correct, and review and approve case closures on time. For SIU, we also found a lack of quality case management and low substantiation rates. See **Finding 1**.

2. **Audit Objective:** In response to the prior audit finding, did the department move child abuse and neglect allegations through key points of the Child Protective Services' (CPS) investigative process as required by statute and department policies?

   Conclusion: Based on our review, management and staff still did not meet key timelines of the investigative process for CPS. We found that investigators did not meet priority response, notify CPIT, conduct safety assessments, and classify or close cases timely. Our expanded review also found that investigators did not complete all monthly face-to-face visits with children. Supervisors did not complete monthly supervisory reviews, ensure all classification decisions were correct, and review and approve case closures on time. See **Finding 2**.

Methodology to Address the Audit Objectives

To address our audit objective, including gaining an understanding of management's processes for receiving and investigating child abuse and neglect allegations and to assess management's design and implementation of internal controls significant to our audit objective, we gained an understanding of the investigative process for CPS and SIU. This included walkthroughs of the entire investigative process from receiving an allegation of child abuse or neglect at the Child Abuse Hotline to reviewing and closing a

case. This also included obtaining an understanding of the department's quality control process for CPS and SIU investigations. We interviewed leadership and staff, including

- Child Protective Services: a former Deputy Commissioner of Child Safety who is now the current Deputy Commissioner of Statewide Services, the Deputy Commissioner of Regional Operations, Assistant Commissioners of Field Operations, and CPS Investigators.
- Office of Continuous Quality Improvement (includes SIU): the Assistant Commissioner, the Executive Director of Quality Compliance; the former and current Executive Director of Internal Affairs, SIU, and the Office of Access and Engagement; the Executive Director of the Accreditation, Policy, and Safety Action Group; the Director of the Provider Quality Team and the Foster Home Quality Team; the former Director of Internal Affairs; the former and current Director of the Special Investigations Unit; and an SIU Team Lead and investigator.
- Other Department Leadership: the Commissioner, the General Counsel, the Senior Associate Counsel, the Internal Audit Director, and the Senior Information Technology Director within Strategic Technology Solutions.

We reviewed the department's 30-day and 6-month corrective action plans that management developed in response to the 2022 performance audit's prior finding. We obtained and reviewed local CPIT protocols. We reviewed the following information for child abuse and neglect investigative processes, including the following statutes, policies, protocols, manuals, and work aids:

- Section 37-1-403, *Tennessee Code Annotated*, Reporting of brutality, abuse, neglect, or child sexual abuse – Notification to parents of abuse on school grounds or under school supervision – confidentiality of records;
- Section 37-1-406, *Tennessee Code Annotated*, Availability for receiving reports – Commencement of Investigations – Examination and observation of child – Reports – Services Provided – Investigators – Interpreter for child who is deaf or hard of hearing;
- Policy 4.4, "Performance and Case Supervision Practice Guidelines and Criteria";
- Policy 14.1, "Child Abuse Hotline";
- Policy 14.2, "Screening, Priority Response and Assignment of Child Protective Services Cases";
- Policy 14.4, "CPS: Locating the Child and Family";
- Policy 14.6, "Child Protective Services Case Tasks and Responsibilities";
- Policy 14.7, "Multi-Disciplinary Team: Child Protective Investigation Team";
- Policy 14.10, "Special Investigations Unit Child Protective Services Investigations";

- Policy 14.11, “Child Protective Services Case File Organization, Documentation and Disposition”;
- Policy 14.21, “Internal Quality Control for the Office of Child Safety”;
- “Protocol for Completion of the Family Advocacy and Support Tool”;
- the *Child Protective Services Tasks Manual*; and
- Work Aid 4: “Special Child Protective Services Investigative Tasks and Activities.”

We discussed the substantiation rate calculation methodology for both SIU and CPS. We obtained and reviewed the substantiation rates for SIU.

To determine the operating effectiveness of CPS and SIU’s supervisory review controls, we obtained a Tennessee Family and Children Tracking System (TFACTS) extract of CPS investigations, CPS assessments, and SIU investigations opened between September 1, 2022, and January 31, 2025. We performed procedures to confirm the completeness of this population. The population for SIU investigations was 3,483 cases, the population for CPS investigations was 18,213 cases, and the population for CPS assessments was 45,922 cases. We then selected a sample of 150 cases: 65 SIU investigations (nonstatistical random), 60 CPS investigations (stratified), and 25 CPS assessments (stratified). We performed testwork on the sample to determine compliance with statutes, policies, and procedures. We stratified CPS investigations and CPS assessments because it has regions, and we wanted to select at least 1 case from all the regions.

Child Safety Part 2: Child Fatality and Near-Fatality Public Notifications

Audit Objective: Did management ensure compliance with the department’s statutory responsibility for publicly reporting child fatalities and near fatalities?

Conclusion: Based on our review of child fatalities from 2023 and 2024, we found that public reporting of child fatalities was impacted by delayed autopsy reports, incomplete or delayed investigative tasks, and delayed death summary reviews. We also found that the department had not publicly reported any near fatalities since October 2023 because it did not have a physician reviewer in place. See **Finding 3**.

Methodology to Address the Audit Objective

To address our audit objective, including gaining an understanding of management’s processes for tracking and reporting child fatalities and near fatalities, and to assess management’s design and implementation of internal controls significant to our audit

objective, we interviewed staff, reviewed the department's public reporting website, and performed walkthroughs. We interviewed leadership and staff, including

- Office of Continuous Quality Improvement (includes SIU): the Assistant Commissioner; the Executive Director of Quality Compliance; the Executive Director of Internal Affairs, SIU, and the Office of Access and Engagement; the Executive Director of Accreditation, Policy, and Safety Action Group; and the Director of Child Fatality Monitoring.
- Child Protective Services: the Assistant Commissioner of West Field Operations, the Assistant Commissioners of East Field Operations, and the Executive Director of West Tennessee.
- Other Department Leadership: the Deputy Commissioner of Statewide Services and the Executive Director for Contracts, Grants, and Procurement.

We reviewed the following information for hotline processes, including the following statutes, policies, protocols, manuals, and work aids:

- Section 37-5-107, *Tennessee Code Annotated,* Confidentiality of Records;
- Section 37-5-124, *Tennessee Code Annotated,* Disclosure of the death or near fatality of persons in the custody of the department of children's services;
- Policy 20.27, "Child Death/Near Death Rapid Response";
- Policy 20.28, "Child Death and Near Death Responses and Review Policy";
- Policy 20.29, "Safe Systems Analysis Policy";
- Policy 14.6, "Child Protective Services Case Tasks and Responsibilities";
- Policy 14.10, "Special Investigations Unit Child Protective Services Investigations";
- "Protocol for Child Death/Preliminary Near Death Assignment and Review," and
- the *CPS Task Manual*.

We also reviewed the department's Child Death and Near-Death Public Notification page on their website to obtain information on public postings from 2023 through the end of our fieldwork.

To assess management's tracking and reporting process, we obtained and reviewed the department's fatality and near-fatality tracking spreadsheets. For 2023, there were 192 child fatality cases, and for 2024, there were 168 child fatality cases. We selected a nonstatistical, haphazard sample of 70 death cases that were opened in 2023 and 2024, for which the department had not yet posted the final details online. We reviewed the case information in TFACTS and discussed these cases with management to determine the cause of reporting delays. We also obtained and reviewed the department's tracking

spreadsheet for the complete population of 58 near fatalities awaiting confirmation by a physician reviewer from October 1, 2023, to May 22, 2025, and discussed these cases with management to determine why no information had been posted publicly.

Child Safety Part 3: Operations of the Child Abuse Hotline

Audit Objective: Did management ensure that the Child Abuse Hotline (the hotline) maintained the required resources to timely respond to allegations of child abuse and neglect?

Conclusion: Based on our review, management largely ensured that the hotline maintained the required resources to timely respond to allegations of child abuse and neglect. Management is also aware of the potentially critical staffing issues that the hotline faces and has taken action to increase web reporting and hire staff. The hotline also did not have benchmarks in place to monitor how quickly staff processed the web-based reports. See **Observation 1.**

Methodology to Address the Audit Objective

To address our audit objective, including gaining an understanding of management's processes for receiving and triaging child abuse and neglect allegations, and to assess management's design of internal controls significant to our audit objective, we gained an understanding of the hotline's operations. This included walkthroughs of the hotline's process for receiving allegations on the phone and online, as well as the hotline's processes for screening allegations and assigning them to the appropriate unit for investigations. To gain this understanding, we interviewed leadership and staff, including

- Child Abuse Hotline: the former and current Director of the Child Abuse Hotline, a Team Coordinator, an Intake Supervisor, and an Intake Analyst.
- Strategic Technology Solutions: the Director of the Office of Data Governance and Analytics, an IT Senior Manager, and current and former Data Analytics Specialists.

We reviewed the following information for hotline processes, including the following statutes, policies, protocols, manuals, and work aids:

- Section 37-1-403, *Tennessee Code Annotated,* Reporting of brutality, abuse, neglect, or child sexual abuse – Notification to parents of abuse on school grounds or under school supervision – confidentiality of records;
- Section 37-1-406, *Tennessee Code Annotated,* Availability for receiving reports-Commencement of Investigations – Examination and observation of child –

Reports – Services Provided – Investigators – Interpreter for child who is deaf or hard of hearing;

- Policy 14.1, “Child Abuse Hotline”;
- Policy 14.2, “Screening, Priority Response and Assignment of Child Protective Services Cases”;
- “Lost Caller Protocol”;
- the *Screening Protocol Manual*;
- Work Aid 1: “CPS Categories and Definitions of Abuse and Neglect”;
- Work Aid 2: “Child Abuse Hotline”; and
- Work Aid 3: “Child Abuse Hotline Tasks and Responsibilities for Referrals Concerning a Child Death and Preliminary Near Death.”

We also reviewed the department’s Structured Decision-Making Tool within TFACTS and obtained industry standards for call center performance from the Service Quality Measurement (SQM) Group.

To assess the hotline’s Cisco reports detailing hotline performance metrics, we obtained and reviewed the reports for September 2022 through April 2025 and performed procedures to confirm their completeness. We analyzed the hotline data to determine the efficiency of hotline call center operations in comparison with the SQM Group’s industry standards for call centers.

We obtained and reviewed turnover and vacancy information for hotline staff. For more information on how we analyzed this data, see the methodology in **Appendix 1**, the **Turnover, Vacancies, Overtime, and Caseload Management** section.

Placements Part 1: Children and Youth Placement Challenges

1. Audit Objective: In response to the prior finding, did management establish a formal process to track children and youth in temporary settings and establish written guidance to dictate standards for consistent quality of facilities housing children and youth overnight in temporary settings until a long-term placement could be found?

Conclusion: Based on our review, we determined that management established a centralized process to track children and youth in temporary settings. Management also established written guidance that had standards for the consistent quality of facilities housing children and youth overnight in temporary settings.

2. Audit Objective: How effectively is the department addressing placement challenges for hard-to-place children and youth and its reliance on temporary housing while working to secure appropriate, long-term placements?

Conclusion: Management acknowledged that some children and youth are harder to place and that this remains one of the department's greatest challenges. See the **Mission Challenge**.

Methodology to Address the Audit Objectives

To address our audit objective, including gaining an understanding of the department's process to address placement challenges for hard-to-place children and youth and its reliance on temporary housing and assessing internal controls significant to this objective, we met with the Commissioner, the Deputy Commissioner of Child Programs; the Executive Director of Network Development; the Executive Director of Child Programs; and the Internal Audit Director. We also conducted a survey to follow up on results from the prior audit's placement survey and reviewed the department's analysis of placement stability related to foster care homes and juvenile justice facilities. We reviewed the Casey Family Programs brief from May 2023 on *Placement Stability Impacts*.

Placements Part 2: Department Responsibilities for Transitional Housing

Audit Objective: In response to the prior audit finding, did management take action to recruit and retain placements for children and youth for whom they assumed custody?

Conclusion: Despite the department's recent improvements, management has not fully met its oversight responsibilities for hard-to-place children and youth remaining in transitional housing. See **Finding 4**.

Methodology to Address the Audit Objective

To address our audit objective, including gaining an understanding of the department's efforts to recruit and retain foster care home placement options and assessing the design and implementation of internal controls significant to this objective, we interviewed the Deputy Commissioner of Child Programs, the Executive Director of Network Development, the Executive Director of Child Programs, and the Internal Audit Director. We also reviewed management's 30-day and 6-month corrective action plans developed in response to the prior audit finding.

We reviewed the department's partnership agreements with the Department of Disability and Aging, The Contingent (an external foster care recruitment agency), and Every Child

Tennessee, which support the department's foster care recruitment and retention initiatives. We also reviewed the department's analysis of placement needs and the department's contract with Casey Family Programs, a national child welfare consulting agency. To obtain an understanding of operational practices, we performed a walkthrough of the foster care recruitment process.

To determine the statutory and policy framework governing recruitment and retention, we reviewed Public Chapter 0187, Department Policy 16.16, and Department Policy 16.46. We used these authorities to evaluate whether management's controls aligned with statutory and policy requirements.

To obtain an understanding of internal controls significant to this objective, we reviewed the Network Development Division's *Utilization Review Tracker*, which lists youth residing in transition homes, assessment centers, or level 3 residential treatment facilities. We observed how Network Development staff used this tracker during weekly meetings to identify placements for youth awaiting more permanent settings. We determined this to be a key internal control for ensuring that the department actively seeks placements for children who must temporarily stay overnight in transitional homes or department offices.

We reviewed revised department policies for transitional houses, as well as department policies governing incident reporting (Policy 1.4, "Incident Reporting"). We visited transitional and assessment houses across the state, including Davidson County Transitional House, Shelby County Transitional Apartments, Knoxville Transitional House, the Nashville Isaiah House, the Clover Bottom Assessment Center, and two Department of Disability and Aging homes located in Nashville and Bartlett. During these visits, we reviewed staff, sitter, and security logs at transitional houses and inspected documentation supporting the department's placement stability analyses.

To evaluate management's monitoring and data reliability, we reviewed and analyzed the department's *Transitional Housing Data* tracking spreadsheet. Each regional staff member documents a child and youth staying in temporary placements on this spreadsheet, with separate tabs for each region. Because the spreadsheet was maintained outside of TFACTS and lacked unique identifiers for each child, we performed data validation procedures to match entries referring to the same individual. These procedures ensured that our analysis accurately reflected the department's data.

We noted that each region began using the spreadsheet in early March 2025, though not all regions began on the same date or maintained consistent updates. Our analysis covered the following periods:

- East Region: March 10, 2025, through September 4, 2025;
- Mid State Region: March 10, 2025, through September 4, 2025;

- Mid West Region: March 10, 2025, through September 4, 2025 (excluding May 13 through June 16, 2025);
- Northeast Region: March 10, 2025, through September 5, 2025;
- Tennessee Valley Region: March 10, 2025, through September 4, 2025; and
- West Region: March 3, 2025, through September 4, 2025.

Using this data, we created pivot tables to identify each child and youth who stayed in a temporary placement and all associated dates. We calculated the average, maximum, and minimum number of nights each child and youth stayed overnight in an office building, transitional house, and both types of placements combined. We also calculated the average, maximum, and minimum number of children and youth per night staying in each type of temporary placement.

Tennessee Family and Child Tracking System

1. **Audit Objective:** In response to the prior audit finding, have department management and Strategic Technology Solutions (STS) management taken action to address system issues with the Tennessee Family and Child Tracking System (TFACTS) while the department works to implement a new Comprehensive Child Welfare Information System?

   Conclusion: Based on our review, we found that department management and STS management implemented enhancements to TFACTS to address a system upgrade; however, TFACTS still does not meet users' needs, which continues to jeopardize management's responsibilities in its child welfare operations. Department management and STS initiated a project to replace TFACTS with a new Comprehensive Child Welfare Information System (CCWIS), with an anticipated go-live date of October 2026. See **Finding 5.**

2. **Audit Objective:** In response to the prior audit finding, did department management and STS management implement effective information systems controls to safeguard sensitive information and follow state information security policies?

   Conclusion: Department management and STS management did not implement effective information systems controls and did not follow state information security policies for one area identified. See **Observation 2.**

Methodology to Address the Audit Objectives

To address audit objective 1, including gaining an understanding of department management and STS management's implementation of a system upgrade to TFACTS and to assess their design and implementation of internal controls significant to our audit objective, we interviewed the department's Deputy Commissioner, the Internal Audit Director, the CCWIS Project Manager, and the Executive Director of Network Development / Provider Relations. We also interviewed multiple STS IT Directors. We conducted walkthroughs of operational processes that relied upon TFACTS, and we obtained copies of both manually created and system-generated reports. We specifically observed examples of manually created reports and workarounds for (1) timeliness of placement entry, (2) a regional placement change report, (3) a network development placement change report, (4) a monthly investigation report created by the Special Investigations Unit, and (5) health screenings.

To determine the status of the new CCWIS Modernization Project, we reviewed CCWIS project status reports compiled by Deloitte, and we analyzed department management's budget-to-actual reports. We reviewed the department's presentations at quarterly Information Systems Council meetings during fiscal years 2024 and 2025. We also reviewed the Statement of Work for the CCWIS Modernization Project and inspected a listing of CCWIS system requirements compiled by the CCWIS project managers.

To address audit objective 2, including gaining an understanding of management's operational processes for TFACTS and to assess management's design and implementation of internal controls significant to our audit objective, we interviewed STS support staff, including the Information Technology Director, Senior IT Managers, an IT manager, as well as the department's Internal Audit Director and a department Program Coordinator. Additionally, we administered internal control questionnaires to department and STS management covering both general technology controls and application controls over TFACTS. To verify management's responses to these questionnaires, we reviewed the state's *Enterprise Information Security Policy*; the department's Information Systems Plan for the three-year period of July 1, 2025, through June 20, 2028; the department's fiscal year 2025 risk assessment; and organizational charts for STS as of January 2025 and for the department as of August 2024. Furthermore, we inspected the department's *Information Technology Requests* internal administrative policy and procedure. We also conducted walkthroughs of TFACTS to evaluate system security settings, user management practices, and software development and change control for compliance with the state's *Enterprise Information Security Policy*. As part of this process, we evaluated the design of segregation of duties over user access management and TFACTS software changes.

To test the operating effectiveness of department management's and STS management's corrective actions to resolve the prior audit finding, we reviewed their monitoring activities

along with evidence of internal control operations to determine if management had addressed the one specific area in the 2022 performance audit finding.

Child Health Screenings

Audit Objective: In response to the prior audit finding, did management establish a process to ensure that all children in custody receive screenings to identify medical and dental needs within the timeframes established by department policies?

Conclusion: Based on our review, management did not implement an automated process to ensure timely dental and medical screenings for children in custody. The department still relied on paper forms and manual processes to complete, review, and follow up on children's medical and dental screenings. Medical and dental screenings are overdue and/or screening forms have not been submitted to the department's regional health unit to ensure timely follow-up care for children in the department's custody. See **Finding 6.**

Methodology to Address the Audit Objective

To address our audit objective, including gaining an understanding of management's processes for recording and tracking medical and dental screenings and to assess management's design of internal controls significant to our audit objective, we interviewed and performed walkthroughs with the Deputy Commissioner of Statewide Services, a regional nurse, a service appeals tracking (SAT) Coordinator, the Director of Nursing, the former Executive Director of Child Health, the Health and Wellness Director, the Public Health Nursing Consultant, and other key departmental staff. We also reviewed the department's 30-day and 6-month corrective action plans that management developed in response to the 2022 performance audit prior finding.

We reviewed Title 42, Chapter IV, Subchapter C, part 441, Subpart B of the *Code of Federal Regulations;* Section 37-5-102 and Section 37-5-106, *Tennessee Code Annotated*; the department's Policy 20.7, *"*Early and Periodic Screening, Diagnosis, and Treatment Standards (EPSDT)*"* and its supplement; and the department's Policy 20.12, "Dental Services,*"* to gain an understanding of the department's medical and dental screening process and related internal controls. We also performed a walkthrough of the regional nurse's process for reviewing the medical and dental screenings and then sending it to the SAT coordinator, who then enters the screening results into the Tennessee Family and Child Tracking System (TFACTS).

We obtained Medical and Dental Overdue and Upcoming EPSDT reports from January 2024 through December 2024 (except for March and May due to the department not

retaining the reports) to determine the total number of screenings reported as overdue. From the population of 10,966 medical screenings and 16,164 dental screenings reported to be more than 30 days overdue during this period, we randomly selected a nonstatistical sample of 30 initial and annual medical screenings and 27 initial and biannual dental screenings. We reviewed each child's case file in TFACTS and discussed the cases with department staff to assess the cause of late reporting.

Turnover, Vacancies, Overtime, and Caseload Management

1. **Audit Objective:** In response to the prior audit finding, did management address the issues hindering their ability to fill vacant case manager positions and adequately address case manager turnover, vacancies, and overtime statewide?

   Conclusion: Based on our analysis of turnover, vacancies, and overtime from July 1, 2022, through June 30, 2025, we identified that management was able to lower turnover to 18%; overtime to a median of 13.44 hours; and vacancies to 9% in fiscal year 2024. Our review did find that rates increased in fiscal year 2025, with turnover rising to 23% and vacancies to 18%. We also found that the overtime median hours decreased to 12.1; however, this was accomplished with 29% more case managers working overtime than in fiscal year 2024. See **Observation 3.**

2. **Audit Objective:** In response to the prior audit finding, did management ensure that case managers' caseloads for each region did not exceed the state's statutory caseload average of 20 cases?

   Conclusion: Based on our analysis of caseloads for case managers from July 1, 2022, through June 30, 2025, we found that caseloads remained below the statutory limits, except for the Mid State Region. See **Observation 3.**

3. **Audit Objective:** Did management ensure that caseloads were manageable and compliant with Section 37-5-132(a)(1)(2), *Tennessee Code Annotated,* within smaller, specialized units, which are more susceptible to experiencing the effects of higher turnover, vacancies, and caseloads?

   Conclusion: Based on our analysis of turnover, vacancies, and caseload averages within specialized units from November 1, 2022, to May 1, 2025, we noted that the department has experienced a higher-than-usual volume of turnover, vacancies, and caseloads with investigators. See **Observation 3.**

Methodology to Address the Audit Objectives

To address audit objectives 1, 2, and 3, including gaining an understanding of management's processes for monitoring case manager and investigator turnover, vacancies, and overtime and to assess management's design and implementation of internal controls significant to our audit objectives, we interviewed the Deputy Commissioner of Child Programs, the Deputy Commissioner of Regional Operations, the Deputy Commissioner of Statewide Services, directors and managers from the Division of Human Resources, and staff from the Office of Data Governance and Analytics. We also reviewed Section 37-5-132, *Tennessee Code Annotated*; the department's Administrative Policy 31.7, "Caseload Assignment for DCS Employees"; Administrative Policy 5.3, "Case Manager Certification"; Administrative Policy 4.5, "Guidelines Related to Working Hours"; and the official job descriptions for each case manager class. To compare department measures to external expectations, we reviewed the U.S. Bureau of Labor Statistics' Job Openings and Labor Turnover Report for January 2025. We conducted an employee survey to follow up on results from the prior audit's turnover, vacancies, overtime, and caseloads. We also reviewed the department's 30-day and 6-month corrective action plans that management developed in response to the 2022 performance audit prior finding.

To assess the operating effectiveness of controls for audit objectives 1, 2, and 3, we analyzed Edison employment data for Case Manager 1 through Case Manager 3 and Investigator 2 and 3 positions from July 1, 2022, through June 30, 2025, to determine turnover and vacancy trends. We also reviewed Edison overtime data to measure the extent of overtime worked during the same period. For caseload compliance, we obtained and analyzed Caseload Compliance and Averages reports and underlying data for the period of January 3, 2023, to May 1, 2025. We recalculated average caseloads statewide, by region, and by program area (Child Protective Services, Juvenile Justice, and Social Services). We further calculated the number of case managers with caseloads over 20, 40, and 60; the duration that case managers held these elevated caseloads; and caseload counts by worker and reporting period. Because of the regional reorganization in March 2025, we performed separate analyses for the periods before and after the reorganization.

Relative Caregiver Program

1. Audit Objective: Did management establish an effective monitoring process over contracted providers to ensure that providers were determining stipend eligibility in accordance with statute, rules, and policy?

Conclusion: At the time of our review, management had not established a monitoring process for provider stipend eligibility determinations. Although we did not identify any ineligible caregivers, providers used inconsistent methods to determine eligibility and did not

complete periodic redeterminations as required. Additionally, the department paid caregivers for periods before they signed stipend agreements, resulting in overpayments. See **Finding 7**.

During our fieldwork, staff at all eight Relative Caregiver Program providers informed us that, because the Internal Revenue Service classifies stipend payments as taxable income, some caregivers have experienced a loss or reduction of other public benefits. See the **Matter for Consideration**.

2. Audit Objective: Did management ensure that relative caregiver stipend payments were issued accurately, timely, and in the correct amounts based on verified eligibility determinations and based on the statutorily prescribed rate?

Conclusion: Management did not ensure that stipend payments for children ages 0 to 11 were accurately determined in accordance with statute, resulting in overpayments. See **Finding 7.**

3. Audit Objective: Did management develop a centralized process to track and prioritize waitlists for relative caregivers across all providers?

Conclusion: Management developed a centralized process to track and prioritize waitlists across providers; however, the department's tracking mechanism lacked enough detail to allow management to monitor wait times, identify service gaps, and ensure equitable access across regions and provider networks. See **Observation 4.**

Methodology to Address the Audit Objectives

To address audit objective 1, including gaining an understanding of management's processes for providers to determine relative caregiver stipend eligibility and assessing management's design of controls significant to our audit objective, we interviewed and conducted walkthroughs with the following staff in the department's Relative Caregiver Program (RCP):

- the Deputy Commissioner of Statewide Services,
- the Executive Director of Statewide Prevention Services,
- the RCP Program Manager, and
- the RCP Program Coordinator.

We also interviewed the department's Deputy Commissioner of Finance and Budget and the Internal Audit Director.

We also met with relative caregiver provider staff during two haphazardly selected site visits to Family and Children's Services in Nashville and the University of Tennessee's Social Work Office of Research and Public Service in Knoxville.

Additionally, we reviewed:

- Section 37-2-422, *Tennessee Code Annotated,* Reimbursement of Relative Caregivers;
- *Rules of the Tennessee Department of Children's Services, Social Services Division,* Rule 0250-07-14, "Relative Caregiver Program";
- Department Policy 14.30, "Relative Caregiver Program";
- the current and draft versions of the *Relative Caregiver Program Manual*; and
- department contracts with each RCP provider.

To assess whether provider staff determined stipend eligibility for relative caregivers in compliance with Section 37-2-422, *Tennessee Code Annotated*, we tested a nonstatistical, stratified sample of 26 caregivers from a population of 772 caregivers with a relative caregiver episode start date between July 1, 2024, and April 30, 2025. See **Figure 43**.

Figure 43: Stratified Population and Sample of Relative Caregivers by Provider

Provider	Population	Sample Size
WRAP Tennessee	252	8
Family and Children's Services	207	7
Childhelp USA	105	3
Shelby County Relative Caregiver Program	60	2
The Center for Family Development	51	2
Upper Cumberland Development District	47	2
The Social Work Office of Research and Public Services at the University of Tennessee	31	1
Southeast Tennessee Area Agency on Aging	19	1

Source: Auditor testwork.

For caregivers in our sample, we performed an analysis of 52 stipend agreements to determine whether the department paid caregivers for periods that took place prior to caregivers signing the stipend agreement.

To address audit objective 2, including gaining an understanding of management's processes for reviewing and approving stipend payments, including calculation of the stipend rate, and assessing management's design of controls significant to our audit objective, we interviewed and conducted walkthroughs with the following staff in the department's Relative Caregiver Program:

- the Deputy Commissioner of Statewide Services,
- the Executive Director of Statewide Prevention Services,
- the RCP Program Manager, and
- the RCP Program Coordinator.

We also interviewed the Deputy Commissioner of Finance and Budget, two department Fiscal Directors, the Department Controller, and the Internal Audit Director.

We reviewed Section 37-2-422, *Tennessee Code Annotated*, and the department's methodology for calculating and setting stipend rates for the 0 to 11 and 12 to 18 age groups. To assess compliance with statute, we also analyzed the 52 children represented in our sample of 26 caregivers to determine whether the department paid caregivers the correct stipend rate for each child.

To address audit objective 3, including gaining an understanding of the department's process for tracking program and stipend waitlists, and assessing management's design of controls significant to our audit objective, we interviewed department and provider staff. We interviewed the Deputy Commissioner of Statewide Services, the Executive Director of Statewide Prevention Services, the RCP Program Manager, and the RCP Program Coordinator. We also interviewed program staff at the providers. We reviewed the *Rules of the Tennessee Department of Children's Services,* Social Services Division, Rule 0250-07-14, "Relative Caregiver Program," and analyzed the department's centralized waitlist tracking spreadsheet for the period of August 2024 to May 2025.

Oversight of Facilities

Audit Objective: Did the department effectively monitor facilities to ensure compliance with applicable laws, regulations, contract requirements, and departmental policies and procedures related to medical care, staffing ratios, and incident reporting?

Conclusion: The department's oversight and monitoring processes for facilities was not sufficient to ensure consistent compliance. Inadequate monitoring procedures, inconsistent data review, and limited enforcement authority reduced the department's ability to

identify and correct facility noncompliance. See **Finding 8** and **Matter for Legislative Consideration 1**.

Methodology to Address the Audit Objective

To address our audit objective, including gaining an understanding of management's design and implementation of internal controls for monitoring facilities for compliance with medical care, staffing ratios, and incident reporting, we interviewed the Executive Director over juvenile justice facilities, the Executive Director of Quality Compliance, the Statewide PREA Coordinator, the Director of Licensing, department case managers and case management supervisors, and management and staff at facilities we visited. We reviewed federal PREA standards for juvenile facilities; *Rules of Tennessee Department of Children's Services,* Chapter 0250-04-08, "Minimum Standards for Juvenile Detention Centers and Temporary Holding Resources"; the *Residential Treatment Contract Provider Manual*; and Department Policy 1.4, "Incident Reporting."

To assess the operating effectiveness of the department's oversight of facilities, we reviewed the department's monitoring reports for various facilities to ensure the required monitoring activities were completed, corrective actions were taken, staff assisted the facility with compliance, and the reports were approved. We also conducted monitoring activities at the following facilities: Standing Tall Music City, Duck River Youth Center, Shelby County Juvenile Detention Center (JDC), Knox County JDC, Davidson County JDC, and Mountain View Youth Academy. See **Figure 44.**

Figure 44: Facilities Visited for Audit

Facilities	Licensed	Contracted
Davidson County Assessment Centers		●
Davidson County Juvenile Detention Center	●	
Duck River Youth Center		●
Knox County Juvenile Detention Center	●	●
Mountain View Youth Academy		●
Shelby County Juvenile Detention Center	●	
Standing Tall Music City		●

Source: Auditor site visits.

We learned the medical care and medication administration processes at each facility we visited. Due to knowledge of previous issues, we reviewed a haphazard sample of youth medical files at the Knox County JDC. In those files, we reviewed medication administration records to determine if medications were administered as prescribed and

that all medications were accounted for. We also reviewed instances where medical and mental health care were not provided as dictated by the standards in the JDC rules.

At the Knox County JDC, we reviewed youth censuses and staff timecards, but the antiquated records lacked the structure needed to determine staffing compliance within the dorms on any given date. At the Shelby County JDC, the staff and youth records were similarly disorganized and prevented us from calculating staffing ratios by dorm.

At the other facilities, where staffing documentation could be used to calculate ratios between staff and youth for each dorm, we analyzed staffing rosters and youth censuses to determine if an adequate number of staff were supervising youth in each dorm on various shifts. At the Davidson County JDC, we reviewed staffing documentation from April 1, 2025, to April 29, 2025. At the Mountain View Youth Academy, we reviewed staffing documentation for February 3, 2025, to March 31, 2025.

We reviewed a list of incidents reported to the TFACTS Incident Reporting System between January 1, 2024, and September 5, 2025. We also reviewed a haphazard sample of paper incident forms and youth files for the facilities we visited, to determine if incidents were being documented and subsequently reported to the department.

Juvenile Probation and Aftercare Programs

Audit Objective: In response to the prior audit finding, did case managers conduct the required number of contacts for juveniles in probation and aftercare programs?

Conclusion: Based on our review, the department revised policies to clarify requirements and improved in five of the six conditions reported in the prior audit. We found instances where case managers still missed some required probation and aftercare contacts. Additionally, we found that management's monitoring process for open cases needs improvement. See **Observation 5.**

Methodology to Address the Audit Objective

To address our audit objective, including gaining an understanding of management's processes for probation and aftercare cases and assessing the design of internal controls significant to this objective, we interviewed the Assistant Commissioner of Juvenile Justice, the State Compact Administrator, and case managers. We also reviewed

- Section 37-5-132(a), *Tennessee Code Annotated;*
- the department's Administrative Policy 13.12, "Juvenile Probation Services";
- the department's Administrative Policy 13.11, "Aftercare Services"; and

- management's 30-day and 6-month corrective action plans developed in response to the prior audit finding.

We obtained case data from September 1, 2022, through January 31, 2025, from the Tennessee Family and Child Tracking System (TFACTS) and reconciled it with reports from Safe Measures to ensure completeness. From this population of 936 probation cases and 360 aftercare cases, we selected random, nonstatistical samples of 60 probation cases and 60 aftercare cases opened between August 1, 2024, and January 31, 2025, to test whether documentation in TFACTS demonstrated that case managers completed required contacts with youth, parents or legal guardians, schools, and service providers in accordance with department policies.

Interstate Compact for Juveniles

1. **Audit Objective:** Did the state's compact office effectively manage Tennessee's responsibilities under the Interstate Compact for Juveniles?

   Conclusion: Because of the national compact's privacy policy, the department's management denied us access to the national commission's UNITY system for juveniles. Therefore, we could not independently verify compliance with either the national commission's requirements or with the department's policy. See **Matter for Legislative Consideration 2**.

2. **Audit Objective:** Did the state's compact office comply with membership requirements established in Section 37-4-101, Article IX, *Tennessee Code Annotated,* including the composition of the required state council?

   Conclusion: Tennessee's state council did not meet the statutory membership requirement to include a representative from the legislative branch. After our review, the legislative branch seat was filled in October 2025. See **Matter for Legislative Consideration 2**.

Methodology to Address the Audit Objectives

To address audit objective 1, including gaining an understanding of management's processes for complying with the Interstate Compact for Juveniles and assessing management's design of internal controls that are significant to our audit objective, we interviewed the Office of Juvenile Justice's management, the State Compact Administrator, and department case managers.

We also reviewed Section 37-4-101, *Tennessee Code Annotated*; *ICJ Administrative Policy*; "UNITY Privacy Policy," 02-2021; and the department's Policy 13.3, "Interstate Compact for Juveniles," to understand requirements for documenting juveniles traveling

into and out of Tennessee under the compact. We intended to review compact application documents, quarterly reports, and other UNITY system records used to document and record juvenile movement under the compact. After our discussion with the department's management, and review of the national compact's privacy policy and the department's policy, the department prohibited us from reviewing the UNITY system, UNITY reports, and any case-related documentation.

To achieve audit objective 2, we reviewed Section 37-4-101, *Tennessee Code Annotated*, to assess whether the state's compact office complied with the membership statutory requirements; and Section 37-4-101, Article IX, *Tennessee Code Annotated*, including the requirement to maintain a state council. We also obtained and reviewed council meeting minutes from 2021 through 2024 to evaluate compliance with this requirement.

Strategic Plan and Risk Assessment

1. **Audit Objective:** In response to the prior audit finding, did management revise their four-year strategic plan and annual Customer Focused Government plans to set goals and objectives focused on the department's mission-critical challenges?

   Conclusion: Based on our review of the department's strategic plan, the department revised its mission in 2023 and aligned its 2024–2027 strategic plan with this mission. Within this updated strategic plan, leadership set goals and objectives that are focused on mission-critical challenges. These revisions also applied to their annual 2025 Customer Focused Government Plan.

2. **Audit Objective:** In response to the prior audit finding, did management ensure that the department's risk assessment included an evaluation of risks and establish mitigating controls within all major divisions and operations?

   Conclusion: Based on our review of the department's risk assessment process, we found that management expanded its risk assessment to include all major divisions and operations and conducted an in-depth review of the department's internal control deficiencies. Although management's risk assessment process has significantly improved since the prior audit, some risks and mitigating controls remain unidentified. In addition, we found risks where management's identified mitigating controls were not effective. See **Observation 6**.

Methodology to Address the Audit Objectives

To address audit objective 1, including gaining an understanding of management's process for developing its strategic plan and annual Customer Focused Government plans and to address management's design and implementation of internal controls significant to our audit objective, we conducted walkthroughs of the processes. We interviewed the department's Office of Continuous Quality Improvement Assistant Commissioner and Executive Director, and the Director for the Office of Strategic Services. We reviewed Section 9-4-5602, *Tennessee Code Annotated*, 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.

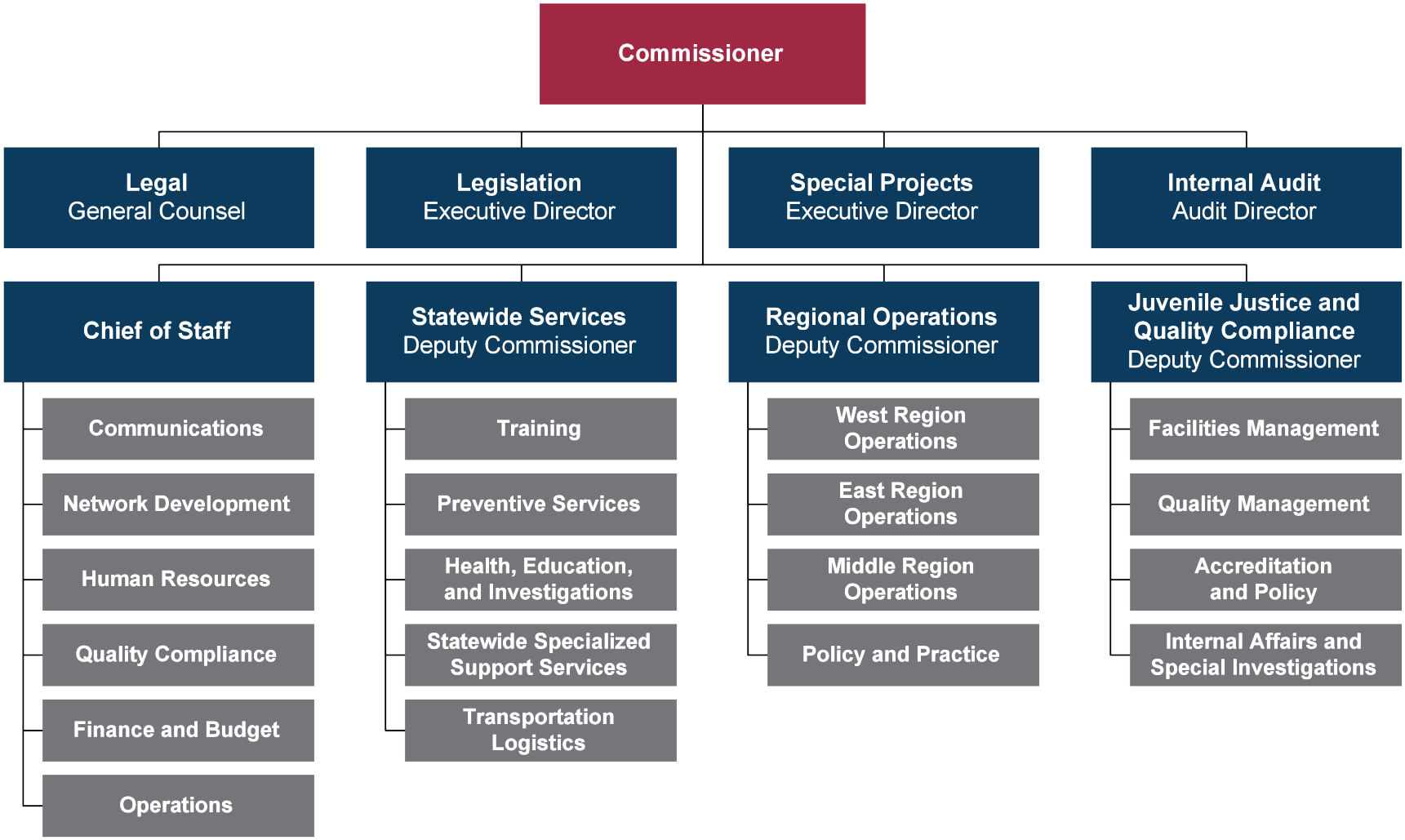
To assess whether management revised these documents to set goals and objectives that are focused on mission-critical challenges the department faces, we obtained and reviewed the department's initial and revised 2024–2027 strategic plan and annual Customer Focused Government plan for fiscal year 2025.

To address audit objective 2, including gaining an understanding of management's process for conducting their annual risk assessment, and to address management's design and implementation of internal controls significant to our audit objective, we conducted walkthroughs of the process. We interviewed the department's Internal Audit Director and reviewed Department Policy 1.7, "Risk Management." We reviewed Section 9-18-101-104, *Tennessee Code Annotated*, to gain an understanding of the requirements of the Tennessee Financial Integrity Act of 1983.

To assess the department's risk assessment, we obtained and reviewed the department's fiscal year 2025 Risk Assessment and management's action plans for self-identified internal control deficiencies to determine whether management had identified risks and controls related to our current audit objectives.

Appendix 2: Organizational Chart and Structure

Figure 45: Department of Children's Services' Organizational Chart as of March 6, 2025



Source: Organizational chart provided by department management.

Organizational Structure

Statewide Services

This division includes the Training, Preventive Services, Health, Education and Investigations, Statewide Specialized Support Services, and Transportation Logistics units.

Regional Operations

This division oversees regional operations for Child Protective Services (CPS), Child Programs, and Juvenile Justice field staff. CPS investigates reports of child abuse and neglect, assesses child safety, and works to protect children while supporting families through intervention, services, and collaboration with community partners. Child Programs develops and oversees services and supports for children in foster care, adoption, and other out-of-home placements. Juvenile Justice provides supervision (probation and aftercare), treatment, and rehabilitative services for youth who are adjudicated delinquent.

Juvenile Justice

This division supports the juvenile justice regional field staff through its Facilities Management, Policy, Programs, and Juvenile Justice Liaison units.

Legislation

This division monitors, analyzes, and advises on state and federal legislative matters, working with lawmakers and stakeholders to advance policies that support the department's mission and improve outcomes for children and families.

General Counsel

The Office of General Counsel provides legal advice, representation, and support to the department. It ensures compliance with state and federal laws and protects the agency's interests in administrative and judicial matters.

Internal Audit

The Internal Audit division plans and conducts internal audit functions for the department and tracks and monitors the department's system of risks and internal controls.

Chief of Staff

This position oversees the department's Communications, Network Development, Human Resources, Quality Compliance, Finance and Budget, and Operations divisions. Network Development is responsible for developing and supporting the department's network of providers and assisting regional staff in finding placements for custodial

children. The Office of Quality Compliance includes the Quality Management,[165] Accreditation, Policy and Safety Action Group, Internal Affairs, Special Investigations Unit, and the Office of Access and Engagement.

165. Quality Management includes Licensure, Provider, and Foster Home Quality Teams; Provider Monitoring and Evaluation; Continuous Quality Improvement; the Process Optimization Team, Customer Focused Government, and Due Process.

Appendix 3: Department's Financial Information

UNAUDITED INFORMATION

Figure 46: Edison Business Units for the Department's Divisions

359.00	Department of Children's Services
359.10	Administration
359.20	Family Support Services
359.30	Custody Services
359.35	Needs Assessment
359.40	Adoption Services
359.50	Child and Family Management
359.60	John S. Wilder Youth Development Center
359.80	Major Maintenance

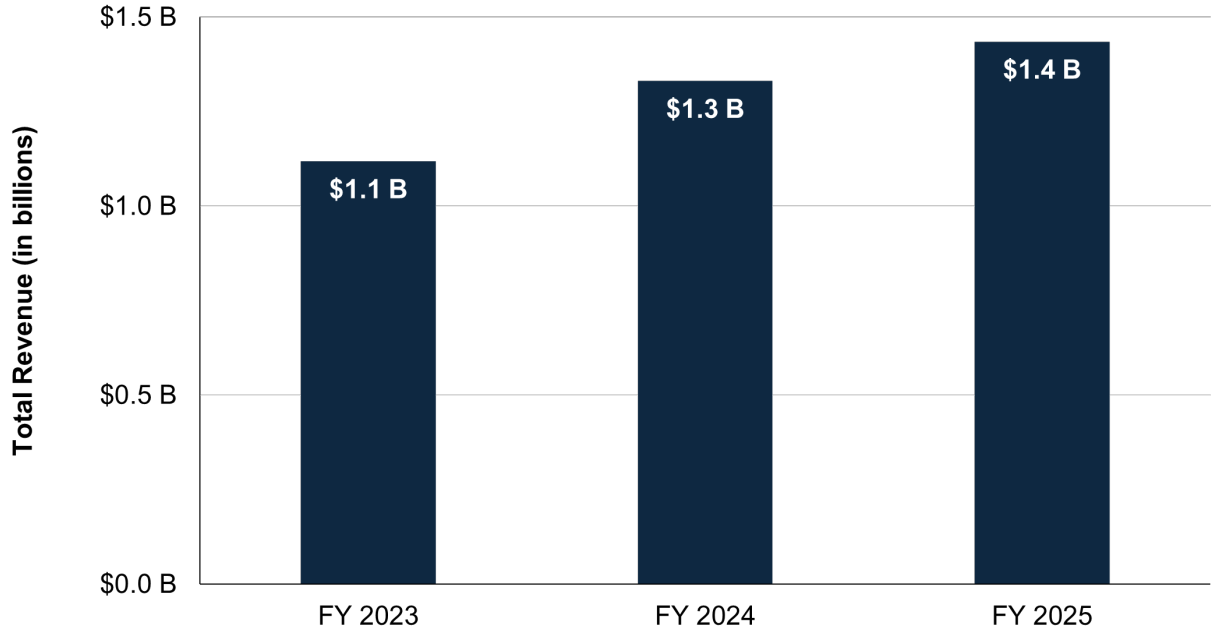
Source: Analysis of the department's general ledger data extracted from Edison.

Figure 47: Department of Children's Services
Fiscal Year (FY) 2023 to 2025 Expenditures and Revenues

Description	Fiscal Year		
Expenditures	**FY 2023**	**FY 2024**	**FY 2025**
Grants and Subsidies	$671,233,149	$782,515,675	$873,090,482
Salaries and Wages	214,822,662	248,775,202	254,894,633
Professional Services Provided by Other State Agencies	88,102,626	113,578,534	130,854,791
Benefits	85,783,480	96,067,613	99,188,664
Third Party Professional and Administrative Services	29,554,068	59,271,122	72,741,019
Computer Related Items	9,332,423	15,385,948	12,774,315
Travel	11,287,305	14,329,931	11,167,296
Maintenance, Repairs and Services Performed By Others	6,626,515	9,709,066	5,178,670
Supplies and Office Furniture	2,546,495	2,620,988	2,489,710
Utilities and Fuel	605,964	640,587	525,345
Rentals and Insurance	407,221	437,074	469,048
Communications and Shipping Costs	428,752	394,045	470,755
Training of State Employees	245,181	502,687	539,913
Refunds for Children in Custody	166,836	224,909	249,437
Awards and Indemnities	128,054	59,478	45,269
Unclassified Expenses	48,596	60,213	64,117
Buildings	-	107,099	31,600
Printing and Duplicating	3,090	35,564	40,925
Equipment	16,650	56,948	2,894
Motor Vehicle Operation	9,350	9,679	779
Inventory	14,998	2,903	-2,352
Total Expenditures	**$1,121,363,415**	**$ 1,344,785,266**	**$1,464,817,309**
Revenues	**FY 2023**	**FY 2024**	**FY 2025**
State Appropriations	$454,375,400	$549,796,000	$618,834,600
Current Services	153,740,614	527,627,918	567,861,898
Federal Revenue	171,546,047	190,155,300	188,270,520
Interdepartmental Revenue	333,315,301	55,566,492	54,262,246
Nongovernmental	5,564,650	5,653,051	5,879,216
Refund of Prior Year Expenditures	106,869	2,368,999	23,220
Interest and Investment Income	245,170	233,307	211,683
Other Revenue	19,889	38,359	19,253
Total Revenues	**$1,118,913,941**	**$1,331,439,426**	**$1,435,362,637**

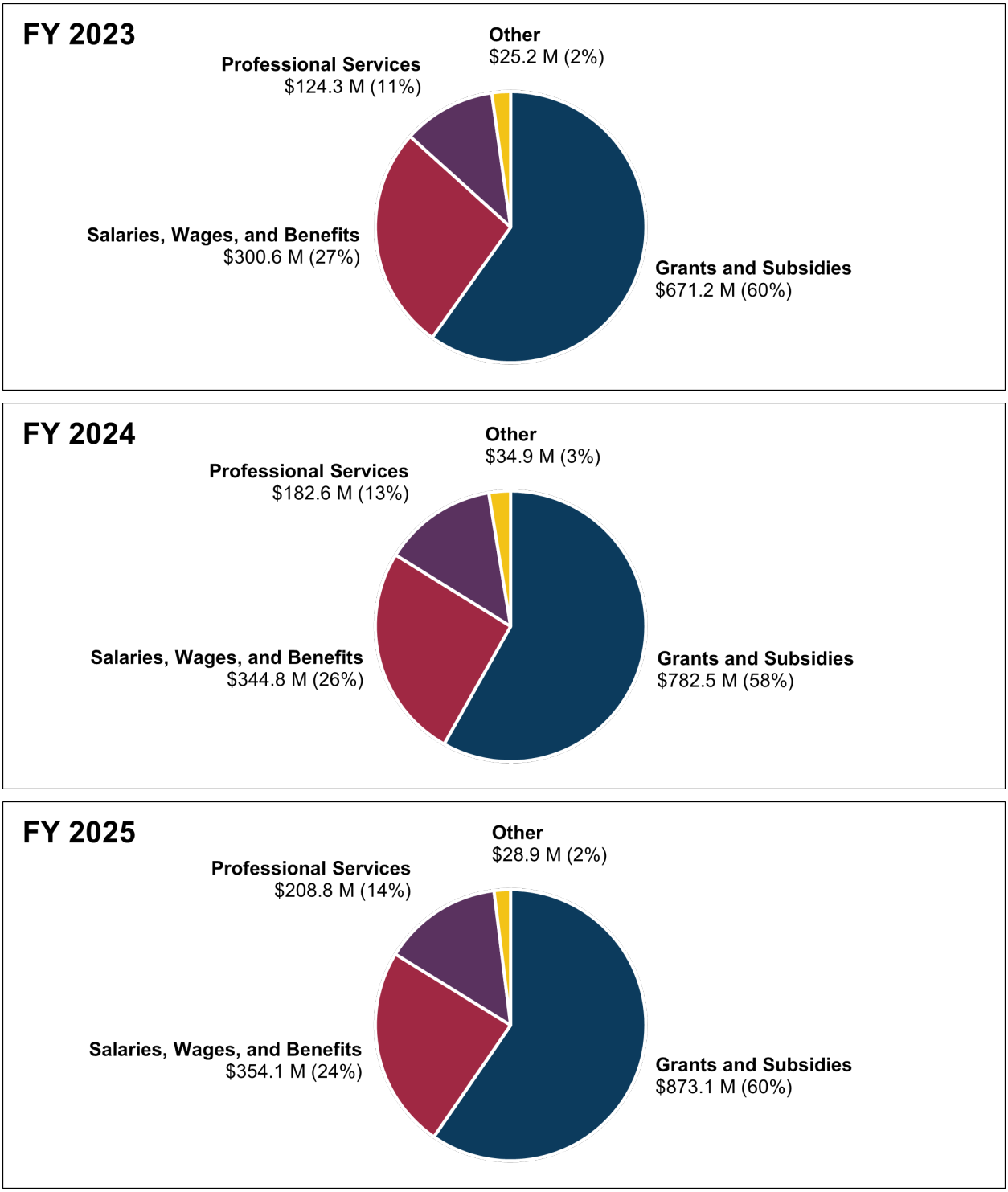
Source: Analysis of the department's general ledger data extracted from Edison and State of Tennessee Budget Publications for fiscal years 2025 to 2026.

Figure 48: Department of Children's Services Revenues by Fiscal Year (FY), 2023 to 2025



Source: Analysis of the department's general ledger data extracted from Edison and State of Tennessee Budget Publications for fiscal years 2025 to 2026.

Figure 49: Department of Children's Services Expenditures by Fiscal Year (FY), 2023 to 2025



Source: Analysis of the department's general ledger data extracted from Edison.

Appendix 4: Child Safety Finding Criteria

Figure 50: Criteria to Support Finding 1 and Finding 2

Condition	Criteria
Missing Safety Assessment	According to the **"Protocol for Completion of the Family Advocacy and Support Tool (FAST),"** the FAST safety assessment must be "submitted to supervisor within five (5) business days from the intake date. . . . As the FAST is inclusive of the sixteen (16) items comprising the Safety Assessment, this timeframe is met if a FAST is submitted to the supervisor within five (5) business days from the intake date."
Untimely Supervisory Review of Safety Assessment	According to the **"Protocol for Completion of the Family Advocacy and Support Tool (FAST),"** "[t]he Safety Assessment must be reviewed and approved by the supervisor within three (3) business days of submission by the worker."
Missing or Incomplete CPIT Forms	According to **the department's Policy 14.7, "Multi-Disciplinary Team: Child Protective Investigative Team,"** "Each CPIT member indicates their agreement or disagreement with the investigation classification recommended by DCS on CS-0561, Child Protective Investigative Team Review and is provided the opportunity to sign the CPIT form. Any CPIT member's concerns about classification are noted on the CPIT form, and the CPS Case Manager documents the CPIT discussion and classification in case recordings in the Electronic Record System."
Untimely Priority Response	According to **the department's Policy 14.2, "Screening, Priority Response and Assignment of Child Protective Services Cases,"** "Priority responses are assigned to reports to determine the timeframe in which the ACV must be seen. Priority response for all reports begins at intake creation date/time." **14.2** also states the following: "1. Priority-1 (P-1): Cases assigned this priority are initiated by a face-to-face contact with the ACV no later than twenty-four (24) hours, but immediately if the CPS supervisor deems it necessary. Priority 1 reports allege that children may be in imminent danger. 2. Priority-2 (P-2): Cases assigned this priority are initiated by face-to-face contact with the ACV within two (2) business days. Priority-2 reports allege injuries or risk of injuries that are not imminent, life threatening or do not require immediate medical care where a two (2) business day delay will not compromise the investigative effort or reduce the chances for identifying the level of risk to the child. 3. Priority-3 (P-3): Cases assigned this priority are initiated by face-to-face contact with the ACV within three (3) business days. Priority-3 reports allege situations/incidents considered to pose low risk of harm to the child where three (3) business days will not compromise the investigative effort or reduce the chances for identifying the level of risk to the child."
Untimely Notification of CPIT	According to **the department's Policy 14.7, "Multi-Disciplinary Team: Child Protective Investigative Team,"** "CPS immediately convenes the appropriate CPIT, per local CPIT protocols, when a report of child sexual or severe abuse has been received or identified through casework."

Condition	Criteria
Untimely Safety Assessment (Not Submitted Within 5 Days)	According to the **"Protocol for Completion of the Family Advocacy and Support Tool (FAST),"** the FAST safety assessment must be "submitted to supervisor within five (5) business days from the intake date. . . . As the FAST is inclusive of the sixteen (16) items comprising the Safety Assessment, this timeframe is met if a FAST is submitted to the supervisor within five (5) business days from the intake date."
Untimely Classifications	According to **Section 37-1-406**, ***Tennessee Code Annotated,*** "No later than sixty (60) days after receiving the initial report, the department or team in cases of child sexual abuse or the department in all other cases shall determine whether the reported abuse was indicated or unfounded and report its findings to the department's abuse registry."
Untimely or Undocumented Case Closure, Transfer, or Extension	According to **the department's Policy 14.6, "Child Protective Services Case Tasks and Responsibilities,"** "A Child Protective Services (CPS) investigation case must be classified within thirty (30) calendar days of the Child Abuse Hotline (CAH) receiving a report. An investigation is concluded within sixty (60) calendar days with a decision to close the case, provide or refer to community services or transition to a Family Service Case Manager (FSW) prior to day 60 for investigation track or day 90 for assessment track."
Incorrect Classifications	According to **the department's Policy 14.6, "Child Protective Services Case Tasks and Responsibilities,"** a preponderance of evidence is "the greater weight of the evidence required in a civil (non-criminal) lawsuit for the trier of fact (jury or judge without a jury) to decide in favor of one side or the other. This preponderance is based on the more convincing evidence and its probable truth or accuracy, and not on the amount of evidence."
Missed Monthly Face-To-Face Visits	According to **the department's Policy 14.6, "Child Protective Services Case Tasks and Responsibilities,"** "Interview/observation of the ACV: a minimum of one (1) face to face contact with the ACV is required each calendar month."
Untimely Supervisory Review of Classification	According to **discussions with management**, supervisors have 3 business days to approve the classification once the case is submitted for approval.
Missed Monthly Administrative Reviews	According to **the department's Policy 4.4, "Performance and Case Supervision Practice Guidelines and Criteria,"** "Child Protective Services (CPS) supervisors provide an initial and closing Administrative Review as a case recording (as an Administrative Review contact type) within the Electronic Case File. Initial reviews are due within fifteen (15) business days of the intake date. Administrative Reviews are then due monthly thereafter."
Untimely Supervisory Review of Case Closure	According to **the department's Policy 4.4, "Performance and Case Supervision Practice Guidelines and Criteria,"** with the effective date of 10/31/2023, "Closing reviews are due within ten (10) business days of case closure."

Appendix 5: Child Safety and Safety Concerns

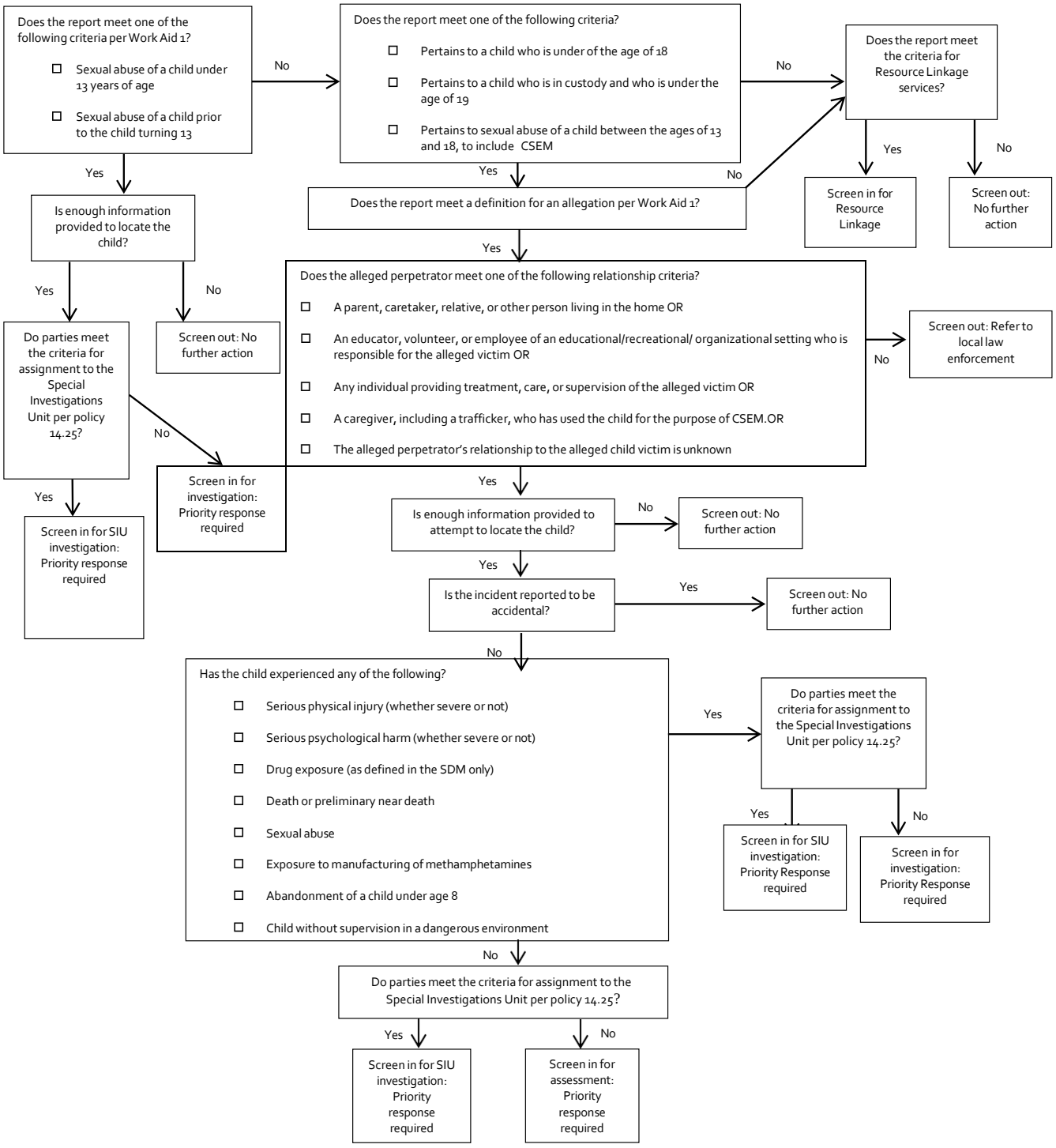
Figure 51: List of Safety Concerns Utilized by SIU When Unsubstantiating a Case

Safety Concerns
Discipline issue (corporal punishment)
Supervision issues (use of too young or questionable persons for babysitting; independent respite)
Environmental concerns (safety hazards such as a pool without a fence, inadequate sleeping arrangements, lack of cleanliness, and hazardous materials around unsupervised youth)
Child-specific issues unrelated to foster parents (child needs a higher or different level of treatment)
Placement issues (child to facility/resource home is not a good match)
Providing bare minimum nurturing (foster children treated inferior to biological children; foster parents don't appear to be bonded with foster children)
Inappropriate behavior/comments (foster parents, agency staff, or household members yelling, cursing, or being demeaning to children)
Lack of appropriate care for youth (children are physically unclean, clothed improperly, or not fed adequately)
Medication issues (incorrect medication administration; missing appointments)
Unaddressed truancy
Poor/limited cooperation of foster parents or agency with SIU
Noncompliance with department personnel policies (lack of appropriate or timely background/fingerprint checks for employees; people living in resource home who are not approved as household members)
Milieu issues (environment in the congregate care setting is not therapeutic)

Source: The department's Form CS-0826, Special Investigations (SIU) – Notification of Case Initiation and Closure.

Appendix 6: Child Safety and the Child Abuse Hotline

Figure 52: Child Abuse Hotline's Structured Decision-Making Tool



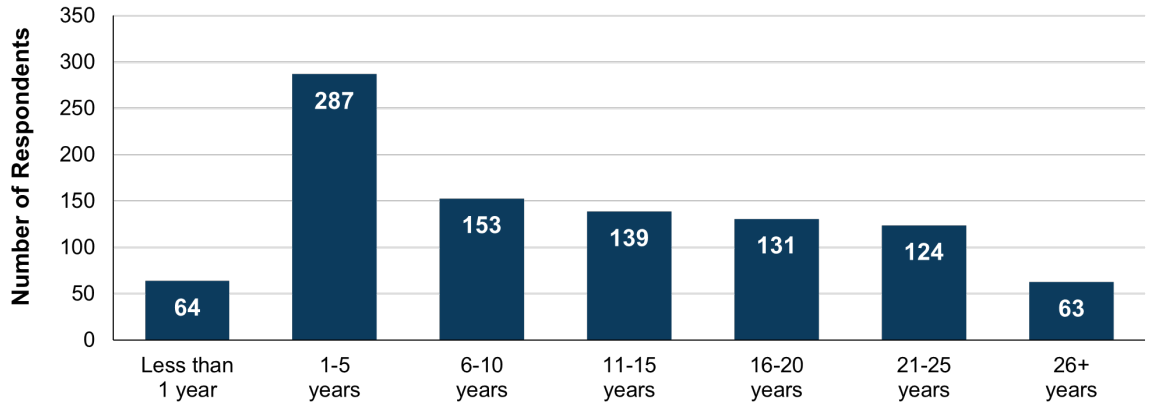
Note: Acronyms used in the decision tool: Special Investigations Unit (SIU), Child Sexual Abuse/Exploitation Materials (CSEM), and Structured Decision-Making Tool (SDM).
Source: *Child Abuse/Neglect Intake Assessment Policy and Procedures Manual.*

Appendix 7: Department Employee Survey

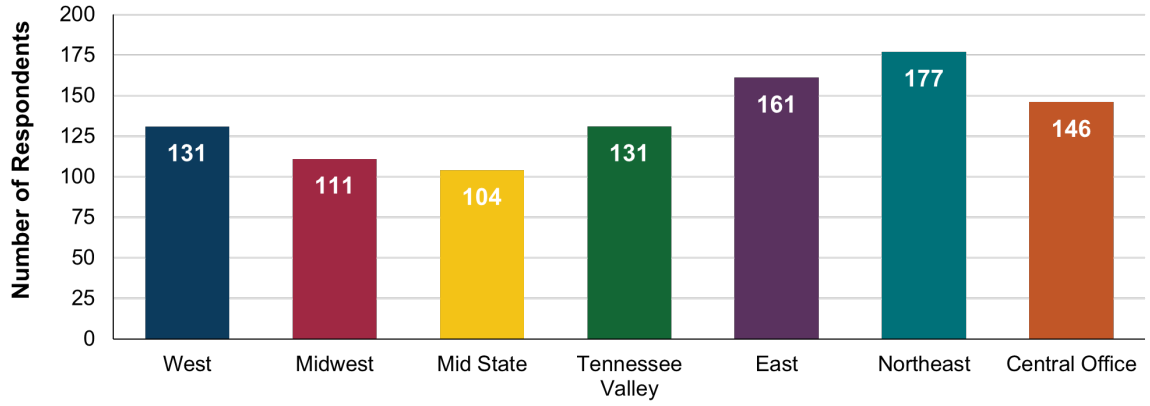
We administered an anonymous employee survey through Microsoft Forms to assess how the Department of Children's Services (the department) is meeting its mission to act in the best interest of Tennessee's children and youth and to understand how the department's operating environment has changed since the 2022 performance audit. The survey invitation was sent to **3,446 employees** who had valid email addresses as of April 28, 2025; **37 of the department's 3,483 employees** were excluded because no email address was listed in the staffing pattern. The survey remained open from **May 1 through May 13, 2025**, and **961 employees responded**, representing a **28% response rate**. **Figure 53** shows the survey questions and summary results. For the question that required a narrative response, to protect privacy, we did not include the full text of narrative responses because some contained personal or confidential information about case managers or the children they serve.

Figure 53: Department (DCS) Employee Survey Questions and Summary Results

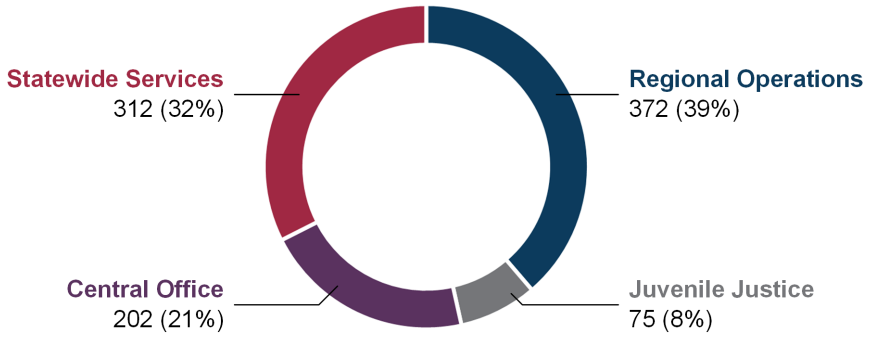
1. How long have you worked for DCS?



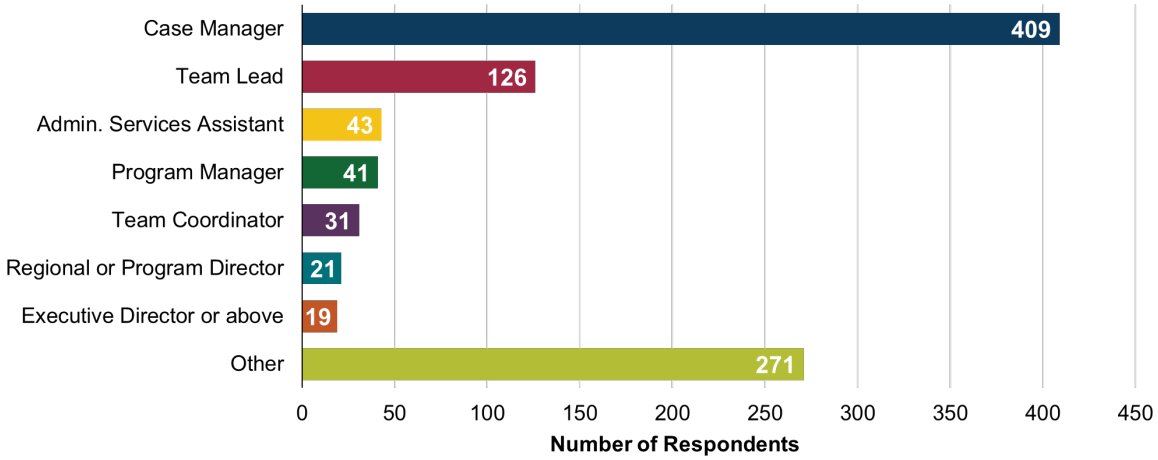
2. In what operational area do you currently work?



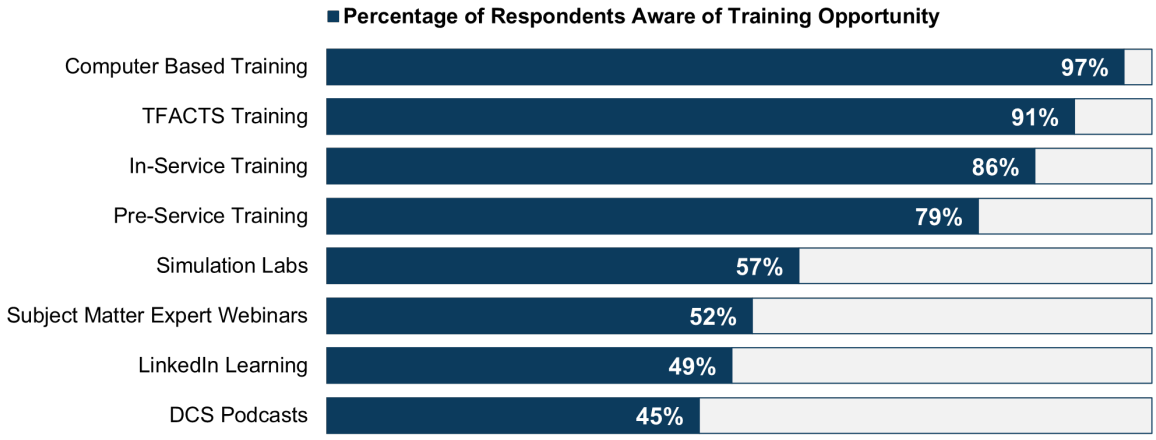
3. What program area are you currently assigned?



4. What is your current role?



5. I am aware of the following training opportunities. (Please check as many as apply.)



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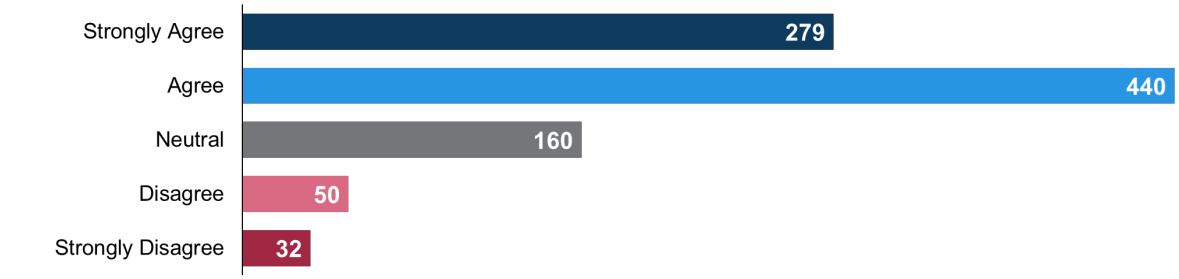
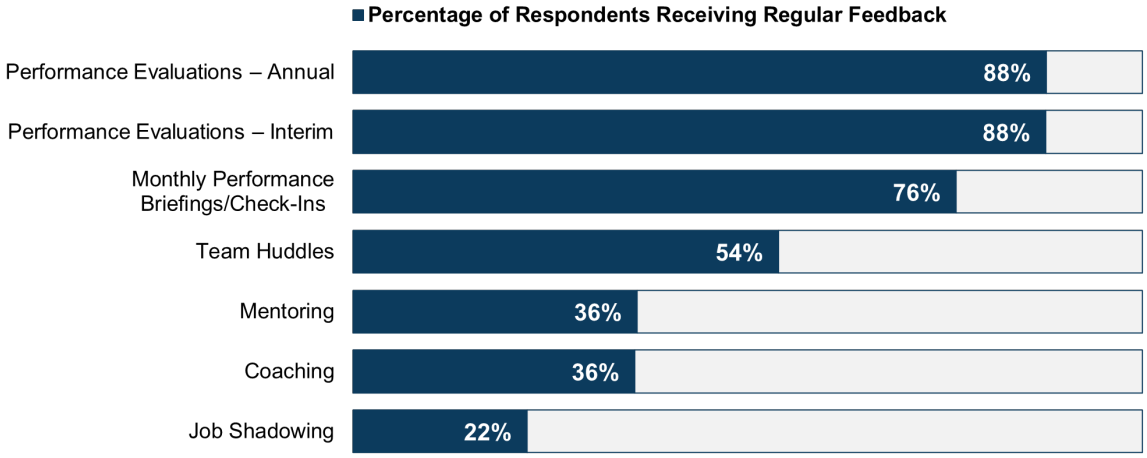
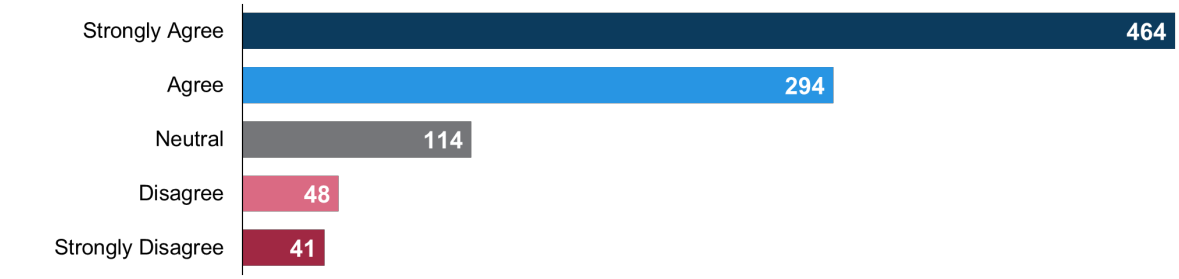
6. Since September 2022, I have been offered on-going training resources to improve my skills related to my job duties.



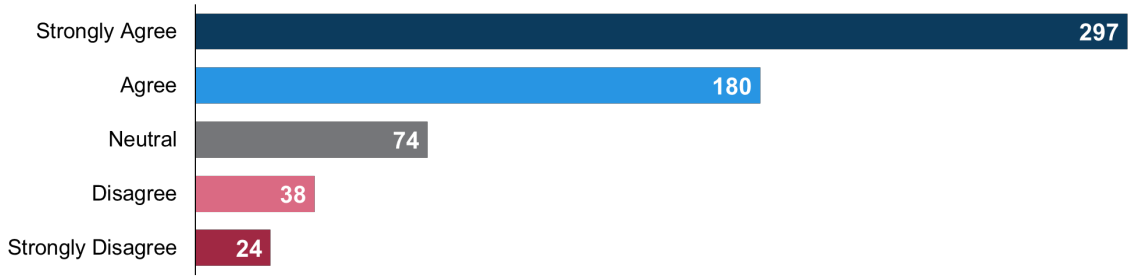
7. I have received regular feedback regarding my performance from my direct supervisor, including the following. (Please check as many as apply.)



8. I have received adequate support and feedback to perform my job duties from my direct supervisor.

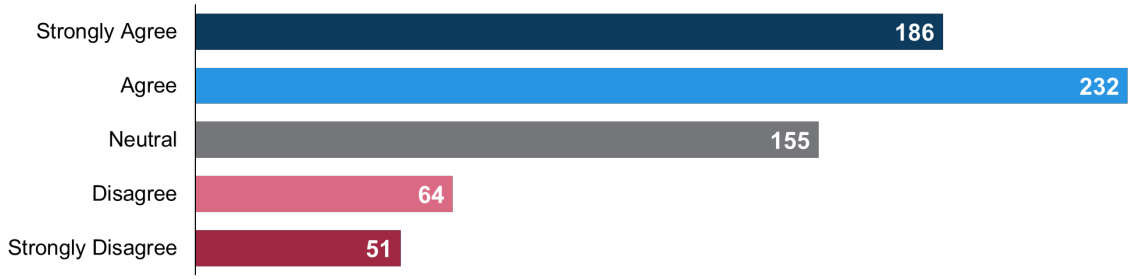


9. I have received adequate support and feedback to perform my job duties from my Team Lead.



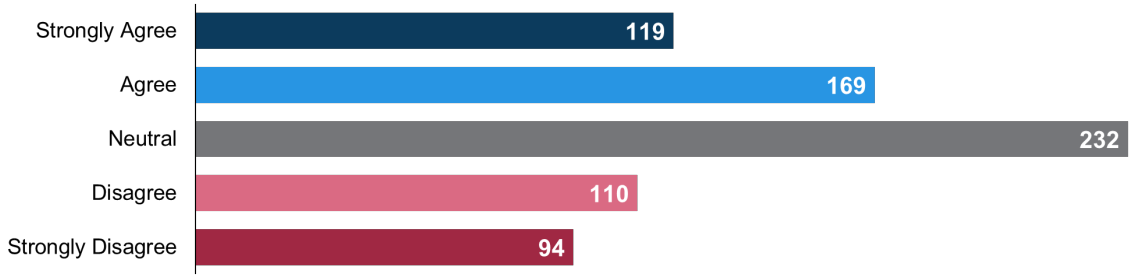
348 respondents selected "Not Applicable – My position does not report to a Team Lead."

10. I have received adequate support and feedback to perform my job duties from my Team Coordinator.



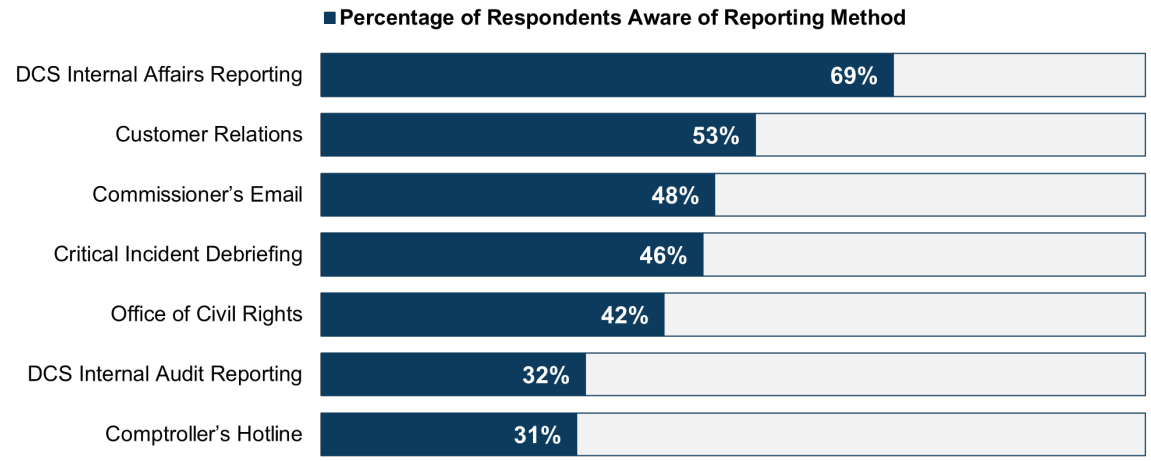
273 respondents selected "Not Applicable – My position does not report to a Team Coordinator."

11. I have received adequate support and feedback to perform my job duties from my Regional Director.

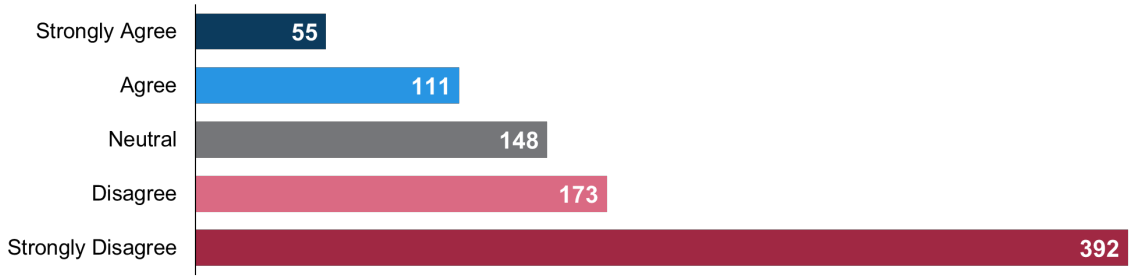


237 respondents selected "Not Applicable – My position does not report to a Regional Director."

12. I am aware of the following methods to escalate a concern. (Please check all that apply.)

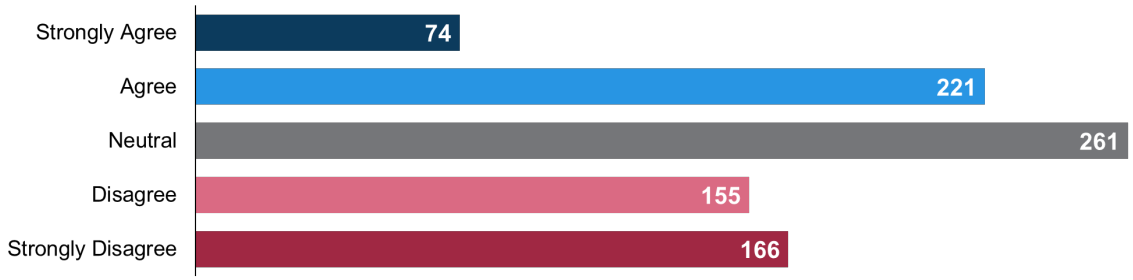


13. Since September 2022, I believe the department has made efforts to improve the work-life balance for staff.



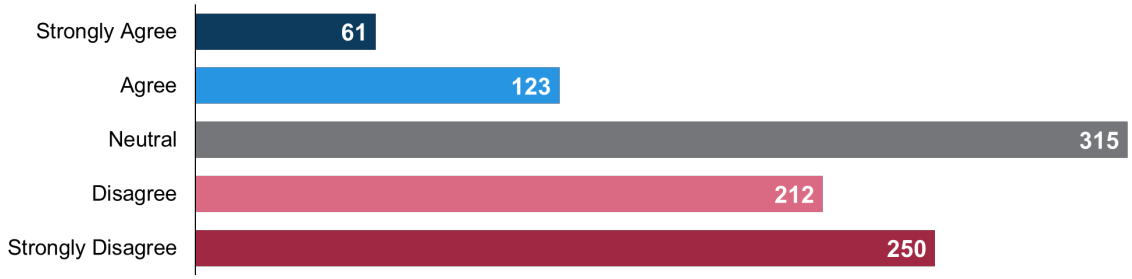
82 respondents selected "Not Applicable – I was not employed prior to September 2022."

14. Since September 2022, there have been changes in policies, processes, or initiatives that have positively impacted children and families.

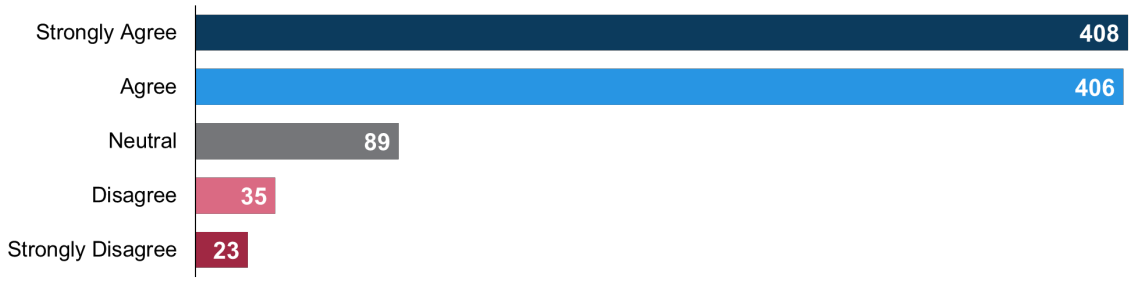


84 respondents selected "Not Applicable – I was not employed prior to September 2022."

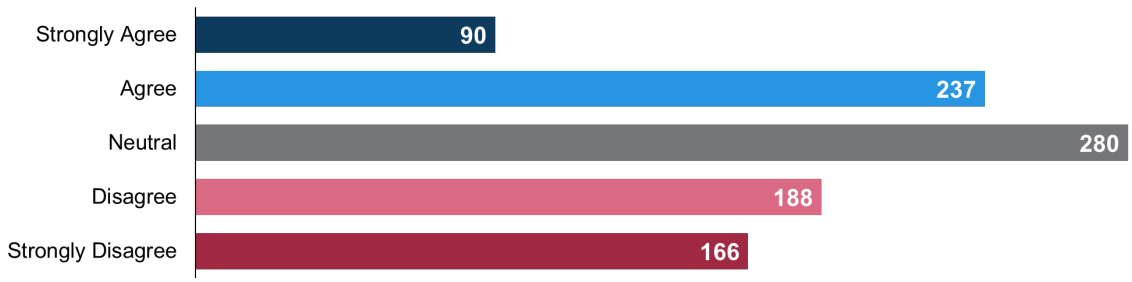
15. I believe the reorganization will improve the overall efficiency of DCS.



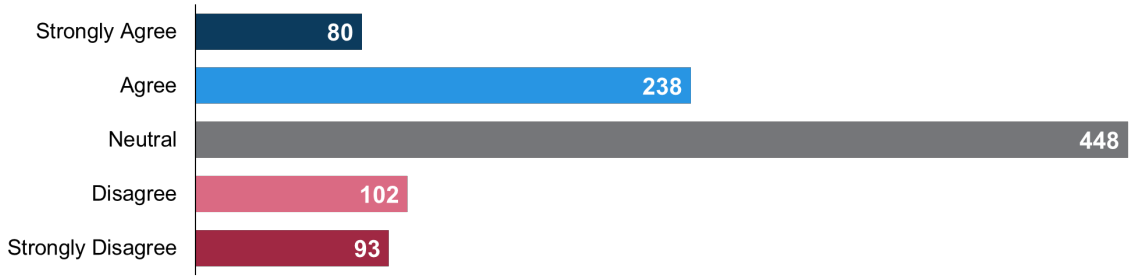
16. I understand how my current job assignment positively impacts children and families in Tennessee.



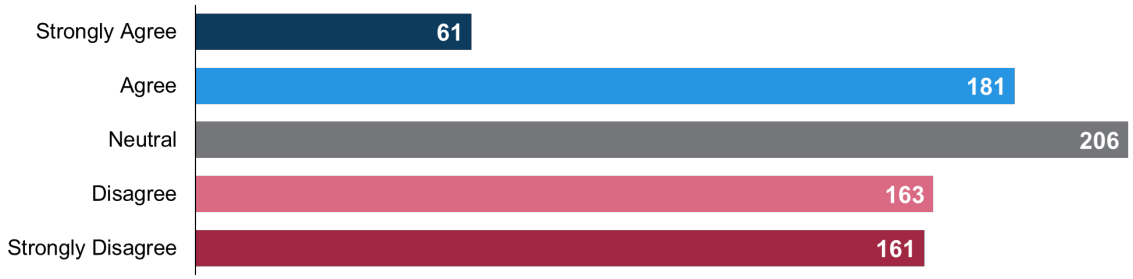
17. I believe DCS has implemented numerous measures to improve safety in the workplace.



18. I believe the DCS real estate plan will have a positive impact on the mission of DCS.



19. I was employed prior to September 2022, and I believe the department is generally on the right track for meeting the best interests of Tennessee's children and families.

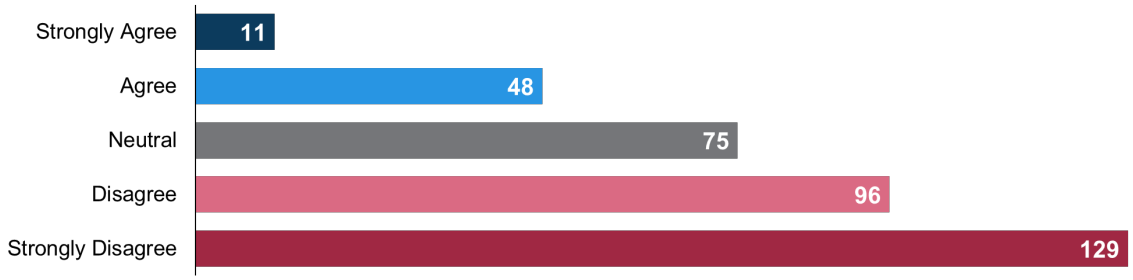


189 respondents selected "Not Applicable – I was not employed prior to September 2022."

20. I believe the current administration (senior executive leadership team) is accessible and transparent with DCS staff.

21. Are you a casefile-carrying personnel?

22. I have been employed since September 2022 and have noticed a reduction in the number of caseloads I actively carry. (*This question was presented to the 454 respondents who answered "Yes" to question 21.)*



95 respondents selected "Not Applicable – I was not employed prior to September 2022."

23. Did you feel pressured to answer this survey in any particular way?

Appendix 8: Temporary Placement Statistics

Figure 54: Number of Nights in Temporary Placement per Youth by Region
March Through September 2025

State Office Buildings					
Region	**Total Youth Served**	**Total Nights Stayed**	**Minimum Night Stay**	**Average Night Stay**	**Maximum Night Stay**
East*	-	-	-	-	-
Mid State	18	29	1	2	3
Mid West	12	84	1	7	15
Northeast	61	1,098	1	18	**104**
TN Valley	52	305	1	6	23
West	29	213	1	7	28
Total	**172**	**1,729**	**1**	**8**	**104**
Transitional Homes					
Region	**Total Youth Served**	**Total Nights Stayed**	**Minimum Night Stay**	**Average Night Stay**	**Maximum Night Stay**
East	240	2,851	1	12	72
Mid State	260	3,111	1	12	89
Mid West	113	1,334	1	12	81
Northeast	218	2,046	1	9	56
TN Valley	157	1,382	1	9	85
West	146	1,243	1	9	54
Total	**1,134**	**11,967**	**1**	**10.5**	**89**
Total – State Office Buildings and Transitional Homes Combined					
Region	**Total Youth Served**	**Total Nights Stayed**	**Minimum Night Stay**	**Average Night Stay**	**Maximum Night Stay**
East	240	2,851	1	12	72
Mid State	261	3,140	1	12	90
Mid West	119	1,418	1	12	81
Northeast	226	3,144	1	14	**160**
TN Valley	175	1,687	1	10	85
West	152	1,456	1	10	58
Total	**1,173**	**13,696**	1	**12**	**160**

* The East Region did not have any youth in office buildings noted during the period.
Source: Auditor analysis of regional transitional housing data spreadsheets covering March 10 to September 4, 2025 (except for Northeast Region: March 10 to September 5, 2025; and West Region: March 3 to September 4, 2025).

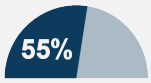
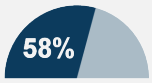
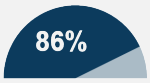
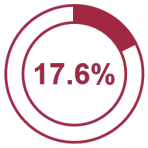
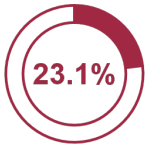
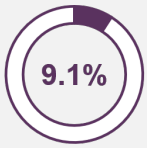
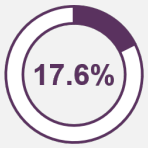
Figure 55: Number of Youth per Night by Region, March Through September 2025

State Office Buildings				
Region	**Total Nights with Youth Present**	**Minimum Youth per Night**	**Average Youth per Night**	**Maximum Youth per Night**
East*	-	-	-	-
Mid State	13	1	2	5
Mid West	29	1	3	8
Northeast	172	1	6	12
TN Valley	124	1	2	6
West	69	1	3	8
Transitional Homes				
Region	**Total Nights with Youth Present**	**Minimum Youth per Night**	**Average Youth per Night**	**Maximum Youth per Night**
East	179	3	16	32
Mid State	179	1	17	32
Mid West	146	2	9	16
Northeast	180	4	11	24
TN Valley	179	3	8	17
West	163	3	8	21
Total – State Office Buildings and Transitional Homes Combined				
Region	**Total Nights with Youth Present**	**Minimum Youth per Night**	**Average Youth per Night**	**Maximum Youth per Night**
East	179	3	16	32
Mid State	179	1	18	32
Mid West	146	1	10	16
Northeast	180	7	17	31
TN Valley	179	3	9	21
West	172	3	8	21

* The East Region did not have any youth in office buildings noted during the period.
Source: Auditor analysis of regional transitional housing data spreadsheets covering March 10 to September 4, 2025 (except for the Northeast Region: March 10 to September 5, 2025; and the West Region: March 3 to September 4, 2025).

Appendix 9: Case Manager Turnover Rates, Vacancy Rates, and Overtime Hours

Figure 56: Details for Turnover and Vacancy Rate, and Overtime Hours by Fiscal Year (FY), 2023 to 2025

Staffing Indicator	FY 2023	FY 2024	FY 2025
Number of Unique Case Manager Positions	2,819	2,796	2,430
% of Case Managers Working Overtime			
Total Overtime Hours Worked	383,719	349,073 ▼9%	385,808 ▲11%
Median Monthly Overtime Hours per Case Manager	14.8	13.4 ▼9%	12.1 ▼10%
Turnover Rate			
Vacancy Rate			

▼/▲ Decrease/increase from prior fiscal year

Source: Auditor analysis of case manager personnel data in Edison.

Appendix 10: Case Manager and Investigator Responsibilities

Based on discussions with department management, we included Case Manager 1 to 4 and Investigator 1 to 3 positions in our turnover, vacancy, and overtime analyses. We did not include Case Manager 4s in any calculations involving caseloads, as their maximum caseload is supposed to be 0.

Figure 57: Case Manager Responsibilities

Case Manager Series

The Case Manager series represents the department's general case management role, responsible for a broad range of case types across various areas of the department.

Areas Assigned

- ★ Social services
- ★ Special investigations
- ★ Placement in foster care
- ★ In-home service
- ★ Juvenile justice
- ★ Child safety
- ★ Family crisis intervention

Case Manager Hierarchy

Case Manager 1 Entry Level	Entry-level role focused on training with direct supervision. Requires pre-service certification, on-the-job training, and one year of service for promotion to Case Manager 2.
Case Manager 2 Professional Level	Performs case management duties of routine difficulty under general supervision.
Case Manager 3 Lead Level	Handles casework while providing training, guidance, and performance oversight to other case managers.
Case Manager 4 Supervisory Level	Oversees larger teams of case managers and focuses primarily on supervision, though may assist with casework as needed.

Source: Case manager job classification specifications provided by department management.

Figure 58: Investigator Responsibilities

Investigator Series

The Investigator series is a specialized case management track focused on assessing allegations of child abuse and other situations involving a child's immediate safety. Investigators collect evidence, collaborate with law enforcement, and testify in court on their findings. Investigators are limited to the same number of cases as the case manager series of positions.

Areas Assigned

- ★ Child Protective Services
- ★ Special Investigations Unit
- ★ Human Trafficking Team
- ★ Drug Team

Investigator Hierarchy

Investigator 1 Training Level	Entry-level role focused on investigative training under close supervision. Handles only the least complex cases while completing required training and gaining field experience.
Investigator 2 Professional Level	Performs investigative casework of considerable difficulty with moderate supervision.
Investigator 3 Lead Level	Manages complex investigations and provides guidance, mentorship, and case leadership to less experienced investigators.

Source: Investigator job classification specifications provided by department management.

Appendix 11: Juvenile Justice Probation and Aftercare Programs

Figure 59: Criteria to Support Observation 5

Condition	Criteria
The juvenile justice case worker did not make monthly contact with the child's school.	According to the department's Policy 13.12, "Probation Requirements for Delinquent Youth," "After the initial thirty (30) day period, the JPO [Juvenile Probation Officer] maintains contact with the youth, parents/legal custodians, and school officials/other collateral contacts as follows: . . . School Officials: A minimum of one (1) contact a month." In February 2025, the department revised the "Protocol for Juvenile Justice Non-Custodial Supervision Program", for school contacts to "A minimum of one (1) contact a month with school personnel if the youth's reason for supervision is due to school related issues, assessments determine the need for school contacts, or school contacts are ordered by the court." According to Policy 13.11, "Trial Home Visit and Aftercare Requirements for Delinquent Youth," "After the initial thirty (30) day THV [Trial Home Visit] period, the JSW [Juvenile Service Worker] maintains contact with the youth, parents/legal custodians, school officials and service provider as follows: . . . School Officials: a minimum of one (1) contact a month."
The juvenile justice case worker did not make monthly contact with the child's service providers.	According to the department's Policy 13.12, "After the initial thirty (30) day period, the JPO maintains contact with the youth, parents/legal custodians, and school officials/other collateral contacts as follows: . . . Service Provider: A minimum of one (1) contact a month." According to Policy 13.11, "After the initial thirty (30) day THV period, the JSW maintains contact with the youth, parents/legal custodians, school officials and service provider as follows: . . . Service Provider: a minimum of one (1) contact a month."
The juvenile justice case worker did not make at least 1 face-to-face visit with the child in the home each month.	According to the department's Policy 13.12, "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."

Condition	Criteria
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.	According to the department's Policy 13.12, "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 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."
The juvenile justice case worker did not perform the monthly face-to-face visits based on the child's level of supervision.	The department policy changed from the prior audit to the current audit, so we could not compare the 2022 results and the 2025 results. Department Policy effective during the 2022 performance audit, 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." Department Policy effective during the 2025 performance audit, Policy 13.12 requires that youth on Probation get 1 face-to-face visits and Intensive Probation get 3 face-to-face visits a month. Policy 13.11 states that, "depending on the type of aftercare, different face to face requirements need to be met: Aftercare: Monthly face-to-face visits. . . .Intensive Aftercare: 3 face-to-face visits a month."
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.	According to the department's Policy 13.12, "Probation – Parents/Legal Custodians: A minimum of one (1) contact a month . . . Intensive Probation – Parents/Legal Custodians: A minimum of two (2) contacts a month." Policy 13.11 states, "Aftercare- Parents/Legal Custodians: A minimum of one (1) contact a month. . . . Intensive Aftercare – Parents/Legal Custodians: A minimum of two (2) contacts a month."